Workers, Citizens, and Health Policy:
A Gendered Political and Economic History of Social Citizenship in ex-British Colonies, with a Focus on Ghana and India

A thesis submitted in fulfilment of the academic requirements for the degree

of

Doctor of Philosophy

in

The School of the Built Environment and Development Studies
University of KwaZulu-Natal

By

Laura Corrigall Alfers

Student Number: 210507026

March 2015

Abstract

This is a study about citizen's entitlements to healthcare, how these have been defined, how and why these definitions have shifted over time, and what implications they have for future health provision in countries outside of the Global North. It focuses on two countries, Ghana and India, which were a part of the British Empire, and on key international organisations, exploring changes that occurred during the colonial and post-colonial period, and using these to shed light on shifts in the terms of inclusion that are currently occurring within the rejuvenated drive towards Universal Health Coverage (UHC). A driving motivation for this work is the need to make sense of these present day changes, particularly those that revolve around the need to include informal workers – workers who work in unconventional places of work, either as self-employed operators and/or with blurred employment relationships – into health provisions. UHC is a term that arose out of the social democratic era, when health became a right of social citizenship. Yet within this model a tension always existed between entitlements to health based on status as a citizen, and entitlements based on status as a worker. Due to their unconventional nature, informal workers present complex difficulties for the extension of UHC within the social democratic tradition. This thesis aims to draw out and explore these difficulties, looking at both the "top-down" politics of health policy making, and the "bottom-up" struggles of informal worker organisations as they engage with these policies. In doing so it explores the tension between a model of the good society that was developed and worked well in a particular context (post-World War Two Britain), and the difficulties and questions that arise in the translation of that model to the very different contexts of Ghana and India.

Theoretically, the study draws largely on Marxist theory, in particular using the Gramscian international political economy model developed by Robert Cox. It is also inspired by Frederick Cooper's work *Decolonization and African Society: The Labor Question in French and British Africa* (1996), which argues that the roots of modern day social policy in Africa lie in the decolonization and post-colonial periods. Methodologically, the nexus of inclusion/exclusion is explored in this study using two concepts which have underpinned inclusion into modern forms of health provision: that of "the worker" and that of "the citizen." The inclusion of both the person-as-worker and the person-as-citizen is not a common feature in the analysis of health policy and provision, but it is the central contention of this thesis that keeping the relationship between the two in view over a period of time allows for important insights to emerge into past and contemporary health policy which are otherwise lost or made obscure. This includes seeing questions of public health in relation to occupational health, a health discipline which has been criticised for its narrow, Northern orientation, and often ignored within the health and development literature. Looking at them in parallel clearly brings into view questions about the responsibility of capital towards the social good. This relational focus is the original contribution to knowledge of this study, and a contribution to the call by Mackintosh and Tibandebage (2004) to add analytical depth to the study of health policy and provision in the developing world. This method has an additional nuance laid over it, through a gendered and contextualised analysis of the worker. Gender analysis here is used as a lens through which to explore the specific context of workers in India and Ghana. Primary data was drawn largely from archival sources, as well as key informant interviews and project notes.

The thesis concludes that it is damaging to the idea of social citizenship to advocate for universal state provision without regard for questions about the responsibility of capital, employment dynamics, and the specificity of social and economic context. It argues that the international organisations – particularly the International Labour Organization (ILO) and the World Health Organization (WHO) – have a potentially constructive role to play in thinking through forms of social citizenship which do take the above considerations into account. However this is circumscribed both by their rootedness in the post-World War Two social democratic model, and by the tensions which exist between the two organisations, which embody the tensions between the state-citizen relationship and the state-employer-worker relationship within this model. It argues that the relationship between the two organisations has reproduced this tension in a manner which has negative implications in the present moment.

Preface

The work described in this thesis was carried out in the School of the Built Environment and Development Studies, University of KwaZulu-Natal, Durban, from February 2010 until February 2015 under the supervision of Professor Bill Freund and Professor Francie Lund.

This study represents an original piece of work by the author and has not otherwise been submitted in any form for any degree or diploma at any tertiary institution. Where use has been made of the work of others this is duly acknowledged in the text.

Declaration - Plagiarism

I, Laura Corrigall Alfers, declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.

2. This thesis has not been submitted for any degree or examination at any other university.

3. This thesis does not contain other persons' data, pictures, graphs, or other information, unless specifically acknowledged as being sourced from other persons.

4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:

    a. Their words have been rewritten but the general information attributed to them is referenced.
    b. Where their exact words have been used, then their writing has been placed in italics and inside quotation marks, and referenced.

5. This thesis does not contain text, graphics, or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the References section.

Signed:

Acknowledgements

In writing this thesis, I have been supervised by Professor Bill Freund and Professor Francie Lund, who have both been a great support to me. I feel very lucky to have worked with two such excellent academics and supervisors. This thesis is rooted in Francie's own work, and it owes a substantial intellectual debt to her. It took me at least two years to really understand what this study was about, but Francie knew all along, and guided me through the process of discovery in a way that allowed me to make it my own. Bill's extensive knowledge of colonial history (particularly in Africa), and international political economy provided me with a very solid foundation on which to build my arguments. His concise and precise critiques of my chapters, and the thesis as a whole, have always got to the nub of the matter and, like all good critiques, have been illuminating as well as critical.

I would also like to thank the Ford Foundation for the award of a PhD scholarship which covered the first three years of my studies, and to the staff of the School of Development Studies (later the School of the Built Environment and Development Studies) who facilitated this scholarship and my enjoyable stay at UKZN. My thanks go as well to my colleagues at Women in Informal Employment: Globalizing and Organizing (WIEGO). Without the experiences gained through my work for WIEGO over the last five years, I can safely say that this thesis would never have been written. Thanks must also go to the worker representatives from StreetNet International, the StreetNet Ghana Alliance, the Ghana Trades Union Congress, the Self Employed Women's Association, and the Kagad Kach Patra Kashtakari Panchayat, as well as other key informants, who gave up their time to speak to me, and whose struggles, thoughts and ideas have been so central in shaping the direction of this work.

Finally, I would like to thank my family: Joe, Helen, Duncan, Hayley, Julian, and Benji, who have looked after me so well during what was without a doubt one of the most trying periods of my life, and whose humorous take on the world meant that I could never lose perspective on life entirely. Julian especially, thank you for all the wonderful meals which kept my brain ticking over.

Table of Contents

Chapter One: Introduction

After the devastation of two world wars, the Spanish Influenza, and the Great Depression of the interwar years, the world's industrialised countries embarked on the institutionalisation of what has come to be known as the welfare state – a state which guaranteed its citizens certain basic services such as health care, social security, education, and housing. This was not a sudden development – welfare policies had been in place in Germany since Bismarck introduced social insurance in the 1880s. In Britain, which is the focus of this study because of its colonial history, state-based welfare policies and services had been in existence since the turn of the 20th century. It was only after World War Two, however, that these policies were systematised and institutionalised in the form of the welfare state. The emergence of the welfare state reconfigured the relationship between the state and its citizens, from one which was based on political and civil rights to one that included what T.H. Marshall (1965) famously called "social citizenship" – a state guarantee of the basics for an individual to lead a decent life. Marshall saw this third aspect of citizenship as both a development arising from the extension of civil and political rights, as well as a prerequisite for citizens to be enabled to participate in those rights.

These social democratic ideas did not stay confined to the industrialised world. The great colonial powers of Europe, Britain, and France, influenced by a complex array of factors from economic and political considerations to the need to rein in increasingly unstable empire, transported (in a very limited fashion) these ideas to their colonies. In the British colonies, health services targeted at certain groups of colonial subjects (mainly workers and urban populations) had developed from the turn of the 20th century in both Asia and Africa, largely out of a concern to increase the productivity of workers and protect the health of Europeans. Between 1930 and 1950, however, there was a noticeably more concerted effort to institutionalise these services as the Empire became increasingly unstable. Frederick Cooper (1996), in his book *Decolonization and African Society: The Labour Question in French and British Africa,* argues that the emphasis placed on social and labour policies during this period by the British colonial establishment was part of its attempt to create stability through the development of a respectable working class. What the administration did not expect, however, was that African workers would take the new language of social rights and use it to push for universal rights – ones that extended beyond the very small working class. This forced a contradiction between Britain's need to profit from colonialism and the need to spend on social services for colonial subjects. It was a contradiction which Cooper (1996) argues led ultimately to decolonisation.

Cooper argues that this process of engagement between colonial administrators, African workers, and international organisations like the International Labour Organisation (ILO) was to create a particular system of entitlements, one which still influences the trajectory of labour and social policies in ex-colonial contexts. Indeed, over the fifty years since the major period of decolonisation in the 1960s, the British colonial heritage in terms of the design of welfare apparatus is obvious in countries as diverse as India and Tanzania.

Yet the frameworks, ideas, and processes instituted by colonial powers, and engaged with by colonial workers, came to take root in a very different context from that in which they originally developed. The reality of life in places like India and West Africa did not fit into the institutional frameworks which had been developed in a European context. At the same time, however, social democracy and ideas of social citizenship inspired liberation movements in colonised countries and came to be seen as a model for such countries to aspire. This set up the basic tension with which this study is concerned – that between a model of the good society that was developed and worked well in a particular context (although is now even coming into question in the present day), and the difficulties and questions that arise in the translation of that model to a very different context. Here, the concepts of inclusion and exclusion are central because they help answer a basic question of political economy: Who benefits from social change and why? Whilst in Britain, the welfare state meant that all citizens had access to social services, but in the colonies this access was only extended to a limited number – the "terms of inclusion" were bounded (Cooper, 1996). It is these contradictions and tensions that have arisen in the struggle for universal inclusion outside of the industrialised world, as well as a contextually appropriate inclusion, that sit at the core of this study.

Adopting an historical approach, this study uses the development of health policies and services in Britain and two of its old colonies, India and Ghana (Gold Coast), to explore these tensions. It does this by looking at how the terms of inclusion into health policies and services have been defined, how these definitions have related to the dominant power structures of the time, how and why these definitions have shifted over time, and what implications these shifts have for future health provision in countries outside of the Global North. In this way it is primarily a study in policy discourse, rather than a study of how policy plays out on the ground.

In exploring the nexus of inclusion/exclusion, this study uses two concepts which have underpinned inclusion into modern forms of health provision: that of "the worker" and that of "the citizen." The

inclusion of both the “the worker” and “the citizen” as a focus in this analysis is not a common feature in the analysis of health policy and provision (historical or otherwise). The academic health literature especially that which applies to the developing world, has focused largely on either the worker *or* the citizen. Here, academic scholarship has tended to follow the emphasis of policy itself. For example, studies of and references to the health of workers are common within the literature on colonial health service provision (Freund, 1981; Crisp, 1984; Dumett, 1993; Hewa, 1995; Behal, 2006), following the emphasis that colonial governments placed on health services as a way in which to ensure the efficiency of labour. Once health care became a right of citizenship after independence, a right guaranteed by the state, citizenship became the basis on which to evaluate health policy. The place of the worker and of the employment relationship in these discussions has been muted, if not totally absent.

What this focus on citizenship alone often obscures, though, is the fact that social provision during Marshall’s time was built on specific assumptions about the labour market and employment (Lund, 2009). The Beveridge Report, commissioned in 1941 by the British government and published in 1942, laid the basis for Britain’s post-war social security scheme and greatly influenced the nature of social provision in Britain’s colonies. Underlying Beveridge’s model was an assumption about the labour regime which continues to inform the making of present day social policies, that is the wide availability of formal employment. Glennerster and Evans (1994: 58) state:

> *At the heart of Beveridge's thinking was a contradictory struggle between his deep desire to cover everything and everyone without a means test and his choice of method, contributory insurance through employment. He wished to give security to all, but to base this security, apart from family allowances on participation in the labour market.*

Social security in Britain was accessed through employment, with a much smaller amount set aside for providing social assistance to those who, for various reasons, could not find work. Employment was central to citizenship.

Admittedly, British health institutions did operate differently. The post-World War Two National Health Service, funded through general taxation, was a free service to all regardless of employment status. However, even then the provision of universally free health care was only possible because of the large tax base on which it was built, which in turn relied on the fact that most men would be employed and able to take care of their household. More directly connected to employment was the other European model of health care provision – the Bismarckian social insurance model, funded through payroll taxes and employer contributions. Both of these European models of health care provision have profoundly influenced the development of health policy in the developing world since

the period of widespread decolonisation during the 1950s and 1960s, and continue to do so. Yet the labour market context into which these models were inserted was a very different one from that in which they originated, and here arises the central problem which this thesis seeks to explore.

The employment relationship on which the welfare states of Europe were built was one where employer-employee relationships were clearly defined and relatively easy to regulate. In the developing world employment has always been structured differently and continues to be so. As the early chapters of this thesis will show, what has now come to be called informal employment has in fact been the dominant form of employment for large numbers of workers, particularly women workers, in the Global South. Informal employment is characterised by low earnings, high levels of self-employment, and blurred employment relationships (Chen, 2012a). It is made up of "unconventional" employment sectors like self-employed agricultural work, market trading, street vending, home based piece rate work, and waste picking. This has important implications for social provision and the terms in which people are able to access their social rights. It poses a conceptual challenge to the frameworks exported from Europe. Informal workers cannot be taxed in the same way that formal workers can be taxed, and it is often difficult to identify employers through whom social protections can be acquired by workers. Large numbers of informal workers therefore challenge the relationship between citizenship and employment, and it is with this point that those who influence the making of policy in developing countries have had to grapple.

Of course for many years economic and social policies in many developing countries chose not to deal with this issue at all. The modernist, industrialist outlook of the post-independence period produced the predominant view that the informal economy was a temporary phase through which developing countries would have to pass on their way to industrialisation and modernised economies. It was seen as the "traditional sector" which would, with time, be absorbed by the modern one (Bangasser, 2000; Breman, 2003). Those who earned their living in the informal economy were largely ignored by politicians and bureaucrats whose ideas were informed by this modernist vision. When they were not being ignored, they were actively discriminated against (Robertson, 1983). This began to change after the economic crises of the late 1970s. The social, political, and economic adjustments that ensued allowed a new understanding of the informal economy to emerge, one which increasingly accepted the fact that the informal economy was not a transient phenomenon, and, under the influence of globalisation, was in fact increasing in size rather than decreasing (Chen, 2012a). This in turn has placed pressure on governments to consider ways in which workers in the informal economy can be included in social programmes; the key question is

how to adapt policies and institutions to a very different labour regime from that in which such policies originally developed.

In terms of health specifically, the result of this re-thinking has led to a number of "institutional innovations." This has been the case both for occupational health – the discipline and practice concerned with workplace health and safety – and for the general provision of health services to citizens. In Brazil and Thailand there are moves to integrate occupational health services for informal workers into basic primary health care, as a way in which to circumvent the more narrow focus of labour departments on formal labour and workplace regulation alone (Santana et al., 2011; Alfers and Lund, 2012). There have also been attempts to devise ways to include informal workers in social health insurance schemes, the Ghana National Health Insurance Scheme being one of the better known examples (Alfers, 2013). There are therefore interesting processes of institutional reform taking place in social policy circles around the world, and a policy-oriented academic literature has developed around this process (Barten et al., 1996; Loewenson, 1998; Lund and Srinivas, 2000; Barrientos and Ware Barrientos, 2002; Alfers, 2013; London, nd).

As with any process of reform there are political and economic interests which underpin certain moves that are made and positions that are adopted. Whilst gains may be made for some through these reforms, others might lose out. Evaluating who gains what and why is the classic question of political economy, one which aims to "make sense" of what happens when such moves are made by particular interest groups (Bakker, 2007). Yet much of the current literature on the policy reforms that are happening around the informal economy lacks a solid evaluation of the political economy of reform. This is particularly so in the health literature, which tends to be dominated by economists and medical professionals rather than historians and political scientists. Moreover, it tends to be located firmly in the present, and leaves little space for examination of the historical processes that have led up to the present institutional configurations. Yet, as Bakker (2007: 541) has argued, adopting an historical approach can deepen our understanding of institutional reform, by making "sense of the changing ontology of the global political economy" out of which it has arisen.

This thesis then aims to contribute to the emerging literature on health reform and informal employment. It is based on the assumption that in order to properly make sense of the institutional reforms that are currently happening, we first have to look at the past. Only in this way is it possible to get a fuller picture of what is being gained and by whom, and what is being lost and by whom. Furthermore, it takes the position that this understanding must be informed by considering the

changing position of the worker in relation to the citizen within health policy. As discussed above, the citizen as worker has been integral to the development of social policy in its post-World War Two form, and therefore in the spread of such policies to the developing world. The changes that are happening now are largely informed, at least implicitly, by the fact that this relationship is being reconfigured by global political and economic processes. Understanding the shifts that have occurred in the relationship between people's status as workers and their status as citizens is therefore central to understanding the current conjuncture.

Time and Place

Before moving onto a review of existing literature, it is necessary to clarify the time and place in which the thesis is situated. The two issues are linked, and it is perhaps most appropriate to start with the geographical places on which the thesis focuses, as this simultaneously provides justification for the timeframes that have been chosen. Geographical location operates on a number of levels within this work. On one level, the focus is on policy making and institution building processes that occur on a level that transcends the national – at first on the dynamics of the British Empire, and later on the dynamics of the post-war international institutions, in particular the World Health Organisation (WHO), the International Labour Organisation (ILO), and, at a later stage, the World Bank. This broad perspective conflicts somewhat with a current consensus that specificity is important – that one cannot paint the experiences of the entire Global South in one shade, and that politics plays out in very different ways in different contexts, even within the British Empire itself (Eckert, 2004). It is certainly difficult to disagree with this argument. Yet, at the same time it became clear when searching through colonial documents in particular that there were very obvious patterns that emerged across colonies in terms of the framing of health policies and practices – policies influenced by Empire-wide processes and ideas. Cooper (1996: xii) was prompted by a similar realisation to broaden his study of labour strikes in Mombasa to an Africa-wide (including French Africa) study of labour when he "became convinced that Mombasa could not be understood simply by studying Mombasa. British rulers could easily have dealt with this city by other means had officials not been thinking in terms of the entire empire."

Likewise within health policy specifically, whilst it is true that in different colonies different personalities and attitudes might have led to variation (for example the progressive Governor of the Gold Coast between 1919 and 1928, Sir Gordon Guggisberg, ensured that this relatively prosperous colony was well resourced in terms of social services), the framing of "the possible" was indeed empire wide in scope. This is reflected in the institutional make up of social and labour policies across the Commonwealth, which often show a remarkably similar structure, closely linked to their

colonial heritage. Ahuja (2007) refers to these state institutions as the institutional "ligaments that helped make the Empire a thinkable whole." These ligaments bring countries which may have little in common socially, economically, or culturally, into a relationship with one another. They have also inspired interesting trans-territorial comparative studies such as that edited by Hay and Craven (2004) which examines the workings of Master and Servant laws from the 1500s when it was first implemented in England, to its final form as colonial legislation abolished as late as the 1960s.

This internationalised approach extends into the analysis of the post-colonial period in Chapters Four and Five, which concentrate on the international organisations attached to the United Nations – the WHO and the ILO. As already mentioned in the literature review, health policy in particular has been a highly internationalised field since the post-war period. Amrith (2006), for example, began his study of post-colonial health interventions as a study of India specifically, but found that the ideas which ultimately informed what happened in India were so closely tied to international processes and connections that he was forced to broaden his study to a pan-Asian focus. An interesting point here is that these international organisations were themselves influenced by colonial thought. Many of the colonial officials involved in the last days of the empire went on to act as consultants for the UN organisations, reinforcing, under the guise of development, what colonial administrations had started, but also coming into contact with specialists from the USA with different ideas that brought to the fore underlying conflicts that are discussed further in Chapter Five.

Yet the fact cannot be escaped that empire wide or international policies had to play themselves out in particular national contexts, with all the added complexity that this entails. For this reason, this thesis shifts between a focus on broader international concerns, and on the ways in which these play out in the arena of national politics in two countries: India and Ghana (formerly the Gold Coast). In doing so, it again follows the lead of Cooper (1996: xii), who states that:

> *The risk of any study this broad is that the variety of contexts which both shape and were shaped by colonial regimes disappears into empty acknowledgements of variation and complexity. I have tried to confront this problem by frequent changes of focus moving from the Ivory Coast in the days of the forced labour debates on francophone African to Dakar when taming urban strikers became the issue, to Mombasa or the Copperbelt to talk about stabilisation, to the Gold Coast to look at the relief with which British officials greeted Nkrumah's efforts to discipline the Gold Coast labour movement.*

The tension that must be preserved is between painting such broad strokes that variation is whitewashed, and focusing in so much on variation that the wider picture is lost.

India and Ghana have been chosen for a number of specific reasons. Firstly, they are of course both different and similar to one another, and because of this they are able to both represent the divergence of national experience and the similarities. India was the first and largest colony of the British Empire, with the establishment of the Raj in 1858. It was also the most industrialised, and therefore had the most developed industrial health system of all of Britain's colonies by the late colonial period. It was where the British began their experiments in setting up colonial administration, experiments which, as Chapter Two will show, informed the development of state institutions in Britain's African colonies. If the intention is to look at the development of empire-wide ideas, then India is a logical starting point. The choice of India as a location also helps to determine the start date of the thesis: the first work-related health policies in the British Empire were implemented in the 1860s in India, and it is this date that is therefore taken as the starting point. Ghana, on the other hand, was and is a much smaller country than India, and it became a British colony much later – it was consolidated as a colony only in 1901. Needless to say, was and is very different culturally from India. The colonial economy focused largely on gold mining and indigenous cocoa production. Although attempts were made to industrialise under Nkrumah, ultimately the country has remained locked into an economy based on primary production.

Nevertheless, the two countries have some important things in common. Their state institutional frameworks for health provision, particularly workers' health, are very similar, emphasising the fact that the colonial ligaments tied together these very different places. Although Ghana was small and relatively non-industrialised, it was the jewel in the West African crown, and its institutional infrastructure was relatively advanced by African standards. Furthermore, both countries have, and have always had, a large population of workers (particularly women) who operated and continue to operate outside of labour legislation – workers who today are called informal workers. In both Ghana and India, the figures for informal employment sit between 80 and 90 percent of the working population. The point of the thesis is to interrogate how the recognition of this informality has impacted on the place of the worker in relation to the citizen within health policy, and it is thus important to look at countries with high levels of informality.

There is also a very practical reason for choosing these countries. As mentioned in the literature review, histories of public health in the Global South abound during the colonial period, but are much sparser when it comes to the post-colonial period. When it comes to occupational health, almost nothing has been written in relation to the Global South. There are very real constraints which have contributed to this. To write the internationalised history of public health in the post-

colonial world (as Amrith, 2006 discovered) requires visiting numerous archives – from the World Health Organisation in Geneva, to the Rockefeller Foundation in New York, to the Wellcome Trust Archive in London. When it comes to occupational health, there is the added problem of a dearth of documentary evidence. Occupational health is a neglected topic in the Global South, and the archival material reflects this. This thesis has pieced together fragments of the documentation that is available from nine different archives located in London, Cambridge, Oxford, Warwick, Geneva, and Accra. In this context it has been necessary to focus on what is available, and here both Ghana and India reveal themselves as fortunate choices. If India was the original "pathogenic heart of darkness" as Amrith (2006) contends, the Gold Coast, once known as "the white man's graveyard" was equally so. Both countries attracted the attention of the colonial medical services, and fortunately much of this documentary heritage survives in the Indian Office Records at the British Library in London, the Colonial Office Records at Kew Gardens, and in the documents at the National Archive of Ghana in Accra. Where necessary, examples from other countries – particularly those in East and Southern Africa – have been drawn on where relevant.

Writing about Health and Labour: Past and Present

By focusing on the shifting relationship between the worker and the citizen in health policy and provision, this thesis sits at an intersection of the existing scholarship on the history of health and labour history. The following section provides a review of literature drawn from both of these academic disciplines in order to ground the thesis in its intellectual precursors and to point out the gaps that it aims to fill. The provision of health services, the policies on which this provision has been built, and the politics which has informed and structured such policies, have all been analysed from a number of different perspectives. For the purposes of analysis, this review section will divide the health literature into three areas: colonial, post-colonial, and present day literature. Labour history is a similarly large field to tackle. This review will focus largely on the literature which relates to the health of labour, but will also examine some important work on labour and social policy more generally.

The Health Literature

Notable authors who have tackled the subject of health under British colonial administration include Maynard Swanson (1977), Shula Marks (1987, 2000), Randall Packard (1989a, 1989b, 1993), Meghan Vaughan (1991), Phillip Curtin (1992), and David Arnold (1993). Their work has covered a wide variety of health-related topics, ranging from a focus on particular diseases, to analyses of the constitution of medical knowledge within a colonial context, to the use of health policies and practices to enforce colonial discipline on the subjects of the British Empire. Although these authors

cannot be classed within a single theoretical tradition, there is a common thread which runs through the body of work: it is the idea that colonial medical knowledge, practices, and policies were produced by colonial power, and in turn, reproduced that power amongst colonial societies (Vaughan, 1991). The emphasis has therefore been on revealing and unravelling how seemingly apolitical scientific and technical institutions were in fact deeply entwined in the power relations of the British Empire.

Earlier works, particularly those by Marks, Packard, and De Beer (1984), used an overtly materialist, Marxist political economy in their approach, embedding their study of health within the wider framework of capitalist social relations. Andersson and Marks (1989) for example famously linked disease patterns in South Africa to the introduction of migrant waged mining labour, as did De Beer (1984). In a similar fashion, Packard's (1989) well known work *White Plague, Black Labour: Tuberculosis and The Political Economy of Health and Diseases in South Africa* linked the spread of tuberculosis amongst blacks in South Africa to the institution of migrant labour and showed how the interaction between competing interests – medical experts, the state, employers, workers, and their unions – influenced in very specific ways the development of health policies and practices around this disease. This type of analysis was no doubt a reflection of the intellectual context of the time, a period which also saw Lesley Doyal's (1979) seminal work *The Political Economy of Health* published. The wave of post-structuralist theory that overtook the humanities and social sciences during the late 1980s has influenced later work on colonial health. Vaughan (1991), Arnold (1993), and some of Packard's (1993) later work have all been influenced in particular by Foucauldian social theory, with its emphasis on discourse, "governmental" practices, and the ways in which these are implicated in the construction of colonial subjectivity. Vaughan (1991) takes issue with Foucault's theory of governmentality being transferred unquestioningly to the colonial context, but nevertheless adapts it to argue that colonial medical practices, and the discourses which arose from them, were able to constitute Africans as the objects, rather than the subjects, of colonial rule.

Over the years then a rich literature around colonial health and medicine has been built up. An important characteristic of the political economy literature is that colonial subjects *as workers* are very much present. This is not the case for the more recent Foucauldian work. A Foucauldian perspective does not in itself necessarily preclude a focus on workers, who were themselves subjects of governmental "technologies of rule," as both Cooper (1996) and Packard (1993) have shown so well. Nevertheless, the "cultural turn" in which the Foucauldian work tends to be embedded has meant a much greater focus has been placed on issues of race and gender, and the focus perhaps

does not fall so naturally on to workers as it does within the Marxist political economy literature. Yet it is clear from the earlier political economy literature, as well as lesser known scholarship, such as that by Patterson (1981) and Addae (1996), that the worker was very much a central concern of colonial health policy.

Citizenship, in the sense of rights being extended to colonial subjects, was not part of British colonial rule, as it nominally was under France. Nevertheless according to Cooper (1996), something akin to a "limited version of universal citizenship" was envisaged for African subjects during the last years of the British Empire. As Chapter Two will show, in terms of health care specifically, the process of extending services to colonial subjects occurred much earlier than other aspects of social policy. This can be seen as a reversal of T.H Marshall's view of how citizenship rights progress – starting with political and civil rights and ultimately culminating in social rights of citizenship. In the colonies it was in fact social provision which preceded political and civil rights (Lund, 2012a). Yet this social provision was very limited. Health programmes were aimed at certain groups which were deemed important to the productivity of the British Empire: workers, and mothers and their children, who were the future workers of the Empire (Allman, 1994; Cooper, 1996; Amrith, 2006). In the colonies, as in the metropole, the worker was synonymous with the (proto) citizen. However, the terms of inclusion were set so that it was only a limited number of workers, working in very specific occupations (largely those who worked for the state or for large colonial enterprises), who qualified for these protections. There was an important gendered aspect to this. "Jobs that came under formal regulation were coded masculine, while the kinds of things women did were more often labelled 'customary labour' or the 'informal economy,' with all the insecurities and vulnerabilities that such a status implied" (Cooper, 1996: 2).

In *Decolonization and African Society* (1996), Cooper argues that it was these changes that occurred during the late colonial and decolonisation period that have had a profound effect on the shape of social policy in Africa today. He criticises prominent post-colonial Africanist scholars such as Mahmood Mamdani of "leapfrogging" this period in their work on institutionalised colonial legacies, which he claims narrows the analysis in important ways. In particular, he argues, it obscures the central place of the worker in colonial social policy. The problem with the literature on colonial health from the perspective of this thesis is similar to the problem Cooper (1996) has identified for social policy more generally. As Anderson (1993) has pointed out, the literature on colonial health tends to take its endpoint as the point when colonialism itself ends. There is a lot of attention paid to the 1930s and 1940s, when health rose to real prominence in British colonial social policy. Marks

(2000), for example, concentrates on the shift to social medicine that occurred during the 1930s and 1940s in South Africa. Vaughan (1991) focuses largely on the 1920s to the 1940s, although she does make reference to the 1950s. Patterson (1981) works up to 1955, Arnold (1993), writing of India where health interventions began much earlier than in the African colonies, concentrates on the years between 1880 and 1914.

There are some exceptions to this. Warwick Anderson (2006) for example agrees with Cooper that the late colonial and decolonisation period is important, and so looks at the way health was used as a modernising force in American colonial policy in the Philippines during this time. Anderson's focus is, however, largely on the way in which race and hygiene became intertwined within this colonial project, paying no attention to workers. Packard's (1989) work is another exception. It traces the history of tuberculosis in South Africa from the 19th century to the 1980s, and in so doing avoids the leapfrogging about which Cooper (1996) warns. Moreover, it has a very distinct focus on workers, and therefore sets a useful precedent for this thesis. There are however still gaps. Firstly, it gives a very specific exploration of the path of a particular disease, rather than a more general analysis of health policy (although it certainly adds to such an analysis). Secondly, Packard explicitly excludes any discussion of occupational health (Packard, 1987). The problem that this sets up will be discussed later in this section when it turns to a review of the literature on health and labour history.

Packard aside, the limited timescale of the colonial health literature means that important tensions which are central to understanding the shifts within health policy today have been left unexamined. The worker might be visible within colonial health policy, but the tensions involved in moving away from a system which prioritised the needs of workers (and future workers), to a system which was ostensibly based on the idea of universal social citizenship is not seen. As Cooper (1996) argues, the conditions of this shift were set up during the late colonial period, but the implications and tensions continued to play themselves out well into the post-independence period. Similar tensions were of course present in Britain as it moved towards its post-war welfare state. In its former colonies, however, the context into which the idea of universal citizenship was inserted were very different. In these countries full employment in formal enterprises, which could be regulated and taxed, was a dream rather than a reality. This had important implications for health policy. The idea of universally free access to health care for all citizens sat in tension with the reality of low tax bases and a concomitant reliance on large, formal industries to provide health services for their workers and the families of workers. The ideal of free health care for all was met by the reality that workers in formal industries were most likely to receive adequate access to health services.

It is perhaps not surprising that the colonial health literature has addressed this tension. By and large, colonial health literature focuses on the colonial, not the post-colonial. Whilst history can shed light on the present, the intention of much of the colonial literature is not explicitly to do so, but rather to understand that period on its own terms. More surprising is that this tension has not been picked up in any significant way by the literature on post-colonial health. This literature is far sparser and less theoretically and empirically rich than its colonial counterpart. Packard (1997) has contributed an important chapter on post-war public health which highlights the fact that public health in the post-war era was effectively "internationalised" outside of the industrialised countries. The World Health Organisation (WHO) and the other agencies of the UN system became powerful forces in terms of setting the terms for national health policies in Asia, Africa, and Latin America. Packard (1997) argues that this internationalisation was part of the broader post-war development project which, at least in part, aimed to increase the consumption of manufactured goods from Europe and North America in developing countries. In this way "health interventions were linked with social and economic development," much as they had been during the late colonial period (Packard 1997: 103). Indeed, as Packard (1997) goes on to argue, there were many continuities between the colonial and post-colonial period in terms of health policies, one being the focus on technical solutions to narrowly defined health problems which took little account of local social and cultural realities.

This is a theme that is also picked up on by Sunil Amrith (2006) who has perhaps written the most comprehensive account of post-colonial health interventions in the Global South to date. Amrith (2006) concentrates on the policies and practices of international public health institutions as they played out in Asia during the 1940s, 1950s, and 1960s. He seeks to explore the tensions encapsulated by international post-colonial public health, and asks the question: "In what sense was international public health post-colonial?" A central tension that he explores is that of the need of post-colonial health interventions to distance themselves from their colonial forerunners. This was done largely by emphasising the technical nature of the interventions, detached "from matters of culture or social transformation," which he argues, were never fully successful (Amrith, 2006: 17). Linked to this were the wider tensions that existed within medical practice at the time between social medicine, which "highlighted the importance of social and economic conditions to the practice of public health," and the "magic bullet" approach which focused on technical solutions, abstracted from their social and cultural context (Amrith, 2006: 18).

Both Packard and Amrith point to the continuities between colonial and post-colonial health policy and practice. There is also an acknowledgement of the changing terms of inclusion into health policy. As Amrith (2006: 72) puts it:

> *Perhaps the most fundamental shift occurring during the war was the emergence of the notion that health was a responsibility of government and a right of citizenship. This was radically different from earlier approaches to public health in the colonised world, where colonial states had never been more than 'fire fighters,' preventing epidemics and ensuring the productivity of labour. Health, the WHO constitution declared, was a 'fundamental human right.*

Both Packard and Amrith go on to discuss the fact that this vision of health as a universal right of citizenship was one which ultimately failed to materialise as rapidly and comprehensively as was expected. Both link this solidly to the continuities between the colonial and the post-colonial state. The extension of health care to all was made much more difficult because it relied on a state infrastructure which remained very similar to its colonial predecessor. In the case of India, according to Amrith (2006), it was also made more difficult by the continued focus of the Indian government on health as linked to productivity. There is an understanding then that despite the rhetoric of universal citizenship, workers in formal industries maintained a privileged position. However, once this is acknowledged, the place of the worker is more or less abandoned as a topic for discussion. Attention turns instead towards the politics of technicist health interventions, the neo-imperialist political imperatives guiding health policy, and the limits of post-colonial governmentality (Packard, 1997; Amrith, 2006).

In the post-war era health was framed as a right of citizenship, and has been analysed on those terms ever since. The worker within health policy begins to disappear in the post-colonial literature, and has also largely remained absent within the present day literature on the political economy of health, which has tended in large part to focus on the privatisation of health care, corporate influence on the medical profession, and the influence of global economic actors (such as the food industry) on health and health policy (Baum and Sanders, 1995; Baum et al., 2009; McIntyre, 2010, 2012). Even then, it must be recognised that this type of scholarship, which understands fundamentally that health is impacted by wider social, political, and economic factors, is in a minority when it comes to the present day literature on health policy. Mackintosh and Tibandebage (2004: 144) argue that scholarly writing on health, particularly in developing countries, suffers from what they call "thick description, thin explanation syndrome." Discussions take their starting point as the fact that the state has usually failed to deliver on the promise of universal health care, framing these as technical failures – failures of system design or management failures – which then leads to

proposals for technical solutions of one kind or another, such as improved management and reworked systems. As James Ferguson (1990) has argued in relation to World Bank programmes, this technical focus ignores the underlying structural factors – both political and economic – which enable or constrain the coverage and effectiveness of health systems. In doing so, it depoliticises what is in fact deeply political.

Health and Labour History

The historical literature on the political economy of health discussed above has existed in parallel with another health focused literature that has been more closely linked with labour history than with public health. This is the history of industrial or occupational health. Occupational health is a term which came to prominence in the post-war period, referring to the discipline and practice concerned with health and safety in the workplace. However, the discipline itself first emerged during the industrial revolutions in Europe and North America, and was initially known as Industrial Hygiene. As a subject of historical investigation it has been somewhat neglected. It sits somewhat awkwardly between public health and labour and perhaps as a result is often ignored by both disciplines (Quinlan, 1997). Nevertheless, there is a small body of notable work on the subject in English.[1] These include Rosner and Markowitz's (1991) study of the politics of silicosis (an industrial respiratory disease) in early 20th century USA, Levinstein and Tuminaro's (1997) study of the present day political economy of occupational health again in the USA, Long's (2011) in-depth study of the "healthy factory" movement in Britain during the early 20th century, Bartrip's (1985, 1990, 2002) work on the development of state industrial hygiene services in 19th century Britain, Harrison's (1991, 1995) study of the gendered implications of occupational health policy, again in 19th century Britain, and collections of smaller studies ranging from the development of workmen's compensation legislation,[2] to the evolving relationship between occupational and environmental health, to a focus on the politics surrounding particular occupational diseases (Weindling, 1985; Sellers and Melling, 2012).

[1] This review concentrates on the English language literature emanating from the UK and USA. Language limitations prevented the author from exploring the European literature on this subject comprehensively, although a brief search in French revealed a number of authors who have concentrated on such history. To cite some examples: Bouillé, M. 1992. 'Les congrès d'hygiène des travailleurs au début du siècle 1904-1911.' *Le Mouvement Social,* 161: 43-65; Moriceau, C. 2009. 'Les perceptions des risques au travail dans la seconde moitié du XIXe siècle: entre connaissance, déni et prevention.' *Revue d'Histoire Moderne et Contemporaine,* 56 (1).

[2] The term "workmen's compensation" is indicative of the gendered nature of early workplace legislation. In both Ghana and India the term remains in place, although in some countries (such as South Africa) it has changed to worker's compensation.

This literature on industrial/occupational health has four particular characteristics that are relevant to this thesis. The first of these helps to ground this thesis in existing work. Within the occupational health literature the worker is very naturally placed at centre stage, whether or not the discussion is focused on the colonial or the modern period. This has the effect of bringing a very particular political economy of health into view, one which foregrounds the relationship between state, society (in this case workers rather than citizens), and capital. As mentioned earlier, since the post-war period when public health became defined as a right of citizenship, the focus has in general been on the state-citizen relationship, with much less attention paid to the direct role of capital. Occupational health, as it has been framed over the late 19th and 20th centuries, is something that has been shared and influenced by the state and capital. Within the British model, occupational health services have largely been left up to employers to finance, with the state acting as regulator (Sturdy, 2000). The role of capital then is very direct, unlike in public health where the relationship between capital and health policy and practice is far less obvious (although this is truer for the British health model than the European social insurance model). As will be seen, this is an important point which helps to justify the particular form that this thesis takes – one that looks at occupational health in relation to public health, rather than seeing them as two distinct subjects for inquiry.

The second characteristic of the industrial/occupational health literature highlight a gap which this thesis will attempt to fill. The focus of the existing literature is very much on the developed, industrialised world. This is not surprising; occupational health policy and practice developed most extensively in European and North American countries, and the academic work has mirrored that fact. However, struggles over occupational health, as well as the development of occupational health policies, were not absent in the colonial and post-colonial world. Work on the gold mining industry in South Africa has produced some particularly rich accounts; Elaine Katz's (1994) history of the politics of silicosis on the Witwatersrand Reef at the turn of the 20th century is an excellent example, as is Jock McCulloch's (2007) history of asbestos mining in South Africa's Northern Cape. There are also significant discussions of health conditions on colonial mines in Ghana and Nigeria by Crisp (1984) and Freund (1981). Furthermore, administrative structures to govern occupational health were set up in the late colonial period. These institutions have tended to be severely neglected, and in some countries, remain largely unchanged from the original colonial institutions (Alfers, 2009). Again, the historical literature has mirrored this neglect; it is difficult to construct histories on an absence of activity. The present day literature suffers particularly badly from "thick description, thin explanation syndrome" focusing largely on pointing out the neglect of occupational

health, suggesting solutions, but rarely looking at the underlying structures that have produced this neglect over time.

Third, the work that does exist on the history of occupational health in the developing world completely ignores the all-important decolonisation and post-independence period. As Cooper (1996) has pointed out, it was during this period that the "terms of inclusion" into social provision in ex-colonial countries were set in a way that has had a long lasting influence on the unfolding of social policy in many ex-colonial countries. It was during this period that "the worker" as the subject of policy began to emerge in a more systematic form. It is also during this time that the most comprehensive administrative systems for the regulation and control of working conditions were put in place by colonial governments. Yet there is no work within the limited literature on the history of occupational health which investigates this period. Following Cooper (1996), a central argument of this thesis is that if the neglect of occupational health in developing countries is to be really understood, it is necessary to consider the late colonial and immediate post-independence period much more closely than has been done so far.

Fourth and finally, the existing literature on industrial/occupational health is heavily biased towards male dominated occupations and workplaces. This is not surprising, as it was men who by and large occupied formal workplaces. As Cooper (1995: 3) puts it:

> *Industrial man, in officials' eyes, was indeed a male. That most migrant labourers who came forth in the early colonial years were male may have had more to do with whom African communities felt they could do without for a period of time than European hiring preferences. But when European officials sought to build a more stable, more acculturated, more experienced labour force, the complexities of African life were of much less concern to them than their own gendered imagery.*

What Cooper (1996) is referring to here is the fact that "the limited version of universal citizenship" – a contradiction in terms, which Cooper argues ultimately forced the decolonisation question – which the British colonial regime tried to set up around a stabilised labour force, was one which saw workers as male. As numerous authors have pointed out this was a central characteristic of the British welfare state itself, based as it was on the idea of a male breadwinner who would be able to support the family financially (Nelson, 1990; Orloff, 1993; Sainsbury, 1999). Women were positioned as mothers and carers whose place was in the home. It was this gendered imagery which the British eventually exported to their colonies, where it interacted with and reinforced indigenous patriarchal customs.

This had a number of important effects. Firstly, colonial health policy and practice focused almost exclusively on women as mothers (Allman, 1994). This remained the case in the post-independence period, where reproductive and maternal health became the guiding force behind the movement for women's health led by the international organisations. There is no doubt that the drive for maternal and reproductive health, particularly in the period between 1960 and 1975, met an important need and did much to improve the position of women in the developing world. However, positioning women as reproductive agents alone fails to engage the complexity of women's lives, particularly the fact that women were and are often both mothers and workers (Kelman, 1923; Pinchbeck, 1930; Clark, 2010). In Britain the welfare state model of the male breadwinner has been criticised heavily for failing to engage with the fact that many working class families were unable to survive on single salaries, and that women were very much part of the labour force. In West African countries women were excluded from working in the large, formal colonial industries, but as feminist historians such as Gracia Clarke (2010) and Claire Robertson (1984; 1988) have shown, they were also important economic actors through their activities in petty trade. In India too, whilst taboos existed on upper and middle class women's movements outside of the home, poor and working class women were very much involved both in formal plantation and mining work, as well as in small-scale home based industrial production and domestic work (Sen, 1999; Roy, 2000; Lahiri-Dutt, 2001).

Theoretical Framework, Research Questions, and Contribution to the Existing Literature

Having described the health policy literature and the gaps within it, it is now possible to lay out the contributions of this thesis. The following section will elaborate on the key research questions which have been used to guide the research, linking these to the gaps that have been identified in the literature. It will also situate the research questions within a theoretical framework that brings together ideas from several sources. The overarching paradigm is a critical one which is based on Marxist political economy. Yet, knowing that the intention of this thesis is to look at the politics and history of a part of the world that was and is different from the world in which Marx developed his theory, it is also necessary to add to this framework from the work of those who have dealt with colonial and post-colonial history and theory. In doing so, this dissertation takes its lead from Morton (2013: 60) who, citing Edward Said (1983), argues that it is necessary always to develop a critical consciousness towards theory, thereby "enabling an awareness of the difference between situations and awareness too of the fact that no system or theory exhausts the situation out of which it emerges or to which it is transported." In particular, this thesis uses the work of the historian of African colonialism, Frederick Cooper, in order to "stretch" the Marxist theory (Fanon, 1965 cited in Morton, 2013: 60), as well as feminist critiques of traditional Marxist theory (Robertson, 1988).

The first aim of this thesis is to provide a comprehensive historical work of political economy which addresses the changing place of the worker within health policy and provision outside of the Global North, and which intends to shed light on the changes that are occurring within the terms of inclusion into health services in the present moment – shifts which have so far been examined largely without an historical lens. On the broadest level the first research question asks: *In relation to the terms of inclusion into health policies at present, how have we arrived at the place we have and why? What light does an understanding of historical processes shed on the current moment?* This question draws on what has become known as neo-Gramscian critical international political economy, after the Italian theorist Antonio Gramsci (Germain and Kenny, 1998; Morton, 2003; Bieler and Morton, 2004). Pioneered originally by Robert Cox in relation to international relations theory, the neo-Gramscian school of critical international political economy is described by Bieler and Morton (2004: 87) as

> *…directing attention to questioning the prevailing order of the world. It does not take institutions and social power relations for granted but calls them into question by concerning itself with their origins and whether they might be in the process of changing. Thus it is specifically critical in the sense of asking how existing social or world orders have come into being, how norms or institutions or practices therefore emerge, and what forces may have the emancipatory potential to change or transform the prevailing order.*

Antonio Gramsci is well-known for developing the concept of hegemony. A follower of Marx, who believed that social change is driven by the conflict between material forces, Gramsci nevertheless critiqued Marxist analysis which was simplistically materialist in orientation. He argued that economic domination is accompanied by a domination that operates at the level of ideas, cultures, beliefs, and subjectivity. This economic domination combined with ideological domination he called hegemony – particular economic systems are upheld because people believe that they are built on a "common sense" which is socially and culturally constructed (Gramsci, 1971). One of Gramsci's central aims was to question this "common sense" and to reveal the power dynamics that lay beneath.

It was Cox who first applied Gramscian ideas to international relations theory in an attempt to rejuvenate what was by all accounts becoming a fairly monochromatic field (Cox, 1977; Morton, 2003). Cox developed a theory of historical change which saw changes in production producing transformations in social relations which in turn produce transformations in the structure of power relations, embodied in what he called "forms of state" and "world orders" (Bieler and Morton, 2004). "Forms of state" refers to the particular configurations of state and civil society that emerge

under different production relations (the state-civil society complex), and which define the terms of inclusion into state policies, and "world orders" which emerge on a global scale. State power and state institutions are seen not as essential givens, but rather as the product of social forces and processes, which themselves are produced by particular forms of production (Bieler and Morton, 2004).

This thesis makes use of certain elements of the neo-Gramscian approach which it considers useful in understanding the changes in health policy that have occurred since the colonial era. Firstly, as mentioned in the review above, there is a gap in the literature on health policy when it comes to taking a long view of its development – from colonial, to post-colonial, to the present, particularly in countries outside of Europe and North America. This is a gap which this dissertation intends to fill. In doing so it draws on Cox and other Gramscian scholars, such as Bakker and Gill (2003), in defining the particular key moments of transformation: colonial capitalism, the welfarism (or Fordism) of the post-colonial period, and the current era which Bakker and Gill (2003) refer to as the "new constitutionalism" where neo-liberalism is the dominant form of production relations. New constitutionalism here refers to the ways in which neo-liberal modes of governance are normalised, "locking in" governments and future governments into particular policy directions (Bakker and Gill, 2003: 30). Tracing the changing place of the worker within health policy through these key moments will hopefully allow for both an understanding of historical processes, and of ongoing processes in which the current "forms of state" have been produced. In this way the thesis elaborates on Cooper's (1996) proposition that an understanding of the decolonisation period is key to understanding current institutional forms of social policy in Africa by including another key and more recent period that has also had a significant impact. In this way the thesis attempts to avoid the leapfrogging that Cooper warns against in relation to historical works that seek to help in understanding the present.

Second, Gramscian analysis is essentially materialist in that Gramsci understood class relations as central to social transformation. However, as already mentioned, one of Gramsci's key insights is that hegemony cannot be understood in materialist terms alone; it contains an ideological/cultural aspect which is equally important to understand. Cox, drawing on this, saw each of his "historical structures" (production relations, forms of state, and world orders) as being made up of both material and non-material elements such as "ideas … and collective images of the world order" (Bieler and Morton, 2004: 87). This has opened up Marxist materialist critical analysis to a sometimes uncomfortable and potentially ontologically contradictory relationship with post-

structural thought (Li, 2007). Yet, the melding of the ideational and the discursive with the material has produced some of the more interesting recent work on both the history of health and the history of labour in colonial and post-colonial contexts. Cooper (1996), whose focus is on the way in which colonial administrators applied expert discourses on labour and social need to Africans in determining "who was to be included and on what terms they were to be included within the bounds of social policy," argues that his work would not have been possible without the years of materialist labour analysis which preceded it (Cooper, 1996: 16).

In relation to health policy and practices, this approach is particularly useful. As with other policy, professional 'expert' bodies (public health professionals, epidemiologists, and medical doctors) have played an important role in the development of policies and other state institutions. It is sometimes difficult, if not simplistic, to understand the role of such expert groups in purely materialist terms. As Latour and Woolgar (1979) have pointed out, understanding the politics of science as purely a result of the interplay of class forces leads inevitably to an analysis of corporate influence over scientific practice. This is not unimportant. Yet, as they go on to argue, science is itself a culturally embedded practice, the politics of which can be read in ways that do not relate to corporate power alone. For many scholars who have taken an interest in health, this has been a key point – doctors and other health professionals have an expert type of knowledge, which as Foucault long ago argued, is itself constitutive of power. This expert knowledge is also itself constituted by and constitutive of particular visions of how the world should be, and the way in which it should operate – all of which ultimately affect the institutions which develop in relation to such knowledge. Understanding "how things got to be the way that they are" therefore entails an understanding not only of the "the historical matrices of social, political and economic relations" in which they are situated, but also how these are related to the ideational politics of science (Packard, 1993: 13).

Yet, as mentioned in the introduction to this section, Gramsci alone is not enough. His ideas were formed in a particular time and place – Italy under a Fascist government in the early years of the 20th century. "How things got to be the way that they are" in the Global North cannot be answered in exactly the same way as in the Global South, although the two are obviously linked through global processes of colonialism and capitalist accumulation and expansion. It calls for the stretching of theoretical frameworks and brings up an important tension, which is explored throughout this thesis, between universality and difference. Indeed this is a tension which runs through all the questions that follow and is explored throughout this thesis: how do we understand the history and politics of health provision in a context very different from the one in which it developed, when the

state provision of health services is itself a construct of a particular time and place? Furthermore, how does this affect the judgements we make on the changes that are currently taking place in health policies? Applying the same conceptual categories and frameworks from Europe and its social forces limits the analysis, creating the danger of a constant deficit in the post-colonial environment, when in fact it is this difference that needs to be grappled with and understood. Avoiding such a trap requires an understanding of the different setting – its societal norms, its history, its politics, and the specific ways in which these have differed from the metropolitan context. As will become clear throughout the following section, it is here that Cooper is of use and can be brought into conversation with Gramsci and Marxist political economy in general – challenging the way we think about how "forms of state" were created within a colonial context specifically.

Narrowing the focus, the second key research question guiding this thesis is: *How has the place of the worker changed in relation to the citizen within health policy in countries of the Global South over time, and what political and economic processes have underlain this shift? What implications do these shifts have for understanding present day policy changes?* As already mentioned, this is a question which emphasises the relational aspect of the citizen and the worker within health provision and its importance as a question emerges from the dialectical method of Marx. The method sought to understand the ongoing *relationship* between economic processes and elements as a way in which to think about the unfolding of social and economic life, as opposed to seeking causal explanations for their being (Harvey, 2010a). In this way, Harvey (2010: 12) argues, Marx was able to see capital not as a thing, "but rather as a process that exists only in motion." In a less abstract sense, the dialectical method allows one to view aspects of social and economic life as mutually constituted. Gill Hart (2006: 21) summarises the advantages of such a position:

> *Instead of comparing pre-existing objects, events, places or identities, the focus is on how they are constituted in relation to one another through power-laden practices in the multiple, interconnected arenas of everyday life. Clarifying these connections and mutual processes of constitution – as well as slippages, openings and contradictions – helps to generate new understandings of the possibilities for social change.*

The citizen and the worker may not always have been constituted in relation to one another (the original Classical concept of the citizen referring to those who lived within a city), but certainly under the British welfarism which was transferred to its colonies and heavily influenced the trajectory of post-colonial health policies, they were deeply intertwined. To be a citizen was to be a worker. It is also this relationship which, under "the new constitutionalism" of the neo-liberal era has undergone important changes. These changes, it will be argued, are able to shed light on the wider implications of the more recent shift towards what has been termed "post-neoliberalism."

A relational view allows for a focus on the citizen and the worker as "dual aspects of a unity" (Harvey, 2010). This in turn allows for an analysis which looks at how the two aspects sit in relation to one another, how their relationship changes over time, and an exploration of the tensions and contradictions which arise from it. In practical terms such an approach serves to address one of the gaps identified in the literature review – the lack of analysis looking at the relationship between public and occupational health. As health policy shifted towards a right of citizenship, the worker was at least rhetorically confined to occupational health. In order to keep both the worker and citizen in view simultaneously then, it is necessary to look both at public health and occupational health in relation to one another. As mentioned already, the two are often assumed to be too different to discuss within a single piece of work. If they are discussed together, it is usually as separate chapters within a general history of health, rather than as relational aspects of a whole (Rosen, 1958; Doyal, 1979). Packard (1987) for example states explicitly in his essay on industrial health policy in South Africa that he will not talk about occupational health, arguing that it is too narrow a field for the analysis he wished to undertake. It is true that occupational health is governed by a different set of institutions from public health (tending to be placed under the control of labour departments rather than health departments). Moreover, as a scientific discipline it *is* a very narrow field, focused as it is on the work-related diseases and injuries of individual workers.

However, as this thesis aims to show it is not only possible to look at both public health and occupational health policies and institutions in relation to one another, it is also necessary to do so if the changes that are currently happening in forms of state are to be understood at a fundamental level. Occupational health and public health fall along what could be thought of as a continuum of responsibility/inclusion that has shifted over the years. On the one end of the continuum is employer responsibility (with inclusion based on status as worker) and on the other end is state responsibility (with inclusion based on status as citizen). Over the years, public health in the Global South has shifted along this scale in complex ways: rhetorically from employer responsibility to state responsibility, but the reality being that formal wage employment was still a centrally important way to access health services. Occupational health on the other hand has tended to stay firmly placed under employer responsibility. With the emergence of the idea of the "informal worker" this has begun to change; institutional solutions to the absence of defined employment relationships have started to emerge which suggest that occupational health should become the responsibility of the state (Loewenson, 1998). This means that the relationship between workers and citizens is beginning to shift; the terms of inclusion are beginning to shift. A blurring that is starting to occur between the

place of the worker in public health policy, and the place of the citizen in occupational health policy – and it is only when both types of health policies and programmes are placed side by side and kept in focus together that a clear picture of these shifts begins to emerge.

There are also some broader conceptual issues which emerge from this relational approach to the worker and the citizen, to public and occupational health. Firstly, it allows for questions to be asked about the apparent separation of the spheres of the social, into which citizenship issues (such as public health) tend to be classed, and of the economic into which work, and by association labour-related policies such as occupational health, are generally classed. Indeed, one of the key aims of this dissertation is to highlight that the separation of the economic and the social is itself part of an ideological construct that needs to be deconstructed if the current shifts in global capitalism and the social policies that arise are to be fully understood. This questioning is opened up by the theoretical framework adopted. As Bieler and Morton (2004: 100) argue, when "… the state is treated as an aspect of the social relations of production … questions about the apparent separation of politics and economics or states and markets within capitalism are promoted."

Secondly, it brings to the fore questions of universality and difference, and emphasises the need to inform the theoretical framework which includes specific perspectives from the Global South. This relates in particular to the differences in the "forms of state" which developed in the colonial world as opposed to the metropoles, and the enduring legacy that this has had on social policy. It is here that Cooper (1996, 2002) makes an invaluable contribution by providing a framework for understanding the specific social dynamics which underpinned post-colonial states, and it is worth quoting him at some length. In *Decolonization and African Society* (1996: 5), one of Cooper's stated aims is to explore

> *…the power of the idea of "modern" social policy in African states: how new leaders – before and after independence and in dialogue with "experts" of the "developed world" – came to define social policy around an imported future more than the extension of an observed present, around a package of institutions like labour unions, minimum wage regulations, and industrial relations machinery rather than around the complex, category-crossing social processes that had been going on around them.*

There are two related issues that Cooper is concerned with here. The first is to unpack the central place that the worker assumed within social policy during the late colonial and post-colonial period in African countries. The second is to understand why such a narrow definition of the worker was adopted – one which mirrored the definition found in Europe, but when transplanted into the African context effectively excluded the vast majority of economically active people – the market

traders, the shoe shine boys, the women who turned their homes into small scale production units. He argues that this was the result of both economic and political imperatives on the part of the British colonial government who attempted to deal with their increasingly rebellious empire by trying to create a stabilised and conservative African working class who they hoped would support their claim to power, and form the backbone of an orderly transition to independence. Health, social security, housing, and labour policies were seen as central to creating this stability. The formal worker, working in a formal workplace, living in formalised working-class parts of the city, and covered by basic welfare provisions, assumed an important place within it.

Cooper argues too the resulting policies also reflected a failure of imagination on the part of British and French colonial officials, a failure to think of alternative institutional structures which might more realistically cope with a society organised along very different lines from Europe.[3] The tensions that emerged out of this – between the rhetoric of universal citizenship inherited from Britain's social democratic welfare state and the reality that it was only the minority of formally employed workers who were truly able to access anything like social citizenship – is a central concern of Chapter Four. Again, this thesis builds on Cooper's insights into the present moment, and the present is interesting precisely because, with the move towards informal workers' inclusion into social policy, social administrators are now starting to grapple with the failure of imagination that Cooper identifies. Yet, as Chapters Five and Six intend to show, this in itself causes a new set of tensions to arise, as this process intermingles with the imperatives of the current dominant economic model. How does the admission of difference play out when it comes to the terms of inclusion and the benefits that can accrue from this? Do the "new" forms of health provision being developed around informal workers really give the citizens of the Global South the idealised set of social rights that citizens of Europe came to enjoy after World War Two? Does the very acceptance of the term "informal worker," which some would argue is necessary to develop a social policy that is realistically suited to the Global South, mean compromising on the quality of universal social rights?

These tensions are also examined through the third key question which guides this thesis: *What role have trade unions and other worker-based organisations played in the development of health policies and institutions? In particular, how and why have their activities affected (or not been able to affect)*

[3] It could be argued that the way in which colonial administrators viewed the African family as the institution which would take care of social reproduction without state intervention was a form of alternative thinking, as was indirect rule as a whole. However, the failure in reality was one of thinking through how state protections might work in a different society.

the shifting place of the worker in relation to the citizen within health policy? This question adds an important additional dimension to the main theme of the dissertation. The two previous questions point more towards a top-down perspective of how policies and institutions are formed. This question specifically directs attention to the contribution of workers themselves to the shifting terms of inclusion into health provision. In this way it allows the dissertation to weave together both forces from above and those from below in its analysis.

Li (2007: 19) points out that Gramsci is centrally concerned "with the ways people become mobilised to contest the truths in the names of which they are governed, and to change the conditions under which they live." Yet for Gramsci "the question of how a collective, critical practice emerges could not be answered with reference to abstract concepts such as capital and labour. It has to be addressed concretely taking into account the multiple positions people occupy, and the diverse powers they encounter" (Li, 2007: 22). However as Drainville (1994) has pointed out, within the neo-Gramscian approach to international political economy, particularly that influenced by Cox, the challenge to understand forces of resistance to the power of the state and of capital has not been taken up as readily as the analysis of state and capitalist power itself. Samson (2010: 406) argues that this results in a situation "where there is little sense of how [social relations] can be disrupted and transformed other than through interventions at the levels of policy formation."

This thesis aims to consider resistance and its role within the building of institutions through collectively conceived forms of agency. It draws ultimately on the idea that is present, for example in the work of E.P. Thompson and Eric Hobsbawm, that organised social groups can make a difference in the world through challenging the status quo. In the context of this thesis, Fred Cooper is again useful in providing a conceptual foundation for the interactions of power and resistance in the colonial and post-colonial context. He argues (1994; 1996; 2000) that there are two sides to understanding how and why things have come to be the way that they are in present day Africa. Firstly, one has to understand the workings of colonial power itself and the legacy left behind. It is here, Cooper (1996) maintains, that many post-colonial scholars end their analyses. However, as he goes on to argue, this is only half the story. Equally crucial is an understanding of the way in which "power is engaged, contested, deflected, and appropriated" by those who encounter it (Cooper, 1994: 1517). So, for example, when the British colonial government started to introduce its labour-oriented reforms during the late colonial period, African trade unions and their allies did not resist. Instead, they seized the opportunity presented by "engaging substantively with the labour specialists of the colonial state, and subtly turning the assertion of authority into a claim to rights" (Cooper,

1996: 4). The contradictions this engendered for Britain, as well as the financial implications, left it with no choice but to abdicate its position. Cooper (1996) emphasises that, as a result of the engagement of Africans with colonial labour regulation, the resulting institutions were European and African hybrid institutions rather than institutions which were simply transplanted from one context to another.

What Cooper does here is to provide a broader historical sense of how forces from below can play a role in the building of institutions, and in doing so he provides an important conceptual base for this thesis. Following Cooper, the emphasis in this study is less on *why* resistance happens (indeed as Bakker (2007: 543) argues it is taken as a given "that economic history can be partly understood as the interaction between top and bottom of the pyramid, a conflictive relationship between the imperatives of capitalism and the necessities of material life."), but rather on the ways in which this resistance happens (for example the engagement that Cooper talks of), the specific strategies that are adopted, and how this contributes to the shape of particular institutional forms. Again, though, there is an attempt to build on Cooper's work. Firstly, by looking at moments where the engagement of workers with colonial and post-colonial institutions were blocked in some way, and secondly by looking at how worker strategies have (or have not) changed over time and what this may imply for the future place of the worker and the citizen within health policy and provision.

The fourth and final question is one which adds a further theoretical angle to what has so far been developed in this section: *How has the gendered definition of the worker and the citizen changed over time, and what implications does this have for our understanding of current institutional reconfigurations?* In asking this question the dissertation seeks to add a gendered dimension to its focus on class, in line with Connell's (1987) contention that constitutive of all world orders is a gender order. Gender here is not taken as an essential given, but is rather understood as a set of shifting social relations between men and women which both produce and are produced by relations of power (Flax, 1987; Albo, 2005; Samson, 2010). This approach, which centres the relationship between the male and female spheres, allows the thesis to move back and forth between them, rather than focusing on one or the other.

As many scholars have pointed out, both the worker and the citizen have throughout history been gendered constructs (Lewis, 1992; Nakano Glenn, 1992; O'Connor, 1993; Mohanty, 1997; Sainsbury, 1999). The post-World War Two European welfare state model was one based on a male breadwinner and a woman who remained in the home to care for the family. Women were

positioned as carers who could access their citizenship rights through their husbands. The gaze of health workers was firmly placed on women as mothers, and correspondingly men as workers. Within and outside of Europe this translated into widespread campaigns focused on reproductive, maternal, and child health (Allman, 1994; Amrith, 2006). These campaigns, which were closely linked to the primary health care movement, achieved a remarkable amount in terms of improvements to women and children's health (Sender, 1999). They were aided by advances in medical technology and the development of antibiotics which greatly improved the efficacy of western medicine. They did, however, also tend to box women into their role as carers, failing to account for the reality that many women – single women, working-class women, women who needed and/or wanted to earn an income – had health needs related to their roles as workers as well.

One of the most important analytical changes in recent decades has been the shift in gendered understandings of the worker and the citizen. To a certain extent this has been prompted by the entrance of middle class women in the Global North into the labour market *en masse* (although as Chapter Three shows many women in the Global South have always worked). Slowly policies have started to adjust to this trend, with "innovations" like flexi-time, job-sharing, day care, and paternity leave becoming more common (Williams, 2001). Within occupational health specifically, questions have started to be raised about the gendered constitution of the science itself, and how the discipline can better contribute to women workers, whose different anatomy and physiologically may require different workplace interventions (Messing, 1998). Woman as workers are beginning to appear within health policy. Yet there is also a tension here, because as Nancy Fraser (2009) has pointed out, the entrance of large numbers of women into the labour market has intersected with the informalisation of labour and the downgrading of worker and citizenship rights. Allman et al., (2002) argue that women's positions tend to disrupt established social binaries – their position as both workers and carers, as both producers and social reproducers, as workers who work in the home, who straddle sometimes contradictory positions. Adding a gendered perspective therefore brings an extra element of complexity and depth to the exploration of the tension that is created between the recognition of workers' rights in the informal economy and the desire to maintain the citizenship rights that were held up as an ideal during the social democratic/post-independence period. The story of the changing place of the worker is also the story of the way in which gender has interacted with these changes.

Gender, although a key theme, is not the main structuring social variable of this dissertation. Rather, the interest is in both class and gender. In doing so, it takes its lead from O'Connor (1993: 509) who

states that, “Welfare State regimes are structured by and in turn structure, both class and gender. Consequently, both dimensions must be incorporated into a comprehensive analysis of welfare.” Not all scholars writing about social policy from a gendered perspective have agreed with this approach, with those such as Lewis (1997) and Sainsbury (1999) assuming an analytical position which sees gender as the primary social category, and is blind to issues of class. Primarily, however, this is a story of class; it is story of how political and economic forces have formed and re-formed over time to produce certain institutional forms which have privileged some groups over others. This of course has important gendered implications, but gender here is seen as a social variable which interacts with class, rather than existing in isolation from it. The aim then is to keep the view on both class and gender, and, in particular, to observe where and how interactions occur. Furthermore, it does so in a context of difference – the ways in which class and gender have interacted within social policy in Europe are not necessarily the same as the way in which these two variables have interacted in countries of the Global South. Here the focus is again on ensuring that the conceptual frameworks drawn from feminist thought, as with Marxist thought, are used in a contextually appropriate manner.

Methods and Limitations of the Study

The above theoretical discussion has included some reference to the methods used in this study. It is Marxist (social actors), and it is relational, and it looks at gender as a key social variable as well as class. Before moving onto a summary of the study and concluding the introduction, it is first necessary to elaborate a little further on the methods used, as well as the limitations of these methods and how they feed into the limitations of the study as whole.

Primary archival material was sourced from London at the Colonial Office Records at The National Archives, the British Library’s India Office Records, the Wellcome Trust Archive, and the London School of Hygiene and Tropical Medicine Archive. The Rhodes House Archive at Oxford and the Churchill College Archives in Cambridge also proved to be important sources of primary material. In Geneva source material was derived from the archives of the International Labour Organisation, the World Health Organisation, and the League of Nations, and in Ghana from The Ghana National Archives in Accra. These primary archival sources were supplemented with a small number of interviews, particularly in Chapter Six where the author drew heavily on her own experience working with informal worker organisations on an Occupational Health and Safety (OHS) project which ran in both Ghana and India under the auspices of the global action-policy-advocacy network, Women in Informal Employment: Globalizing and Organizing (WIEGO). The author’s personal notes, as well as

official ones, taken at WIEGO workshops, meetings and conferences were another important source of primary information.

Despite the large amount of primary material available, it is true that Chapters Two and Three draw heavily on a synthesis of secondary sources rather than on these primary sources. There are two reasons for this. Firstly, as mentioned earlier, the history of colonial health and labour policies have been relatively well explored already. Except for a few small additions, the author has had little original contribution to make to an already rich field of study. The original contributions that this study makes are to be found primarily in the chapters which cover the post-colonial and present day periods. Secondly, and leading on from this, the first two chapters are really intended to provide background and historical context to the three subsequent chapters, rather than to make new arguments about colonial policies.

The methods used in this study have also meant that this is a story, which, although incorporating a recognition of the agency of workers, is still very much a story about the contradictions of policy as it is theorised and made in the sphere of discourse and ideas. It is not a classically Gramscian ethnographic study of workers or citizens on the ground and how they appropriate, resist, and transform the relations of power than exist around them. Chapter Six does of course take a view from the ground up, but even then the agency of workers is collectively conceived, and does not explore the motivations and subject positions occupied by those who are engaged in the resistance to power (Drainville, 1994; Li, 2007; Hart, 2013). Such analyses relate local acts of conflict, contradiction, and resistance to wider structural processes, something which is absent in this thesis which is focused on broader structural processes and which uses material from which such inferences cannot be drawn. As argued earlier, however, this does not mean that it is impossible for the study to consider resistance and its role in the building of agencies. It just does so through a collectively conceived form of agency, similar to that used by Cooper (1996).

This has also not been a close study – it is one that has spanned wide geographies and time spans, the difficulties of which were discussed in the introduction. This broad perspective has been necessary in order to get a sense of shifts that have occurred over a long period of time, in a subject area that has been little explored. It also provides a broad framework into which more detailed studies of health policy and provision in the post-colonial developing world may fit. More detailed studies could, for example, involve a comparison with French and Belgian colonial traditions in Africa. A closer study of the politics of workers' health in India would also certainly be interesting.

This study used documentation derived largely from the India Office records in London, but there are likely to be illuminating documents in India itself, particularly at the Tata Steel headquarters in Jamshedpur from where much of the post-independence OHS work was driven. This could also shed light on another omission of this study – the relationship between large corporations, nationalism, and adherence to and promotion of labour protections. Here the question is why certain corporations – such as Tata in India or Anglo Gold Ashanti in the Gold Coast – tended to provide relatively good health services to their employees and why some did not, and whether and how this tied into imperialist or nationalist projects.

A final omission from this study is a more detailed discussion of small scale agricultural workers and indeed "the peasantry" in general. It is true that in Chapter Three there is some discussion of the importance of small scale farming in both India and Ghana and how this fed into and was influenced by the colonial labour market. Nevertheless, into the post-colonial and present day periods, the focus is largely on either the workers in the large colonial industries – plantations, mines, and factories, or on those who participated in "informal" economic activities aside from agriculture. There is no discussion, for example, of how rural health programmes may have interacted with agricultural legislation, and/or how the international organisations tried to grapple with the problem of extending occupational health legislation to rural areas. This has largely been done to limit the scope of this already large study.

Summary and Structure of the Thesis

In summary, this thesis is an examination of the shifting place of the worker in relation to the citizen within health policy. The four main questions which guide the analysis are as follows:

1. In relation to the terms of inclusion into health policies at present, how have we arrived at the place we have, and why? What light does an understanding of historical processes shed on the current moment?
2. How has the place of the worker changed in relation to the citizen within health policy in countries of the Global South over time, and what political and economic processes have underlain this shift? What implications do these shifts have for understanding present day policy changes?
3. What role have trade unions and other worker-based organisations played in the development of health policies and institutions? In particular, how and why have their activities affected (or not been able to affect) the shifting place of the worker in relation to the citizen within health policy?

4. How has the gendered definition of the worker and the citizen changed over time, and what implications does this have for our understanding of current institutional reconfigurations?

In order to answer these questions, the thesis has been divided into five further chapters. Chapters Two and Three examine health policy in India and the Gold Coast under British colonial rule and in doing so act as a base on which to build the rest of the thesis. Chapter Two looks more broadly at the place of the worker in health policy, whilst Chapter Three takes a gendered lens and looks specifically at the place of the woman worker. Chapter Four moves into the late colonial (post-World War Two) and post-independence period, exploring the tensions between the ideal of universal citizenship that post-colonial governments promised their citizens, and the reality of constrained resources and health systems that continued to favour formal workers. This chapter also challenges Cooper's theory of worker engagement in relation to occupational health, arguing that there were important constraints on how workers could engage with this aspect of labour policy. Chapter Five acts as a bridge between the post-colonial period and the present, examining the shifting relationship between the worker and the citizen in the health policies of the international organisations, the WHO, the ILO, and the World Bank, over a period of fifty years. Chapter Six looks to the future by analysing the responses of organisations of informal workers to present day health policies, and asking whether these have the potential to catalyse radical socio-economic and policy reform. Chapter Seven is the conclusion.

Chapter Two: Specificity and Continuity: Health and Labour in Colonial India and the Gold Coast, 1860-1945

Introduction

One of the crucial periods on which this thesis hinges is the development of the British welfare state and its transportation, in a limited form, to the colonial territories. It was during this period that what TH Marshall (1965) called "social citizenship" – the idea that citizenship included not only civil and political rights, but also rights to health, welfare, and social security – was institutionalised in the British state, and began to influence the late colonial policies with which Cooper (1996) is concerned. However, as both Gladstone (1999) and Hobsbawm (1987) have noted, whilst "the legislation of the 1940s may have constituted a defining moment in welfare collectivism," it did not emerge out of a vacuum. It was the culmination of a long process of social and political reform which had its roots in the period 1875-1914 when nationally organised labour unions, democratic government, and "modern welfare legislation" began to emerge in Britain (Hobsbawm, 1987: 17). Likewise in the colonial territories, the policies of the late colonial period were themselves the product of many years of changing economic and political thought about the role of the colonial state.

The purpose of this chapter is to explore the development of health policies over a period of seventy years in Britain and two of its colonies, India and the Gold Coast, tracing the way in which particular economic and political configurations impacted on these policies and their terms of inclusion. It takes as its starting point 1860 when the first regulations relating to health were instituted in the Indian tea plantations. The end point is the end of World War Two, after which the British welfare state was established and the drive towards decolonisation began. The post-war conjuncture will form the subject of Chapter Four. Following the theme of the thesis, this chapter is particularly focused on the place of the worker within health policy and how this changed over time. What is important to trace is the gradual movement towards a language of liberal entitlements and where the worker was placed in relation to this. In doing so, this chapter lays the conceptual base on which the rest of the thesis is built.

The chapter is divided into three sections which look at the development of health policies and legislation in Britain, India, and the Gold Coast between 1860 and 1945. Within each of these sections critical shifts in the political economy of health and in the ideological reasoning attached to these are delineated. In his analysis of colonial health policies in colonial Ceylon, Hewa (1995)

defines his periods of analysis in materialist terms, differentiating between the earlier era of "plantation capitalism," characterised by *laissez-faire,* and the later period of "monopoly capitalism," which emerged at the turn of the 19th century and was characterised by greater state intervention as colonial industries developed and European nations increasingly began to compete for greater shares of the international markets, and to source raw materials to feed the needs of increasingly technologically advanced industry. Indeed, it would be difficult to refute the fact that economic reasoning lay behind much of the colonial expansion that occurred during the period of monopoly capitalism.

Yet Ashford (1986: 10) argues that purely materialist analyses of the development of social policies do not "allow us to pose the most difficult political question of how institutional values were adjusted to include the values of social need and social equality." Indeed, as Ashford (1986: 10) goes on to show, a central dilemma in the development of social policies in Britain was the ideological question of how to "reconcile the basic tenets of liberalism" (which promoted individual freedom and *laissez-faire*) with the idea that democratic states had obligations to society. A consideration which contributed greatly to this dilemma was the need to reconcile liberalism with state intervention in order to develop and maintain a labour force to feed growing industries in both Britain and abroad (Cooper, 1987; Hobsbawm, 1987). In this way, political ideas and economic realities existed in complex relation to one another, and this chapter views them as inextricable parts of a whole.

In doing so the chapter engages with the changing nature of the colonial state over this period, which is itself the source of considerable debate. Meghan Vaughan (1991), for example, has critiqued the use of Foucauldian frameworks to analyse the colonial state. Foucault's influential work *Discipline and Punish* argued that modern, liberal states develop disciplinary techniques which act on the subjectivity of individual citizens in order to maintain social order. Social policies in particular were singled out as part of this disciplinary apparatus, and his theories have inspired a large literature on the operation of power through social policies in the colonial state. Vaughan (1991), however, argues that colonial states were not modern, liberal states and relied on much cruder and more violent forms of coercion and repression to manage subject populations. In this context health policy and regulation had little to do with liberal modernist forms of social discipline, objectifying rather subjectifying Africans. Guha (1997) makes a similar point critiquing the use of the Gramscian concept of hegemony to describe the colonial state, arguing instead that the colonial state in India

was unable to assert ideological control over the population, and instead was forced to rely on what he terms dominance, which was characterised by more overt forms of violence.[4]

Despite their differing theoretical origins, the above perspectives on the colonial state do share a commonality in that they view the state – and its policies and legislation – as predominantly oppressive institutions. While there is little doubt that violence and oppression were a part of the colonial project, it is important that this is nuanced – particularly when it comes to issues such as health. The extension of Western forms of medical practice, and the institutions which supported these during the colonial period, were deeply problematic, particularly when they clashed with local understandings of health and disease and health practices (Arnold, 1993). As Guha argues, the ways in which health policies – particularly at the level of local government – were enacted was imbued with violence. Violent forms of discipline, court orders, and intrusions on private households were a part of the modus operandi of colonial health provision, particularly in times of epidemic disease. On the other hand, the spread of medical innovations, and of Western style health facilities, cannot be framed purely in terms of violence and oppression, just as it is simplistic to frame the colonial state in such terms alone.

Medical discoveries around diseases such as cholera and malaria, the development of effective treatments and prevention strategies, particularly in the period after World War Two when advances were made in antibiotic treatment, and the means by which to distribute these to increasing numbers of people through clinics and hospitals and medical training facilities led to improvements in mortality and morbidity (Dumett, 1993; Sender, 1999; Deaton, 2013). The fact that post-colonial states prioritised, at least in theory, the extension of Western style universal health coverage after independence indicates something more positive about colonial health provision: while it may have been part of what was ultimately experienced as part of an oppressive machinery, it was also valued and continues to be valued by the many who argue for its continued extension. Here the argument about colonial health services takes a different direction – far from focusing on the oppressive nature of the health apparatus of the colonial state, it views the main problem as being that the colonial state did not extend this health apparatus widely or comprehensively enough (Harrison, 1994). Indeed it was actually relatively few colonial subjects who felt the touch of colonial medical and health services. The colonial state was first and foremost one that was based on the extraction of economic resources, not one which wanted to expend resources on subject

[4] Both Vaughan and Guha refer here to non-settler colonial states. White settlers could not be dealt with in such authoritarian ways.

populations. As Amrith (2011: 129) points out, despite the rhetoric of the late colonial period, health and welfare could never be a top priority of an essentially extractive state, arguing that "what is most striking about the medical infrastructure that the Raj bequeathed to independent India is its weakness and limited reach."

Moreover, as Cooper (1996) has argued, the British colonial state, its need for labour, and its rule of law provided both a language and political openings which ultimately could and would be used by the colonised to expand their claims to social entitlements such as health care. Cooper (1996) shows that this process began to speed up after World War One, as colonial states were forced through international pressures and their own internal contradictions to grapple with the possibility that colonial subjects may also be the rights-bearing individuals of the modern democratic state. Consequently, in addition to this top-down approach, this chapter is also interested in exploring resistance from below, and how this impacted on the form of colonial health policies. Following Cooper (1996) it looks at how different logics of rule opened up or closed down possibilities for resistance, and indeed, changed its very nature, from simple acts of desertion to strikes and disturbances, and finally to the "engagements" with power that Cooper (1996) talks of, where trade unions were able to use the language of liberal entitlements to widen the scope of these entitlements until the contradiction became too great from Britain.

Cooper's arguments here are a critique of two theoretical positions. It is a critique of Foucauldian political theory, which has been criticised for emphasising the workings of power at the expense of an understanding of resistance to power (Arnold, 1993; Li, 2007). It is also a critique of a certain style of post-colonial theory which Cooper (1994) argues emphasises "the binaries of coloniser/colonised, Western/non-Western and domination/resistance." Cooper (1994: 1517) sees these binaries as "useful devices for opening up questions of power," but argues that they "end up constraining the search for precise ways in which power is deployed and the ways in which power is engaged, contested, deflected, and appropriated." It is important here to recognise that colonial societies were also internally stratified by class, and that these class differences also played an important role in determining the form and direction of resistance (Sender and Smith, 1986).

A tension that runs through this chapter is that of continuity and specificity in the politics of the institutions which will be discussed. There is a balancing act to perform between the discussion of health policy as an empire wide phenomenon, and the specific politics which surrounded the development of these institutions in particular countries. What is striking about state institutions in

Britain and its colonies is how similar they appeared in their outward form. The regulation of occupational health and safety, for example, was governed by Factory Acts and Workmen's Compensation legislation in Britain, Ghana and India, and local government health regulation centred on the Medical Officer of Health in all three countries. There was a logic used here that stretched from Britain, to its other colonies, often via India where the colonial version of British legislation and state apparatuses were experimented with before being sent on to Africa and other more minor colonies. There was a template of sorts, and how and why this template came to spread throughout the British Empire is important to understand. Equally important, however, is to acknowledge the differences between colonies, as well as between British legislation and that which existed in the colonies – to understand the very specific politics that surrounded these institutions in particular times and places, as well as to explore the ways in which they were both constituted by and constitutive of colonial difference.

The Place of the Worker in Health Policy and Provision in Britain, 1860-1945

The extension of social policies to Britain's colonies, including those related to health and welfare, has to be understood within the context of the prior developments in the metropole. By 1860 Britain was in the midst of what MacDonagh (1958) called the "Nineteenth Century Revolution in Government," where experimentation in the governance and regulation of a newly industrialised and democratic society were being carried out. The years between 1789 and 1848 in Europe had seen what Hobsbawm (1975) refers to as a "dual revolution" – an economically driven transformation of industrialisation and proletarianisation and the politically driven revolution of the French. The 1830s and 1840s had seen major social unrest and, although by 1848 the labour movement had been decimated by the failed Europe-wide revolutions, by 1860 national labour unionism began to emerge.

There is disagreement as to whether forces from below had much influence on these developments. Ashford (1986), for example, argues that the development of 19th century social policies was primarily led by intellectuals and politicians in a quest to reconcile liberalism and state intervention. Yet, as Hobsbawm (1975: 13) points out, without the threat of social unrest, this contradiction may never have come to the attention of these intellectuals and politicians:

> *Behind the bourgeois political ideologists stood the masses, ready to turn moderate liberal revolutions into social ones. Below and around the capitalist entrepreneurs the discontented and displaced 'labouring poor' stirred and surged.*

Ashford (1986: 67) argues that by the turn of the 19th century "Britain was astoundingly unprepared for dealing with an industrial labour force," for two main reasons. Firstly, the strength of liberal

ideology – in both social and economic matters – meant that state intervention was a concept not easily accepted within the echelons of power, and that the government therefore lacked "a concept of state" that could help "leaders and thinkers of the period to assemble their ideas and programmes" (Ashford, 1986: 67). Secondly, the state intervention and policy was largely oriented towards protecting the interests of the landed gentry, at this time still a powerful political force. Yet by the 1860s the sheer social need that industrialisation and urbanisation had created, as well as the push from prominent social reformers such as Edwin Chadwick, Robert Morant, and the Earl of Shaftesbury, meant that the British government had been forced to develop a new set of interventions to meet this demand (Ashford, 1986). The fact that they had "no concept of state" meant that these programmes and policies seemed somewhat scattered and ad hoc, developing according to specific needs within specific sectors. Nevertheless, by 1880, the Factory Acts which governed working hours and conditions in factories (first instituted in 1802) had been through several amendments (Henriques, 1979), and urban public health services had become an increasingly prominent issue after Chadwick's publication of The Health of Towns Commission Report of 1845, which "drew forcible attention to the connection between disease and bad drainage, poor ventilation and inadequate living spaces" (Henriques, 1979: 87).

There are two points worth emphasising here regarding British health policies up to 1880. The first is that such policies were closely related to the development of an industrial working class. It was this group – divorced from the land, living in cities which could not cope adequately with the influx of people, insecurely employed, and prone to disease and injury which could wipe out their ability to sell their labour power – who most needed protection by the state. It was also this class, a class that was still in the process of formation, but whose labour power fuelled industry, that "the new men of the industrial…class" relied on to keep industry running, and whose vote was needed as electoral democracy grew to be the organising principle of the state (Henriques, 1979: 113; Hobsbawm, 1987). The result was that the policies and programmes which were developed during this period placed their focus on the working man. For example, the history of public health policy, which is now more closely linked to citizenship than to work status, was in fact "intimately tied up with the history of working class housing" (Henriques, 1979: 87). For example, one of Chadwick's famous public health reports was called *The 1842 Inquiry into the Sanitary Conditions of the Labouring Population of Great Britain*. Rosen (1958) points out that public health was also closely linked, in its sanitary focus, to demands for the improvement of working conditions in the factories, the focus of the Factory Acts.

The second point is that it was only after 1880 that the groundwork was laid for what was to become Britain's welfare state. Between 1860 and 1880, this process was far from complete, and *laissez-faire* as a guiding principle was still strong. The Poor Law Amendment Act of 1834, which had lifted the state protections to the poor afforded by the Elizabethan Poor Laws, was actively enforced. The so-called "New Poor Laws" were based on a mixture of Benthamite utilitarianism, Ricardian wage theory, and Malthusian population principles and were essentially designed to make social assistance to the poor as unpleasant as possible, so that the rural poor migrating to cities were forced to find employment. Poor relief was available only in the infamous workhouses ("outdoor relief" being discouraged as providing a disincentive to work) (Ashford, 1986). Master and Servant legislation, which had first originated in 1562 in order to deal with the labour shortages created by the Black Death, was also in force. Through its provisions, which included until 1875 penal sanctions for servants who broke the law, the Master and Servant Act of 1867 attempted to instil labour discipline and control inflation by preventing workers from "bidding up wages," and to "prevent trades from leaving towns for the countryside, and forestall or repress widespread and dangerous riot and disorder caused by recurrent harvest failure and depression" (Hay, 2004: 64).

The period between 1860 and 1880 then was a period of transition. On the one hand the provision of social services was beginning to emerge as a function of government. There was also beginning to be a recognition, with Chadwick's influence, that labour productivity could suffer because of dirt, disease, and poor living and working conditions, and that, even worse, this would increase the burden on the state's workhouses as illness resulted in an inability to work (Rosen, 1958: 185). Interestingly, Chadwick had sat on the Poor Law Commission of 1832, and did not want to admit that disease amongst "able-bodied" adults might be a consequence of poverty (which would "have rendered a deterrent Poor Law morally indefensible"). Instead he chose to argue that poverty followed from disease, and that it was disease and the environment which produced it that needed to be tackled (Henriques, 1979: 87). Yet despite these shifts towards more interventionist forms of governance, much of the focus of health and labour policy remained on building up a regular waged labour force to feed the growing industrial machine through overtly coercive "incentive" mechanisms such as the Poor Law Amendment Act of 1834 and the Masters and Servants Act, and not on the provision of state entitlements to rights bearing individuals.

However, from 1880 onwards state intervention in Britain began to take on a qualitatively different form as the challenges to *laissez-faire* became increasingly strong. There were a number of factors which prompted this change. Firstly, the economic depression that occurred between the years of

1873 and 1896, as well as rapid industrialisation in the rest of Europe, forced the British government to begin rethinking its economic and social policies. The depression transformed European countries from an "aggregate of national economies" to "a group of rival economies, in which the gains of one seemed to threaten the position of others" (Hobsbawm, 1987: 58). The result was that it was not just firms, but nations, which began to compete with one another, ultimately contributing to a declaration of war in 1914. By the turn of the 20th century Britain was becoming increasingly insecure about its position as global superpower. Apart from the increasing economic competition, the Boer War in South Africa had revealed a startlingly incompetent and undernourished military and its population was growing at a slower rate than any of the other European states, leaving many in Britain "anxious to restructure the national life and overhaul the machinery of government, to fit Britain more adequately for the Great Power rivalries of the twentieth century" (Searle, 1971). Investments in the nation's human resources were seen to be a key part of this – attention was therefore paid to education and, in particular, health. Healthy, strong, well-educated Britons were to be the backbone of a stronger state and economy – an underlying logic of health and welfare policies which Pickstone calls "productionism" (Searle, 1971; Pickstone, 2000).

This period was also a turning point for organised labour. The political power of the landed aristocracy was waning and the institutions of mass electoral democracy were becoming entrenched. In 1874 the first trade unions entered Parliament and by the turn of the century labour was an increasingly powerful political force, contributing after World War One to the downfall of the Liberal Party and the rise of the Labour Party in British Politics (Dangerfield, 1935 (1961)).[5] Moreover, it was recognised that the skilled regular workman was the backbone of the industrial economy, and that policies which aimed to increase productivity needed to focus as well on improving the living and working conditions of this "respectable working class" (Hobsbawn, 1987).

After 1880 the laws regulating working conditions in factories and mines were strengthened considerably, and the departments administering them bolstered (Bartrip, 2002, Mills, 2008). In 1898 the Home Office appointed Dr. Thomas Legge as the first Medical Inspector of Factories, thereby giving statutory acknowledgement to the fact that workplaces could be a source of disease as well as injury (Melling, 2010). However, Britain still had no centralised, state provided universal

[5] In his book *The Strange Death of Liberal England,* Dangerfield argues that four "rebellions" contributed to the downfall of the British Liberal Party after World War One, despite their relatively innovative and impressive policies. These were: the Tory resistance to the Parliament Act of 1911 (which reduced the powers of the House of Lords), the threat of civil war in Ireland, the Suffragette movement, and the rise of militant trade unionism.

health service, although arguments towards this end were already being heard from the Fabian Society (Ashford, 1986). Doctors worked privately, except in the poor-house health facilities, which were administered by local governments. Local governments also continued to administer urban health and sanitation services. This was to change to a limited extent, however, in 1911 with the introduction of Lloyd George's National Insurance (NI) Act, which included both unemployment and health insurance provisions (Gladstone, 1999; Sturdy, 2002).

Unemployment was, in fact, one of the major concerns of British politicians and social thinkers around the turn of the century. According to Ashford (1986: 196), "In the late 19th century, officials and academics had only a dim idea of what unemployment meant." Unemployment was seen as an inevitable fact of life and "for most of the nineteenth century inadequacy of income as such, whether caused by low wages, irregular employment, or even by sickness, was not considered a legitimate object of state interference, beyond the conditional subsistence granted by poor relief" (Harris, 1992: 44). The long depression that lasted for 23 years between 1873 and 1896 had revealed that unemployment was not necessarily an inevitability, but something that arose from the economic structure of society. The central problem facing the government was how to "revise obsolescent liberal policies concerning the poor and less educated" to deal with this reality (Ashford, 1986: 196). At the time, the answer came in the form of the NI Act, which looked to incorporate the mutual insurance schemes of the Friendly Societies into a state-administered scheme which offered protections to regular wage-earning men. No doubt influenced by Bismarck's scheme already in operation in Germany, the NI Act was also a convenient way for Lloyd George to ensure the continued dominance of private insurers, who were given favoured status as providers, and thereby ensuring Tory support (Ashford, 1986; Sturdy, 2002). In terms of health provisions the NI was very limited – providing health insurance benefits to working men only, whilst excluding their families.

According to Hobsbawn (1975: 15), the start of World War One in 1914 represented the end of an era in Europe – the end of "the world made for and by the bourgeoisie." After 1914, an amalgamation of forces – the entrenchment of mass electoral politics, the rise of working class political parties (such as the Labour Party in Britain), Keynesian economic theory, a weakening ideological opposition to state intervention, as well as the social consequences of two world wars and the Great Depression pushed Britain towards "a comprehensive welfare ideology" in which "social expenditure could be seen to change and improve society" instead of merely reacting to social crises (Gladstone, 1991: 3). Productionist ideology was still very much a part of this – the wealth and efficiency of the nation relied on state investments in the health and welfare of the

population. However, this was now framed within a conception of social justice – a wider idea that health, education, housing, welfare and social security were social rights that citizens could claim from the state. Although it was only after World War Two that Britain's welfare state was institutionalised under Clement Atlee's Labour Government with the publication of Sir William Beveridge's Report (1942) and the passing of the Education Act (1944), the National Health Service Act (1946), the National Insurance Act (1946), and the National Assistance Act (1948), the debates leading up to this had already taken place in the 1920s and 1930s (Gladstone, 1991).

Within these debates was a central tension that in later years would play itself out across the colonies – a tension between inclusion into the new social policy regime based on status as a worker (and therefore contributor) versus inclusion based on a more universal conception of social rights. Glennester and Evans (1994: 58) have analysed this tension within the work of Beveridge, arguing that:

> *At the heart of [his] thinking was a contradictory struggle between his deep desire to cover everything and everyone without a means test and his choice of method, contributory insurance through employment. He wished to give security to all, but to base this security, apart from family allowances, on participation in the labour market.*

Ultimately, they argue, Beveridge was forced to choose this path because it was a compromise that had been agreed upon by employers, workers, and the state, and he would have risked the alienation of the trade unions, who were determined to protect the rights of the "respectable working classes" if he had not (Glennerster and Evans, 1994). The result was a system based largely on social insurance, with contributions to be collected through payroll taxes. One of the great exceptions – an exception that will be discussed in more detail in Chapter Four – was the annulment of the 1911 NI Act and its replacement with the National Health Service (NHS), which converted the public health system into a centralised state system that was free to all (Whiteside, 1999).

The Place of the Worker in the Health Policy and Provision in India, 1865-1945

A complex mix of factors brought the attention of colonial officials to health matters in the colonies, and it was a mix that inevitably changed over time. Contributing to the implementation of health reforms in colonial societies were a number of factors, including: colonial economics, changing ideologies about the role of the state and the rights of the individual, the increasing strength of reform movements both religious and secular in Britain and its colonies, the need, particularly as the nature of the colonial project shifted, to keep onside ruling elites, as well as the increasing resistance and calls by colonial subjects themselves to have the benefits of western scientific advances. In implementing these reforms, it was inevitable that colonial officials would look to Britain for models

and examples. Once these models had entered the colonial realm, however, they were modified to suit the specific political economy, and were adjusted to local social and cultural contexts. This meant that the history of health reforms in the colonies, although certainly having a connection to the metropole, had their own specific politics.

An important catalyst for the initial introduction of health legislation in the colonies was the end of slavery, which was finally abolished in the British Empire in 1843. The Abolitionist Movement in England had a number of influences, from the religious (Quakers and Evangelicals featured prominently in the movement) to the philosophical as enlightenment ideas regarding individual freedom and equality spread through Europe after the French Revolution. However, as Cooper (1987) points out, there were also sound economic reasons for abolishing slavery in the colonies. Slavery was not an efficient way to develop and maintain the labour force that became increasingly necessary as the nature of colonial capitalism began to shift from what Hobsbawm (1975) calls "private enterprise colonialism," based on trade and which required a minimal local labour force, to a colonialism that required large amounts of local labour for plantations and later on factories and mines. With slave labour "discipline" was never guaranteed as slaves resisted by exerting their "personal autonomy" and deserting frequently. The violence required to maintain the slave labour force was also not conducive to the kind of stable society from which a regular labour force could be drawn (Cooper, 1987: 16).

The end of private enterprise colonialism in India was signalled by the 1857 Indian Mutiny, which put an end to the rule of the East India Company. The administration of India was thereafter transferred to the British Crown. This shift created the conditions that would force the state to develop legislation and policies to regulate key areas of social and economic life in India. It was now the state that was responsible for the governance of a subject population, which included the administration of towns, labour, and public health. It was also the state that now had to deal with the fundamental problem of "creating the conditions that fostered internalised discipline among…workers" in the absence of the compulsions of slavery – something which forced a movement away from the previously favoured *laissez-faire* and towards a more interventionist stance (Cooper, 1987: 13).

Here health legislation was to play an important role as it was discovered how difficult it was to produce a consistent and productive workforce when death rates from disease were very high. The first British colonial legislation regulating the health of workers was developed in India in 1865 and was aimed at the tea plantation zones such as the Assam Valley in north-eastern India, where

European planters had been operating since 1833. The provisions of the 1865 regulations stated that:

> *In the interests of the coolie, Protectors of Labourers and Inspectors of Labourers were appointed and these officers and the District Magistrates were empowered to inspect gardens…every estate was to maintain a hospital and estates employing over 300 labourers were also bound to employ a medical officer approved by the Local Government.*[6]

The legislation had largely come about as a result of problems with labour discipline and the inability of European planters to recruit adequate numbers of workers, particularly during the tea boom that lasted from 1860-1865. Planters could rely on networks of private labour recruiters known as *sardars,* as well as the introduction of an indentured system of labour and the Indian Penal Code of 1860 which allowed planters to institute criminal proceedings against workers who deserted their employers during their period of indenture (Anderson, 2004; Mohapatra, 2004). These provisions were nonetheless still unable to prevent large numbers of workers from deserting. Eventually, a series of commissions were established to enquire into the reasons for the continued loss of labour, and attention was drawn to the "altogether appalling"[7] death rates of the labourers, which, it was argued, was a strong contributing factor to high rates of desertion. One official account reported that between 1863 and 1866 out of a recruited labour force of 85 000, 35 000 (over 40 percent) had either died or deserted (Behal, 2006). Health loomed large within commission reports, and the influence of Chadwick's environmentalist outlook was apparent. A commission which sat in 1868 blamed the death rate on the "want of proper houses, over-crowding, unhealthy sites, insufficient and unsuitable food, impure water and want of proper medical attendance," arguing in addition that the "Protectors of Labour" in the tea areas had "no special sanitary knowledge" and should be replaced by Inspectors with appropriate powers of sanitary enforcement.[8]

A similar problem was faced in later years by the Bengal coal mines, which boomed in the late 19th century (Roy, 2000). Labourers in the coal mines were drawn from the surrounding rural areas, and were usually from the 'poorest strata' of society. Even these workers, however, had their limits in terms of how much they were willing to risk the loss of life and limb for wages. In a 1909 report, mining officials noted that the high incidence of cholera in the area was "driving labour from the mines."[9] Earlier reports had argued that the improvement of public health and sanitation around the coal fields was of utmost importance; plague had hit the Jharia coal fields during 1905, as well as two

[6] British Library (hereafter BL), IOR/V/26/670/2: Report of the Assam Labour Enquiry Committee, 1906.
[7] *Ibid*.
[8] *Ibid*.
[9] BL, IOR/V/3065, Report of the Chief Inspector of Mines, 1909.

serious epidemics of cholera. Workers had returned to their villages, some of which were over 50 miles away, "and alarming rumours about the unhealthy conditions of the mining districts are quickly spread over at least 10 000 square miles of recruit-grounds."[10] Realising the danger this posed to the labour supply, government and the mine owners were forced to establish Health Boards to oversee sanitary inspections of the mining area and additional staff for the resident doctor.

Although these mining health regulations developed at a later stage, and were certainly influenced by the increasing attention paid to health and sanitation by the turn of the 20th century, the basic issue was similar to the one faced by the plantations in 1865: it was difficult to keep workers in place when death and disease had become synonymous with the workplace, despite the availability of violent and coercive measures such as penal sanctions. It became increasingly apparent that force alone was not enough. Dead workers were not able to produce anything for their employers. Workers were also less likely to finish their contracts when working on the plantations or mines appeared to amount to an almost certain death sentence.

This fact points to a further important insight – that early workers' health legislation was profoundly influenced by the resistance of the workers to the labour regime. This type of resistance was different from Cooper's idea of an 'engagement' with power. The discourse of rights was not yet available to the majority of colonial workers, meaning that it was not possible to engage on that basis with the colonial state. Even then, as Cooper (1987) has also shown in relation to East African plantation labour, workers could vote with their feet, and in doing so forced the colonial state and employers to react in certain ways. In India during the period 1860 to 1880, and in later years on the mines and mills, the fact that labourers either refused to go to the plantations or deserted in such large numbers when they did, was a form of resistance against which the colonial state was forced to react with legislative measures, including those which, at least in theory, provided some protection to the health of workers.

However, the ability of workers to effect change during this period should not be overestimated. The structure of the colonial state in India during this time was one in in which the planters had an enormous amount of power, and this would always limit the protections workers would receive. Secondly, where health regulations were developed, they were not rigorously applied. As Bartrip (2002) has pointed out, this reflected a similar situation in Britain itself where labour protections for

[10] BL, IOR/V/3065, Report of the Chief Inspector of Mines, 1906.

workers were only rigorously enforced after 1880. Nevertheless, there were differences. For example, the penal sanctions in India, which were derived from British law, excluded the employee protections afforded to British workers (Anderson, 2004). These penal sanctions were also strengthened during the late 1800s, and, despite many abuses of the privilege, private powers of arrest were allowed to continue well into the early 20th century, whilst health and welfare regulations remained patchy at best (Mohapatra, 2004). Planters were willing to flout regulations, knowing that it was unlikely that they would be forced to pay a penalty. As James (1997: 350) puts it:

> *In terms of racial arrogance, the tea and indigo planters had shameful reputations; like plantation owners and managers in every corner of the world, the Indian planters believed that they had the right to do as they pleased with their labour force and exercised it in defiance of the letter of the law.*

As in Britain itself, a qualitative change in the breadth and intent of health legislation came about after 1880. The depression of the late 19th century had also affected Britain's colonial ambitions, and this had an important impact on the development of both health and labour legislation in India. Although the connection between the depression and the imperialist expansion that began after 1880 has been much debated, Hobsbawm (1987) argues that the two were connected, albeit in complex ways. Hewa (1995: 12) argues that the period of colonial expansion which occurred after 1880 represented a change from "plantation capitalism" to "monopoly capitalism," characterised by "the emergence of giant firms with the ability to exercise a great deal of influence on their markets and suppliers." As Hobsbawm (1987) points out, much of the colonial expansion in this period was based on the need to find new markets for European manufacturers in the belief that the "crisis of overproduction" which had occasioned the depression could be resolved through what David Harvey calls a "spatial fix" (Harvey, 2010b). Whilst India had always been Britain's prized possession, it now began to take on a new importance. Up to 60 percent of British exports were going to India and the Far East during this period, with over 40 percent going to India alone (Hobsbawm, 1987). In addition to this, colonial territories like India began to be seen as an important source of the raw materials needed to feed European industry.

In India this process led to the emergence of a coal industry centred in Bengal. Coal fuelled the steam engine which in turn fuelled Europe's Industrial Revolution. In order to allow for the efficient export of coal, the Indian state built railway networks between ports like Calcutta and the interior. In turn the railways themselves required coal to operate, further bolstering the industry. Unlike most other British territories, however, India had its own capitalist class who were, to a limited extent, able to take advantage of the coal boom, so that a significant number of the smaller collieries supplying about one-third of total production by 1947 were Indian owned (Roy, 2000). A large scale,

Indian-owned textile industry also began to emerge after the first modern textile mill was set up in Bombay in 1854. This signalled a drastic change for the organisation of the Indian textile industry, which, since the 18th century, had serviced the cloth needs of much of the world. Hitherto the industry had been organised around village weavers who sold their product on to merchants who then sold the cloth on to foreign trading firms for export (Roy, 2000). The introduction of large scale modern textile mills, owned largely by the middle-men merchants, changed this production process, creating a market for British mill machinery and bringing textile workers into the now growing cities.

As in Britain, the period of monopoly capitalism was also characterised by greater state intervention, as the colonial administration was forced to grapple with the difficulties arising from urbanisation and an increasing wage labour force. Health, in particular, began to take on greater importance, particularly as the productionist ethos in Britain began to filter down to the colonies. This occurred first through the doctors of the increasingly established colonial medical services, which began now to take a wider interest in both urban and labour health (the combined Indian Medical Service was established in 1897 and a Gold Coast Medical Service during the 1880s), as well as in the African colonies through the Colonial Secretary Joseph Chamberlain (1895-1903) whose emphasis on urban sanitation was heavily influenced by Chadwick and his successors (Baker and Bayliss, 1987). It was during this period as well that scientific advances in understanding diseases such as malaria and yellow fever were made, leading to the founding of the discipline of "Tropical Medicine" (a subject that will feature more later into this study), the establishment of several influential schools of tropical medicine in both Britain (London and Liverpool) and in India (Calcutta).

Although there were similarities between the emphasis on improved health provision in Britain and India after 1880, there were also crucial differences – differences which gave rise to the very specific tensions and contradictions that characterised colonial India and its approach to health provision. In Britain, the greater commitment to state protections had developed through a process in which an understanding that individuals had some right to claim entitlements from the state had developed. This conception of the state-individual relationship was not present in the colonial context. The underlying logic was instead one of paternalism and trusteeship – Britain would look after its colonial subjects until they "were ready" to look after themselves (Anderson, 2004). Paternalism and trusteeship had the advantage that state intervention in matters of health would be more widely spread than the very specific concern in the earlier period with the health of Europeans and of isolated rural areas where labour was concentrated. However, this paternalism was always to come

into conflict with the fact that an overarching logic of colonialism was one of profit maximisation for Britain. Spending on social provisions was not a priority, and this did not change.[11]

These tensions and contradictions were to play out within the sphere of health, as administrative concerns with budgets came increasingly into conflict with the "new men" of the Indian Medical Service. A key aspect of the period after 1880 was the innovations of medical science, led by the officers of the Indian Medical Service, who hitherto had focused their efforts on the health of the British military in India. The years between 1871 and 1921 had heralded in a "woeful crescendo of death" in India (Klein cited in Arnold, 1993: 200). The reasons for this have been much debated, with some scholars arguing that India had been opened up through greater travel and trade to previously unknown pathogens, whilst others have emphasised the fact that the deteriorating social and environmental conditions were the greatest contributing factor (Arnold, 1993). Certainly, it was the degraded social and environmental conditions which drew the attention of the colonial medical officers who were starting to make waves in India around this period.

During this time medical officers such as Ronald Ross (who discovered the relationship between malaria and the mosquito while working for the Indian Medical Service), William Simpson (the Chief Medical Officer for Calcutta during the 1890s), and Patrick Manson (who had preceded Ross's discovery by establishing the link between filiariasis and mosquito borne parasites) were in the process of establishing the discipline of Tropical Medicine (Baker and Bayliss, 1987). This discipline was heavily influenced by Chadwick's sanitarianism and focused on environmental management as a way in which to control disease. Indeed, Simpson's later lectures at the London School of Hygiene and Tropical Medicine were described by one observer as "a maze of drains, ditches, lavatories and houses" (Baker and Bayliss, 1987: 457). At the same time, as Arnold (1993) points out, Tropical Medicine was not just a transported product – it was a practice of medicine that was both influenced and transformed by the specificities of the Indian environment and people.

A number of historians of colonial health have argued that Tropical Medicine was both produced by and productive of colonial difference (Arnold, 1993; Anderson, 2006). It emphasised the difference between Britain, where diseases of the environment had been conquered through sanitary reform,

[11] Sara Berry argues that Britain exercised "hegemony on a shoestring," particularly in relation to its African colonies (less so in India). This meant relying on "indirect rule" through princes and chiefs in rural areas, whilst concentrating spending on urban areas and rural zones in which there were high concentrations of labour servicing colonial industries.

and India whose inferior level of development meant that they had not (Anderson, 2006). It also emphasised the intrinsic otherness of India as "a pathogenic of heart of darkness" from whence terrifying diseases unknown in Britain emerged (Amrith, 2006). An aspect of Tropical Medicine that is often ignored, however, is that it also contained a universalising streak – one which inspired the belief among men like Simpson that the answer to the mix of poverty and disease that by the 1890s was laying siege to India's towns, lay in the same approach that had been used in Britain. This was essentially Edwin Chadwick's approach to disease prevention: the upgrading of basic sanitation infrastructure, the demolition of slums, and the building of hygienic housing for the working classes. The fact that this universalising tendency within Tropical Medicine is not one that is paid much attention by historians of colonial health is perhaps a reflection of the general orientation of post-colonial theory, with its focus on the production of difference. Yet it is when the work of medical men such as Simpson is seen in terms of their efforts to transfer a universal standard of sanitation to India, whilst at the same time being confronted by the need to keep social spending to a minimum, that the contradictions of the late colonial project become obvious.

The rhetoric behind sanitary upgrades in India had been present since the 1880s (a Commission on Sanitation sat in Calcutta in 1885 for example), but it was really only after the 1896 plague epidemic that efforts were actually made to "turn rhetoric into reality" (Harrison, 1994: 97). During the 1880s, in a bid to cut costs, the Government of India had declared that the public health of towns would be the responsibility of local councils (partly made up of elected Indian officials) and would have to be self-financing (Amrith, 2011). The results did not work in favour of the public's health – the Calcutta Sanitation Commission Report of 1885 noted that:

> *Confining ourselves…to the mortality as shown in the returns made since 1867, it would seem that there has been no real improvement in the health of the Town. On the contrary, if the figures are to be trusted, it would appear that the public health has actually deteriorated during the last nine years as compared with the previous five or six years.*[12]

By 1896 this had deteriorated further, the general filth and squalor of the growing industrial towns in particular leading to an unprecedented outbreak of plague between the years 1896 and 1904. According to Arnold (1993) by 1901 the plague mortality figures exceeded a quarter of a million deaths, and by 1904 this had risen to over a million. As Arnold (1993) points out, the plague had devastating economic as well as social consequences as workers fled the cities in fear for their lives. "At the height of the plague exodus, only a fifth of Bombay's millhands remained at work. Calcutta was to experience a similar, if briefer exodus, in April 1898 when possibly a quarter of the city's residents fled" (Arnold, 1993: 2055).

[12] BL, IOR/V/26/840/8: Calcutta Sanitation Commission Report, 1885.

The plague forced the government to respond with public health measures. In 1904 the Report of the Plague Commission recommended the strengthening of public health works, and the addition of health posts under the provincial government Deputy Sanitary Inspectors.[13] This meant that public health was no longer solely the responsibility of local councils, but would receive support from provincial governments as well. One of the key areas of concern after the plague epidemic was the upgrading of slum housing. In Bombay the Bombay Housing Trust was established to find solutions to the problem of "overcrowding and insanitary housing" (Kidambi, 2001). However, as Kidambi (2001) shows, the Housing Trust itself was a victim of the contradiction between improved medical knowledge, the need and desire to improve social conditions, and the need to rein in social spending, and it ultimately failed to provide much in the way of relief to the urban housing crisis. Although the problem was framed as one that sought to resolve the housing crisis of the poor in general, in reality it ended up targeting industrial workers. In order to limit the investment of state resources, it first looked to mill owners to build low-cost housing for their workers. Eventually in 1913 the Poorer Classes Amendment Scheme was passed which mandated the trust to spend money on the building of houses for the working classes. These houses were then leased to mill owners at a rate that would allow the trust to recuperate its expenditure plus four percent interest over a 28 year period. Even this more limited scheme was unsuccessful, with only one mill actually agreeing to participate (Kidambi, 2001).

Tensions and contradictions were also evident in the health legislation that developed around the Indian textile industry. The industry had become a key source of revenue for the Indian state, and was largely controlled by the indigenous elite on whose support the Raj relied. At the same time, however, Britain's textile industry had competed with India's for a share of the global market since the last two decades of the 18th century. Although Britain had gained the upper hand, the mechanisation of the Indian textile industry after 1860 meant that this competition was renewed. This meant that trade-offs had to be made between the needs of the British textile Industry and that of the Indian textile industry, and between the political needs of the metropole and the political needs of the colony.

The development of the Indian Factory Acts were emblematic of these dilemmas. The initial 1881 Act, recommended by the 1875 Arbuthnot Commission, had focused largely on issues such as age restrictions on working children, limits to the working day, protection of machinery, and availability

[13] Government of India, Report of the Health Survey and Development Committee Survey, 1946 (Bhore Committee Report).

of drinking water.[14] Although the factory reforms in India were also influenced by social reformers concerned with the welfare of women and children, the predominant concern was to balance the needs of Lancashire with the needs of the Government of India and the Indian elite. On the one hand the Lancashire Textiles Lobby was concerned that the increased regulation that they were experiencing under the British Factory Acts would mean that the unregulated Indian mills would gain the economic advantage.[15] On the other hand the Indian mill owners argued that the imposition of the Factory Acts was a protectionist move by Britain. The result was a compromise of sorts. As the Arbuthnot Commission noted:

> *In a point of caution the Commission were unanimous in their opinion that any Imperial Act that may be passed should not interfere more than is absolutely necessary with the working of factories, for these must be considered as highly important both financially and politically and of great benefit to the country as a whole.*[16]

This meant that the Act was minimalist, and arguably had more to do with increasing the costs to Indian factory owners by pushing them to make greater investments in the physical safety of factories and limiting the use of cheap child labour, than it had to do with a concern for Indian workers. Nevertheless, despite these origins, with the passing of time the Act was used by Indian labour organisations to extend the depth and breadth of labour protections. This move was presaged by Dr. T.M. Nair, Municipal Commissioner of Madras in a dissenting minute of the 1908 Factory Commission:

> *However much, I, as a native of India, may be opposed to the interference of Lancashire in questions closely related to the manufacturing interests of India, I cannot but help admit that the result of Lancashire's interference has, on some occasions at least, been of considerable benefit…Abuses are abuses whether they are pointed out by friends or foes.*[17]

Sanitary matters were only addressed in a rudimentary form after 1884 when a resolution was passed which allowed local government sanitary inspectors to inspect factories. However, it was only after the turn of the century that it began to be seen as a central concern, when unhealthy living and working conditions began to be linked to the "low efficiency of operatives" in the Indian mills.[18]

---

[14] BL, IOR/V/26/670/85, Report on the Commission appointed by the Governor of Bombay in Council to Inquire into the Conditions of the Operatives in Bombay Factories and the Necessity or Otherwise of the Passing of the Factory Act (Arbuthnot Commission), 1875.
[15] Kydd, J.C. 1920. A History of Factory Legislation in India. Calcutta: Calcutta University Press.
[16] BL, IOR/V/26/670/85, Report on the Commission appointed by the Governor of Bombay in Council to Inquire into the Conditions of the Operatives in Bombay Factories and the Necessity or Otherwise of the Passing of the Factory Act (Arbuthnot Commission), 1875.
[17] BL, IOR/V/26/670/6, Report of the Indian Factory Labour Commission, 1908.
[18] *Ibid.*

The tensions inherent in British colonialism would continue to escalate as the 20th century matured. As Cooper (1996) has argued, it was ultimately the great contradiction between the need for the colonial state to intervene in social and economic life in an increasingly liberal and progressive fashion, contrasted against the basic laws of profit that finally bought the Empire to its knees. In India, Britain's oldest colony, the cracks began to show in a serious way after World War One, although signs of difficulty had been increasingly obvious since the first partition of Bengal in 1905 under Lord Curzon, which separated the western Hindu region from the Eastern Muslim region, leading to a great deal of unhappiness amongst Hindus. Radical elements within the Indian National Congress were stirred, creating a split in 1907 between the moderates and extremists who began to call for *swaraj* (self-rule). In Bengal itself there was an upsurge in worker strikes, as well as the growth of terrorist cells known as *samiti*, which were repressed "ruthlessly" by the military machine, but continued to destabilise the area (Wolpert, 1993). In 1906 Curzon was replaced by the Earl of Minto, a Liberal appointee, whose general incompetence meant that it was the Secretary of State, John Morley, who was largely in left to quell the tide of resentment arising from Bengal (James, 1997). Morely was a Gladstonian Liberal who believed that stability to India would not be bought by military power alone, and that it would be necessary to go further and incorporate the moderate Indian elite into government. He steered the Raj towards the Indian Councils Act of 1909, which allowed for elected Indian representatives to sit on various legislative bodies (James, 1997).

After World War One, however, the need to placate India became even more pronounced. Britain had relied heavily on the help of its major colony during the war, financially and in the use of the Indian Army on the battlefields (James, 1997). To entice India into the war effort, promises were made that it would be on the path to dominionhood as were Canada and Australia. At the same time though, whilst Britain had by now lost any enthusiasm for imperial expansion, Darwin (1980: 657) notes that post-war colonial policy "was strangely reluctant to liberate Britain's dependencies or hold out firm promises of independence." Perhaps this was not so strange – as James (1997: 436) argues, Britain still hoped to defend its status as a leading global power, and the loss of India, the "keystone of the Empire," would have signalled the end of these hopes.

In the meantime, the compromise was the implementation of a series of liberal reforms, first in India and by the mid to late 1930s in the rest of its colonial territories. Violence and coercion would remain a part of the way in which the colonial states operated on the ground, but, in official rhetoric, this was now replaced by a liberal regime which acted as a trustee to colonial peoples, safeguarding their welfare until they were able to safeguard their own. It was during this period when the

institutions and administrative structures, and the ideological rationale for their shape and structure, were laid down in such a way that they continue to influence policies in the old British colonies to this day. It was also during this period that resistance to British rule began to take on its most organised and potent form, first in India and later in Mauritius, the West Indies, and the African colonies, drawing on the language of rights and entitlements and ultimately forcing Britain to abandon its Empire and direct imperial rule.

In India specifically, a crucial turning point for the Raj was the massacre at Amritsar in 1919, when British Army forces opened fire on a crowd of peaceful protestors in the Jallianwalah Bagh garden in Amritsar, Punjab. The Indian Munity of 1857 has been described by Hobsbawm (1987) as "the last kick" of old India against the new imperial power. Amritsar can be thought of as a similar "last kick" of the colonial state which used such overt violence as its primary means of social control. The fact that this was considered an international scandal reflected the changing norms of the time. The massacre, coupled with the fact that it was becoming increasingly clear that Britain was not making good on its promise of dominion status for India, led to an upsurge in Indian nationalism and anti-Raj sentiment and through this to the reinvigoration of the Congress party as a "dynamic mass movement which embraced the peasantry and the growing class of industrial workers" (James, 1997: 464). The "midwife" of this process was Mahatma Gandhi, who would lead India in the various "Round Table" negotiations on India's status within the Empire during the 1920s and 1930s (James, 1997: 464). After Amritsar, the Raj was forced into the enactment of liberal reforms, where it first began to experiment with the use of these as a means to buy the favour of the Indian elites whose support they relied on and who had been outraged by the actions of the British army (Wolpert, 1993, James, 1997).

Two main sets of reforms dominated the period prior to India's independence in 1948. The first was the Government of India Act of 1919 (also known as the Montagu-Chelmsford Reforms), which set up a system of "dyarchy" – a dual system of government, where responsibility was shared between the provinces and the central government. Under the 1919 reforms Agriculture, Local Government Supervision, Health, and Education became provincial government responsibilities, whereas Defence, Foreign Affairs, and Communications remained central responsibilities (although financial control ultimately continued to reside in the centre). Provincial councils were to contain a majority of elected representatives, and local councils were "Indianized." Elected representatives were also allowed onto the Imperial Legislative Council. The reforms did not do much to pacify Indian demands; they were seen as appeasing measures whilst press freedom was clamped down on and

the Round Table negotiations failed to result in the promised dominion status for India. Partly in response to this dissatisfaction, the 1919 Act was reviewed in 1929 and ultimately replaced by the Government of India Act of 1935, which allowed for free elections and which saw in 1936/7 the election of the Congress Party to government. Congress, as James (1997: 585) notes, "had now become a partner in government."

The reforms had a significant impact on the administration of health in India. As mentioned above, the 1919 Act mandated the transfer of health administration to the provinces. The 1935 Act, whilst giving more autonomy to the provinces, did lead to some health functions returning to central control (such as medical education). According to Amrith (2011: 131), the 1920s were a period when health became "a rallying point" for India's elite and middle classes, with the "modernising nationalists" of the Congress party by the 1930s committing themselves to a "deep intervention by state in society." Here "the health of the population became part of a much broader agenda of the transformation from above" (Amrith, 2011: 131). However, according to Harrison (1994), although spending on health did increase during the inter-war period, provincial governments continued to operate with insufficient budgets and "the commitment of many Indian politicians to sanitary reform remained dubious, with a marked preference for expenditure on education" (Harrison, 1994: 436).

Certainly at central level, the issue of public health had not been a priority. During the Legislative Debates in 1946, Mr. SHY Oulsnam noted that "…it is many years since any public health matter had occupied the time of this House."[19] Partly, he argued, this was because the reforms had designated it a provincial matter, but it was also because "in former years the subject itself did not attract the same attention as other more attractive matters."[20] Yet he went on to say,

> *The idea that grew that the Central Government was hardly concerned with the health of the country … I may say, no longer prevails. It is now recognised that the Centre, although it may have no legislative powers and it may have no executive power, it cannot be indifferent to the state of public health of the country, that it must take an active part in the solution of health problems and that it can promote the solution of health problems even within constitutional limitations.*[21]

Oulsnam's comments were made in response to the publication of the Report of the Health Survey and Development Committee, led by Sir Joseph Bhore, which in 1944 had been given a mandate to carry out an extensive assessment of the state of public health in India and to make recommendations on its future. The Bhore Commission Report, as it became known, was strongly

[19] BL, IOR/V/9/186, Legislative Debates, 28th February-14th March 1946.
[20] *Ibid*.
[21] *Ibid*.

influenced by two of the world's leading experts on social medicine, John Ryle and Henry Sigerist, and ultimately recommended a system of health care very similar to that which became the National Health Service in Britain.[22] Although the Bhore Report received support from Congress, after 1948 and its election into power, the party chose instead to implement a health insurance scheme – the Employee's State Insurance Scheme (ESIS). This choice will be analysed further in Chapter Four; the purpose of this chapter is to provide the necessary historical background. Amrith (2006) has discussed the choice of the ESIS over Bhore's recommendations, but provides little in the way of explanation for this decision, other than that the disruptions of independence and the partition of India meant that Congress altered priorities. This may well have contributed to the change of policy, but Amrith's explanation omits another central issue – the very central place that the worker occupied in health policy during the late colonial period in India, a period in which social insurance was promoted as a solution for both unemployment and the provision of health services.

In 1925 the last of the legislation which mandated penal sanctions against labour was repealed, and the Government of India began to introduce systems to deal with a "free" labour market (Anderson, 2004). As Anderson (2004) points out, in reality the Indian labour force was far from free, as it continued to be based on a system which relied on *sardars* and the holding of wages in arrears for labour discipline. Nevertheless, pressures in the international sphere, particularly from the International Labour Organisation (ILO) which had been formed in 1919, meant that Britain had to show a willingness to institute a modern system of labour administration in India. Pressure for this was also to come from London, as the Labour Party entered into its coalition government during the 1920s. Health was central to the ensuing labour reforms. A number of commissions on the welfare of labour in industry, plantations, and mines sat during the 1920s, and legislation covering these areas was strengthened. The most prominent of these commissions was The Royal Commission on Labour in India which concluded an extensive survey of labour with a report published in 1931.[23] The report spent a great deal of time on health issues, arguing that it was "a matter of cardinal importance" in relation to labour.[24] The report advocated for a number of measures aimed at improving the welfare of Indian workers. One of its more significant recommendations was for the implementation of a National Health Insurance Scheme – a contributory scheme for workers to be modelled on Britain's 1911 National Insurance Act.[25]

[22] Government of India, Report of the Health Survey and Development Committee Survey, 1946 (Bhore Committee Report).
[23] BL, MSS EUR F174/1031A, Report of the Royal Commission on Labour in India, 1931.
[24] *Ibid.*
[25] *Ibid.*

A particularly striking aspect of the Indian legislative debates during the 1930s and 1940s is how much space the subject of insurance took up. In 1923 the Government of India had been forced by the ILO to implement a Workmen's Compensation Act. The Act introduced in India was not equivalent to that existing in Britain at the time. For example, there was a schedule of occupations, so that only eleven occupations were initially covered (a practice abandoned in 1906 in Britain).[26] The Indian Act placed a very low cap (300 Rupees) on the earnings of eligible workers. British legislation had maintained this, but the cap was significantly higher at 420 Pounds.[27] The Indian Act also upheld the principle of contributory negligence – i.e. that an employer was not liable for compensation if it could be proved that injury or illness had been caused by the worker's own negligence. This was still in operation in Britain under the 1925 Workmen's Compensation Act, but by the late 1930s could not be used by employers as a defence.[28]

In what Rose et al., (2006) describe as a "foundational paper" on the Foucauldian theory of governmentality, Defert (1991) has analysed the emergence of Workmen's Compensation as "political technology" in France. He argues that state-based insurance schemes, which in France replaced workers' mutual schemes, were part of the liberal project to constitute the individual as a political subject by creating an "immediate face-to-face" relationship between the state and the individual. Insurance, he argues, was central to the project of control and surveillance that developed within European liberal regimes. The introduction of the Workmen's Compensation Act in India did certainly mark an important change in the relationship of the state to the workers – it was representative of a shift to more liberal forms of social control. It related to workers as individuals rather than a collective within a factory, mine, or plantation. Yet an analysis such as Defert's (1991) leaves out an important part of the story of this legislation, and it is here that Cooper's (1996) analysis is important. While it was certainly an attempt to reconfigure and reshape the Indian worker, and Indian society, into a modern form that the state could understand and deal with, it simultaneously gave Indian workers a discourse of entitlements which they used to widen the benefits for themselves; it allowed them to engage with power rather than to merely resist it.

[26] BL, IOR/V/24/64, Workmen's Compensation Statistics for Years 1926; 1939. The eleven initial occupations covered included factory workers, tramway workers, builders, miners, dock labourers, linesmen, sewage workers, railway workers, seamen, and members of the fire brigade. Plantation workers were left off the original schedule, although included later.
[27] Clow, A.G. 1924. The Indian Workmen's Compensation Act. Allahabad: The Pioneer Press.
[28] TNA, CO 859/149/2, Comparison between National Insurance (Industrial Injuries) Act, 1946; Workmen's Compensation Model Ordinance (East and West Africa), and Workmen's Compensation Act (UK) 1925; 1946.

This engagement with power was nowhere more obvious than with the Workmen's Compensation Act. Defert (1991) implies that the introduction of Workmen's Compensation legislation in France had a detrimental effect on social cohesion within the workers' movement because of its emphasis on the individual rather than the collective in the form of the mutual societies. In India, however, it appeared to act as something for workers' unions to mobilise around and use to strengthen their membership. Worker associations had existed in India since the 1880s, but it was not until the early 1920s that a significant number of workers began to be unionised and to take part in organised strike action (Arnold, 1980). Part of the reason for this was that it had become a policy of the Government of India to encourage apolitical trade unions to act as a valve for worker grievances and to try where possible to avoid violent strike action – much like the original intentions behind the formation of the Indian National Congress in earlier years (Morris, 1955; Arnold, 1980). During the rapid inflation and decreasing wage rates after World War One this was becoming necessary, and in 1926 the Indian Trade Unions Act made the encouragement of unionisation official. This was a policy that the colonial administration was to enact during the 1940s in the African colonies as a way in which to contain the widespread disturbances of the time.

Unionism in India was from the start a fractious affair, with a number of unions arising and disappearing in a relatively short period of time. As Arnold (1980) notes, the "law and order" approach of the Raj made it difficult for unions to organise effective strike action until the 1940s. Yet it is also true that legislation like the Workmen's Compensation Act gave the trade unions something with which to improve conditions for their workers. Although colonial officials complained in 1924 of a lacklustre performance by trade unions making use of the Workmen's Compensation Law,[29] by 1948 it was noted that Indian trade unions were taking "an active" interest in ensuring "proper compensation" for injured workers.[30] The limitations of the Workmen's Compensation Act also created footholds for Indian labour and its supporters to argue for further gains. Over a twenty year period, labour representatives in the Legislative Assembly, such as NM Joshi (a founding member of the Bombay Textile Labour Union and general secretary of the All India Trade Union Congress from 1925-1929 and from 1940-1948), were able to push the boundaries of those limitations further and further. They argued for better compensation scales, for all occupational groups to be included within the legislation, for the definition of dependents to be widened, to amend the clause on wilful negligence, and to increase the wage limitation which cut off workers earning above 300 Rupees.[31]

[29] BL, IOR/V/24/64, Workmen's Compensation Statistics for Years 1924 and 1925.
[30] BL, IOR/V/24/64, The Working of the Workmen's Compensation Act of 1923, 1948.
[31] BL, IOR/L/E/9/431, Extracts from Legislative Debates Relating to Workmen's Compensation.

The arguments made on behalf of Indian workers were not always successful, but they did lead to a number of changes in the Act.[32] Moreover, the existence of the Workmen's Compensation Act, and the amount of time spent debating it, certainly created a space for discussions around social insurance that may not have otherwise existed in the legislative chambers. The fact that the Royal Commission on Labour had recommended the implementation of a health insurance scheme gave further impetus to this discussion, particularly as the Indian members of the legislature continued to try to use the gains made against the Workmen's Compensation Act to push for a more comprehensive social insurance scheme. For example, despite the publication of the Bhore Report, the jurist and Dalit activist BR Ambedkar announced in 1946 that "we have in contemplation a Bill which deals with State Insurance, which will include sickness insurance, workmen's compensation, maternity benefit, more or less on the lines of the social security measures adumbrated in England."[33] This Bill had first been mooted in 1942 as a Unified Scheme of Social Security for Factory Workers, inspired not only by calls to reform the Workmen's Compensation Act in India, but also by the "general trend of opinion in other countries [which] appears to be in favour of compulsory State Insurance,"[34] and by the Royal Commission on Labour's "strong case for health insurance in India."[35]

Cooper (1996) argues that British policy makers in the late colonial period lacked imagination in their social policies – preferring to remain with a reality that belonged more to Britain that it did to the colonies. In doing so they had defined a very limited "realm of the possible" for the extension of health and welfare policies – they would revolve around workers, defined in the narrowest possible terms. This of course also had an economic rationale – the extension of universal social citizenship to colonial subjects was not an economically viable proposition for Britain, already stretched at home with increased social spending after the Great Depression. In defining the realm of the possible, through the extension of insurance-based mechanisms, the British also defined the trajectory that Indian activists and administrators took during the late colonial period. The writings of Professor BP Adarkar, who designed the ESIS, reveal very clearly that health policy had become intertwined with the idea of a working class, rather than a more general conception of universal citizenship:

[32] In 1933 the Act was amended to increase the number of scheduled occupations from 10 to 29, to increase the available compensation scales, and to reduce the waiting period for payment. In 1939 it was again amended to include workers who were paid "other than monthly," and in 1946 the cap on earnings was increased to 400 Rupees.
[33] BL, IOR/L/E/9/430: Labour: Workmen's Compensation (Economic and Overseas Department), Extract from Official Report of the Legislative Assembly Debates, 8th February 1946.
[34] BL, IOR/L/E/9/430, Memo from BP Adarkar, Department of Labour, Government of India to All Provincial Governments and Chief Commissioners, 30th of June 1945.
[35] BL, Adarkar, B.P. 1945. Report on Health Insurance for Industrial Workers, Labour Department, Government of India. 1945.

> *Social security measures are meant for the poverty-stricken masses, just as a country-wide health programme is meant for the diseases and unhealthy. The poverty-stricken masses fall into two broad groups: the industrial workers and the landless agricultural proletariat. Health insurance here is meant for industrial workers, but surely the State is free to devise medical assistance, with or without income security, for the agricultural working classes.*[36]

The reasons that Congress chose to remain with this trajectory in the post-colonial period will be explored in Chapter Four. As a final point, however, it is also important to note that the timing of India's independence was likely an important factor in their choice of health insurance over universal health care funded through general taxation. In 1948, the year of India's independence, the National Health Service had only just become operational and was not yet a tested proposition. This led Adarkar to express a cautionary note, saying that he was "quite well aware that Sir William Beveridge had proposed in his monumental report a separation of medical treatment from the administration of cash benefits," but that the "conditions in Britain were peculiar," and that whilst India may one day have a scheme such as Britain's, it was not yet ready for that.[37]

The Worker in Health Policy and Provision in the Gold Coast, 1920-1945

Colonial health legislation and policy in the Gold Coast has a shorter history than that of India. Partly this was because of the timing of Britain's colonial expansion. The African colonies were only consolidated in the period after the 19th century depression when the "scramble for Africa" began, as the European powers looked south for new markets and sources of raw materials. In 1870 Europe controlled only 10 percent of the African continent; by 1914 it controlled 90 percent (Hobsbawm, 1987). In the Gold Coast, British troops fought wars with the Ashanti until their incorporation into the colony in 1896, and it was only in 1901 that the Gold Coast, incorporating Ashanti, and the Northern Territories emerged as a single entity. However, timing was not the only reason. There was also what Anne Phillips (1989) calls the Colonial Office's "West Africa Policy." The main objective of the policy was to make the West African colonies financially self-sufficient, requiring only investments in export facilities and the encouragement of local economic activity which could be taxed (Constantine, 1984). In the Gold Coast this policy manifested itself in the encouragement of indigenous cocoa farming, with the state reaping the rewards of export in a time of global commodity boom. This meant that, at the time, the Gold Coast government had little interest in the development and maintenance of an urbanised wage labour force or any of the accompanying health and welfare policies. For example, whilst Master and Servants legislation had been introduced in the colony in 1874, the reason for its introduction had less to do with the need to mobilise a

[36] *Ibid.*
[37] *Ibid*.

labour force (as in India), and more to do with "eroding slavery" by introducing the idea of a labour contract (Rathbone, 2004).

However, by the turn of the 20th century competing ideas were beginning to surface about the role of the colonial state in West Africa. In 1895 Joseph Chamberlain was appointed as Colonial Secretary. He was an early advocate of a developmental approach to the African colonies, arguing that scientific expertise could aid in the development of the colonies in a manner that would ultimately benefit British economic interests (Hodge, 2007). Under the influence of Chamberlain's directives, urban public health policies began to be implemented in Accra. In 1889 a Municipalities Ordinance was passed which included basic sanitary provisions. However, as in India at the time, the emphasis on sanitary upgrades was placed on areas inhabited by Europeans, whilst the responsibility for the management of other areas of town was offloaded onto the African residents. Town councils were expected to raise their budgets on tax contributions from African residents alone. As a result all expenditure on public works and sanitation (except that which maintained the health of European officials) was halted (Addae, 1996). Not surprisingly the results of this experiment in "local self-government" were similar to those in India. A devastating outbreak of plague in 1908 brought Professor William Simpson, who had by now left India and was lecturing at the London School of Hygiene and Tropical Medicine, to Accra to advise on the implementation of sanitary measures (Parker, 2000).

Simpson's arrival in the Gold Coast was emblematic of a trend that would become more noticeable as the 20th century wore on and health and welfare policies became a feature of Britain's colonial administration and increased in both size and scope. This was the increasing interconnection between colonies. Cross-empire advisory committees were established on topics such as health and labour, and later included housing and social security. As Cooper (1996) points out, these advisory committees were central to formulating and codifying scientific, health, and welfare policies for the Empire as a whole. Here, India often served as a model. Progressive reforms had started earliest in India, and model legislation for Africa and the island colonies was often drawn from existing Indian legislation rather than from its British counterpart. The justification for this was that British legislation was too advanced for colonial societies, but the reality was that the Indian legislation offered less substantive protections to workers and was less onerous on employers and the state.

Acting on Simpson's advice, in 1910 the reform of sanitation began in the Gold Coast, and in 1912 the Towns Ordinance was passed in Accra which set up a Central Health Board to co-ordinate

sanitary activities.[38] In 1913 tours of the interior were carried out by sanitary inspectors in order to develop similar structures for the large towns of the interior such as Kumasi, the Ashanti capital (1996). Freund (1988: 12) points out that the growing emphasis on harnessing science for development also began to intersect with the growing productivist sentiment that was starting to spread throughout the empire: "that Africa's resources could be harnessed only if labour could be developed in a more efficient manner." Impetus was added to this by the growing mining industry in Ashanti which began to challenge the *laissez-faire* approach to labour regulation in the colony. The gold mines had boomed between 1900 and 1902 and were struggling to develop an adequate waged labour force to serve the industry's needs (Crisp, 1984).

Nevertheless, it was only during the 1920s that enough factors converged to promote greater state intervention in the Gold Coast. A key one was the arrival of Gordon Guggisberg as governor between 1919 and 1927. Guggisberg was a reformer intent on social development and the bolstering of education and health services in the colony. The need for greater state intervention was also driven by a labour shortage crisis on the mines. By 1920 even the migrant workers from the endemically poor Northern Territories who had made up the bulk of the mining wage labour force were becoming less available to the mines, as the cocoa industry boomed and competition for labour grew. As Governor Guggisberg put it, "... the prospective migrant worker had learnt to pick and choose, and to know his own value on the labour market" (cited in Crisp, 1984: 50). Although between 1906 and 1920 the mines had been engaging in covert forced recruitment (with some support from the government) in the Northern Territories (Thomas, 1973), the government was becoming increasingly unsupportive of the practice (Crisp, 1984).

The progressive health reforms put in place by Guggisberg, which included the designation of Mining Health Areas (discussed further below), the building of several schools of hygiene, and the bolstering of urban sanitation work, were taken further during the 1930s, a decade which could perhaps be considered the most active period of health reform in the colony. Internally this was given impetus by a group of enthusiastic medical officers, but external forces played a role in this as much as internal ones. In the early years of the decade waves of "disturbances" and strikes rolled across the Empire. In the African colonies workers were becoming increasingly well organised and militant, and Indian workers who had spread throughout the Empire began to demand the same rights that their counterparts at home were receiving (Crisp, 1984; Phillips, 1989). International pressure on the

[38] Although, as Parker (2000) points out, these reforms had less to do with the idea of development or productivity than they had to do with the Gold Coast government's concern with stamping their authority on the urban space that was also the domain of the long urbanised Ga people of Accra.

Colonial Office was also mounting as the ILO began to take an interest in labour matters in "non-metropolitan territories." In 1934 the ILO sent a mission to West Africa to report on labour conditions, which had not reflected altogether favourably on the Gold Coast Government.[39] Horror stories about the conditions on the Gold Coast mines had reached England via reports in the Daily Express, and further advocacy around working conditions in the mines had been arranged in London by a civil society group called the International African Service Bureau.[40]

In Britain, the Colonial Office was developing its plans to bring stability to the African colonies – the plans which Cooper (1996) has described so well in *Decolonization and African Society*, which saw the development of an orderly, stabilised African working class as central to the stability of the Empire as a whole. Yet as Cooper (1996) shows, this project was one that contained the central contradiction that had also been seen in India – providing entitlements to one group of subjects opened the door for claims to widen and extend those entitlements, ultimately laying bare the conflict between doing so and the need to keep spending on the colonies to a minimum whilst reaping the maximum profit.

Health played a central role in this agenda, and, as in India, exemplified this central contradiction. The first concerted effort in the Gold Coast to extend health services beyond the urban population alone and to wage labourers occurred in relation to mine workers, and was linked to the crisis of labour supply. Working conditions on the mines were abysmal – underground conditions were unsafe and living spaces were cramped and unsanitary. According to Crisp (1984: 49) death rates were so high amongst the workers that men considered working on the mines as a death sentence, something that was paralleled amongst the coal miners and plantation workers in India. The mortality rate per thousand in 1923/4 ranged from 31.34 at Prestea Mine, to 65.73 at Abontiakoon, to an astonishing 104.32 at Abosso (Crisp, 1984). To contextualise these figures, it is useful to compare to Indian mortality rates. In 1920 the mortality rate on the Assam Plantations was estimated at 31.54 per thousand after reaching a high the year before of 83.82 per thousand, attributed in large measure to the Spanish flu.[41] These figures were considered unacceptably high, so the figures from the Gold Coast were particularly shocking, and, as the Indian planters had learned in the late 1800s, did little to attract labour to the mines.

[39] National Archives of Ghana (hereafter NAG), ADM 1/1/448, Report to the Director, ILO if a Mission to the British West African Dependencies, 1936.
[40] Rhodes House Archives (hereafter RHA), MSS.Brit.Emp.s.322, Papers of Sir Arthur Creech Jones.
[41] BL, IOR/V/26/670/81.

In 1921 the Secretary of State for the Colonies appointed a "Commission of Enquiry into the High Death Rate Among Native Labourers," to be led again by William Simpson.[42] Simpson's report ascribed the high death rate on the mines to the "unfit and tuberculous" men sent down from the Northern Territories, unsatisfactory housing on the mines, and polluted and insufficient water supply. He placed most of the blame, however, on hookworm disease, the presence of which he attributed to "constant re-infestation from infected latrines in the mines and villages."[43] The report recommended that a Mining Health Areas Ordinance should be enacted "to make regulations for securing and improving the health and housing of natives employed in or about Mines or Works."[44] The Regulations provided for a Government Medical Officer of Health based at Tarkwa whose sole duty was to monitor the state of health in the mining areas. The regulations also provided for a decent standard of sanitation in the actual mine and the areas in which migrant mine employees are housed. Provision was also made for the compulsory registration of deaths – something which Simpson complained was lacking, regular medical examinations, and the provision of adequate facilities for medical treatment.

The report established the basis for health policy in relation to mineworkers for the next 20 years, and is described by Dumett (1993: 221) as "one of those rare turning points in the history of public health administration where a commissioned report actually propelled policy change." No doubt the report was successful because of the changing attitude of the Colonial Office towards its African colonies – Simpson's 1908 report on plague in Accra had led to very limited reforms. By 1925, when his second report was released, enough had changed in the Colonial Office's outlook that his report was greeted with much greater enthusiasm. In relation to this thesis, Simpson's second report is important because of its influence on what unfolded in the 1930s, when health became a hotly contested subject in the Gold Coast. The report, and the way in which it was contested in the 1930s, reveals much about the changing direction of medical practice in the late colonial period. Importantly it also gave rise to a tension between the extension of health services to workers and a more universal application to the colony as a whole – a tension similar to that experienced in India, and one which was to continue to play itself out in the post-colonial period.

[42] NAG CSO 11/14/245, Summary of Events Leading up to the Declaration of the Mining Health Areas Regulations.
[43] NAG ADM 14/1/22; Simpson, WJ. 1925. Preliminary Report on the Investigation Regarding the High Death Rate of Mine Labourers. Gold Coast Sessional Papers IV, 1925/6.
[44] *Ibid*.

The emphasis that Simpson placed on hookworm disease as the main cause of ill-health amongst miners in the Gold Coast is striking in its difference from the sentiments of the Gold Coast doctors at the time his report was released, and the opinions of those who came to replace them. For example, after the publication of his report in 1929 a Gold Coast Medical Department Report simply noted that "larger numbers of individuals harbour the parasite and appear to suffer little."[45] This is a very different discourse from that described by Hewa (1995), when the doctors in India and Ceylon first "discovered" hookworm and its effects on plantation labourers in the late 19th and early 20th century. In 1911 these doctors were reporting that the numbers infected by hookworm had reached 490 million within the Empire, and that hookworm was in fact responsible for many more deaths than it was given credit for, mainly due to the difficulty in detecting the parasite (Hewa, 1995). In 1908 the British Medical Association had deemed hookworm to be of such importance that it set up a conference on the matter, as a well as an advisory committee made up of some of the leading minds in parasitology at the time (Hewa, 1995).

This was Tropical Medicine at its zenith, a medical practice which was deeply engaged with the tropical environment and the exotic diseases which arose from it – diseases which exemplified the "otherness" of colonial geographies and people (Anderson, 2000). Yet, as is argued in the section on India, Tropical Medicine also had within it a universalising streak – one which was present even at the time of Simpson's stay in India. By 1930 this universalising element had grown stronger within the colonial medical service – one that continued to be based on the environmentalism of Chadwick and the school of Tropical Medicine, but which also began to engage with diseases that were seen to be less specific to the tropical environment and more universal in nature.

This trend was exemplified by a concern with tuberculosis in the colonial territories – a disease which until the 1930s had been seen as a concern solely for industrialised countries (Harrison and Worboys, 1997). The Depression in the 1930s, the emergence of unemployment in the colonial context, uncontrolled urban growth, deteriorating health conditions in the colonies, and "the loss of self-confidence in the civilising mission" which had underpinned Tropical Medicine, led to a reframing of disease in the colonial context (Harrison and Worboys, 1997: 109). Tuberculosis came to be seen as an endemic disease which had been exacerbated by capitalist development, and which the colonial state had a moral duty to address (Harrison and Worboys, 1997). Importantly, the focus on tuberculosis bought together medical experts from the colonies and the metropoles, and out of this emerged "an international epistemic community of tuberculosis experts who, whatever the

[45] TNA, CO 98/53 Gold Coast Medical Department Report, 1929.

changes in knowledge and whatever part of the world, operated within a single discourse" (Jones, 2003: 664).

In the Gold Coast the champion of the fight against tuberculosis was a young medical officer named Percy Selwyn-Clarke. Selwyn-Clarke had first entered the Colonial Medical Services in 1919, and was posted to the Gold Coast where he remained until 1929. He then transferred to Nigeria, but returned to the Gold Coast in 1932 until 1936, when he moved to Malaya. During this time he worked his way up from a position as Medical Officer to Deputy Director of Health Services.[46] Prior to joining the Colonial Medical Service, however, he had spent time working with working class patients under Lloyd George's National Insurance, something which had certainly influenced his outlook on the importance of tuberculosis prevention and its link to adequate housing.[47] The National Health Insurance provided health cover for workers, but not for their wives and children. This had led to a moral dilemma for the young Selwyn-Clarke who was forced, when dealing with the non-insured members of a workers family, to choose between

> *…accepting my visiting fee – which varied from 5s to 7s6d…according to mileage from the main surgery – or on the other of waiving the fee, suggesting a suitable home diet of milk, broths and fruit juice, and writing out a prescription which might cost the patient as least 2s6d at the chemist. Without means of my own I could not afford to give free treatment on the scale that the situation demanded.*[48]

This eventually became too much for him, and Selwyn-Clarke decided "to do his life's work in the medical field on the basis of a fixed salary, and free my mind forever from any thought of payment from a patient."[49]

During the time that Selwyn-Clarke worked in the Gold Coast his views on the importance of tackling the tuberculosis problem were made clear in numerous reports and memos to his superior officers.[50] Prevention of tuberculosis, he argued, "resolves itself briefly under three heads:

a) *The improvement of housing conditions in the large centres, townships and rural areas. A long procedure which will take time. A much better type of house is being built on layouts in the large centres, but in most, if not all, overcrowded warrens still are in existence. In the rural areas the question is to a great extent one of education and example.*
b) *The extension of layouts in the township and rural areas.*

[46] RH, MSS.Brit.Emp.s.470, Papers of Sir Selwyn Selwyn-Clarke, Footsteps: The Memoirs of Sir Selwyn Selwyn-Clarke.
[47] *Ibid*.
[48] RH, MSS.Brit.Emp.s.470, Papers of Sir Selwyn Selwyn-Clarke, Footsteps: The Memoirs of Sir Selwyn Selwyn-Clarke.
[49] *Ibid*.
[50] NAG, CSO 11/14/237, Howells to Colonial Secretary, June 1936.

c) *Education in its broadest sense of people of all ages and classes, with particular stress on the school child.*[51]

The fact that Selwyn-Clarke's solutions revolved largely around housing and education bought him into direct conflict with the Gold Coast political administration and in doing so showed clearly the contradictions of the British late colonial reforms in Africa. Together with his colleagues, Drs. Howells and Duff, Selwyn-Clarke began to argue for the removal of the complex, enclavist public health regulations, which covered only major towns and the mining health areas, and to replace them with a comprehensive public health act which would cover the entire colony, including the rural areas. The mining health areas regulations, argued the medical officers, although useful in forcing the mining houses to provide accommodation for their workers, were insufficient for dealing with the "mushroom villages" full of "insanitary hovels" that continued to spring up on the outskirts, and were home to migrants looking for work, large numbers of workers who the mines claimed they were not able to house in the mining area, as well as numerous other groups attracted by the economic activity in the area.[52] Moreover, improved transport and increased migration to the cities meant that it was no longer possible or desirable to draw a *cordon sanitaire* around the towns and mines. As Duff argued in a letter to the Colonial Secretary: "The Gold Coast is now so opened up and such facilities for transport exist everywhere that the problems of rural sanitation is linked inextricably with the problem of the urban areas. For that reason alone the rural problem must be faced."[53]

Although pressure had been put on the mines to expand the circumference of the mining health areas, they had steadfastly refused to do so, and ultimately the government had been left to deal with the problem in the face of growing pressure from the workers themselves over housing conditions in the rural areas surrounding the mines (Crisp, 1984). Yet the government itself was torn between the dictates of the original West Africa policy, and the new interventionism. On the one hand, there were doctors like Selwyn-Clarke, Howells and Duff, whose ideas about health provision were in many ways universal, and to whom it made little sense to provide health for limited groups of people. On the other hand, there were the political officers, whose mandate it was to uphold indirect rule, and who reacted violently against the suggestion of a comprehensive public health act. As the Chief Commissioner of Ashanti put it:

[51] TNA, CO 98/62, Gold Coast Medical and Health Department Report, 1932/33.
[52] NAG, CSO 11/14/183, Howells, WM. 1933. Report on the General Sanitary Condition of the Mines Areas of the Gold Coast.
[53] NAG, CSO 21/8/13, Duff to Colonial Secretary, 17/6/1933.

> *It is apparent that [the Deputy Director of Health Services, Dr. Selwyn-Clarke] regards the Political Administration as being thoroughly antagonistic to the aims and objects of his Department, and this is mistaken. Any points of difference that may arise affect only the methods by which results aimed at are to be obtained, and so long as the objective of the Health Department is to obtain direct control over all towns and villages in Ashanti these differences will continue to exist…as long as their efforts to concentrate on establishing direct bureaucratic control in direct opposition to the indirect control through the chiefs which is aimed at by the Political Officers such co-operation cannot exist.*[54]

As Cooper (1996) argues, however, ultimately the British late colonial project could never move towards a real universalism – the costs of doing so nullified the point of colonial rule, which was to increase Britain's resources. The campaign for the implementation of a universal public health ordinance by the Gold Coast doctors did have a lasting effect, however. Despite the political opposition to the bill, and its incompatibility with the structure of rule in the Gold Coast, it was kept alive as a proposition well into the 1940s because of its appeal to the universalist language that Britain was starting to use in relation to health and welfare policies in the African colonies. In 1938, for example, Governor Hodson underlined in his speech to the Legislative Council the need for improved rural sanitation and publicly declared that the Public Health and Township Bills were now under consideration by the Secretary of State,[55] although it was only to be implemented after the constitutional reforms.

The debate over the public health ordinance was an important one that set the tone for the structure of the health services in Ghana, which gained its independence in 1958. Unlike India, Ghana, under its charismatic first president Kwame Nkrumah, instituted a universally free health service, based on the model of the NHS. This was a direct result of the recommendations of the 1952 Maude Commission Report on the Health Needs of the Gold Coast, chaired by Sir John Maude, who had played an important role in the development of the NHS itself.[56] Yet the influence of Selwyn-Clarke on Nkrumah's thinking was clear – in 1957 he was invited back by Nkrumah to do an inspection tour of the health services in the Gold Coast and to submit his recommendations.[57] In his report Selwyn-Clarke noted that "the Public Health section of the Ministry of Health in Ghana … is a pallid shadow of its former self," an indication of the problems that were to beset the public health services more generally under Nkrumah.[58]

---

[54] NAG, CSO 11/14/179, Chief Commissioner of Ashanti to Colonial Secretary, 24/9/1932.
[55] NAG, ADM 14/2/27, Governor's Report to Legislative Council, March 1938.
[56] TNA, CO 98/102, Report of the Commission of Enquiry into the Health Needs of the Gold Coast (Maude Commission), 1952.
[57] RH, MSS.Brit.Emp.s.470, Papers of Sir Selwyn Selwyn-Clarke, Footsteps: The Memoirs of Sir Selwyn Selwyn-Clarke.
[58] *Ibid*.

As the following chapters will show, although Ghana arrived at independence on a different trajectory from India in terms of health, similar tensions between the place of the worker and the place of the citizen were eventually to emerge, as will be discussed in Chapter Four. Before ending this chapter, however, it is important to elaborate further on why Ghana's outcome was different, apart from the institutional legacy left by the doctors of the 1930s and the reformist and universal discourses of the Colonial Office after World War Two. Firstly, it is perhaps safe to say that the timing of independence played a role. Ghana attained independence a full ten years after India, when the NHS in Britain had been in operation for a decade. Unlike India, where the model of health care had been influenced strongly by the National Insurance Scheme of 1911, Ghana had an established model of universal health care to follow.

Secondly, it may also have to do with the position of workers in relation to the Gold Coast legislature. By the 1940s pressures for reform in the colony were growing, the loudest voices coming from the United Gold Coast Convention (UGCC) which had in its a midst a young Kwame Nkrumah, who in 1949 would break away to form the Convention People's Party. Despite the importance of labour to the colonial apparatus, prior to World War Two trade unions in the Gold Coast were courted less intensively that the coastal bourgeoisie who made up the UGCC and the chiefs who were the backbone of the system of indirect rule (Austin, 1964). Partly this was because trade unions had not yet developed into a coherent political force. Although the earliest trade unions in the Gold Coast dated to the 1920s, it was only from the late 1930s that trade unionism was actively encouraged by the colonial government in an attempt to quell rising labour resentment at falling employment and wages (Jeffries, 1978; Freund, 1988). A united union of mine workers only emerged in 1945, as did a national federation of unions – the Ghana Trades Union Congress (GTUC) (Jeffries, 1978).

There was also, however, a greater tension between UGCC and the trade unions, particularly the strongest union, that of the railway workers, headed by the radical unionist Pobee Biney (Jeffries, 1978). Biney had little in common with and was openly antagonistic to some of the leading members of the UGCC (Jeffries, 1978; Freund, 1988). Constitutional reforms had begun in 1946 under the reformer Governor Alan Burns, who forced the Gold Coast Legislative Council to accept an African unofficial majority in 1946. These reforms maintained the power of the chiefs, doing so, however, by maintaining the electoral colleges as the Joint Provincial Council and the Ashanti Confederacy Council – councils of the chiefs (Crook, 1986). It was only after 1948, when riots shook Accra, killing

29 people and injuring 200 more, that more far reaching constitutional reforms were enacted under the recommendations of the Watson Commission. Yet even then, it was the UGCC (and later Nkrumah's CCP) that dominated the assembly, and it was only after 1954 "that chiefs were ousted from the central legislature and a directly elected assembly of 104 members set up" (Crook, 1986: 25). The opposition of chiefs to labour legislation was made clear in the legislative debates. It was the chiefs who controlled the lucrative cocoa industry, and they were not inclined to support legislation such as workmen's compensation, which would require them to provide labour protections for their employees.[59] While their opposition sometimes met with resistance from the UGCC/CPP representatives, there were no voices from the labour movement in the room until well into the 1950s.

Partly due to the resistance from the chiefs, which coincided with resistance from the now powerful Gold Coast Chamber of Mines, a Workmen's Compensation Ordinance was only implemented in 1942 in the Gold Coast, and only after the Secretary of State for the Colonies had "forced it upon" the government.[60] The model ordinance (developed for East Africa and based on the Indian Act) had been developed in 1934. Even once it was in place, the absence of workers in the legislative assembly meant that it was more difficult for them to engage with the legislation, to widen the benefits and, importantly, to carve out a central position for the worker in social policy. This is very different from India where labour leaders like NM Joshi were also political figures. Although, as Morriss (1955) has pointed out, the fact that Indian trade unions have generally been led by politicians rather than workers has led to innumerable problems – under colonial rule it did at least mean that workers' interests were superficially present in the legislative process. The absence of this in the Gold Coast did not mean that workers were not agitating around workmen's compensation and other labour legislation (as Jeff Crisp has shown, they certainly were) – but it did mean that this was done mostly outside of the legislature where, until 1954, the government, the chiefs, and the mining interests held sway. In the actual making of policy, however, it was harder for those sympathetic to workers' struggles to take forward a specifically worker focused agenda in relation to health policy. Discussions around social insurance, for example, only began to be heard in the mid-1950s. This meant that the contributory model of health provision held less sway over the imagination of policy makers, and it meant that, in terms of health policy at least, the worker occupied a less central position than it had in India.

[59] NAG ADM 1/1/474, Report of a Sub-Committee of the Colonial Labour Committee appointed to revise the Model Workmen's Compensation Ordinance, 1937.
[60] NAG CSO 21/8/19, Discussion of Gold Coast Executive Committee on Workmen's Compensation, 3rd June 1937.

Conclusion

This chapter has detailed the development of colonial health policy over a period of eighty years in the British Empire, focusing on the specific experiences of India and the Gold Coast, and in doing so has built the base for the rest of this thesis. In particular its focus has been on the development of health policy in relation to workers. This has allowed for a perspective which emphasises the point that the development of health policy and services, in both Britain and the colonial context, was deeply entwined in one of the central economic contradictions of colonialism: the need to create a healthy and productive labour force whilst at the same time maintaining an Empire that was profitable for Britain.

This chapter has also emphasised the fact that this process of development should not be seen in purely material, economic terms. The development of health policy over this period was also influenced by important ideological debates which had their roots in the basic conflict between the individualistic, *laissez-faire* philosophy of liberalism, and the clear need for some form of state intervention in the working conditions and lives of workers, which ultimately expressed itself through the productionist philosophy of the early 20th century. These ideological debates were also related to changing rationalities of rule – a shifting of colonial governmentality, which in turn had an important impact on the types of resistance colonial subjects could employ – a resistance, which, particularly in later years, was able to shape health policy in significant ways.

Another aspect of the thesis as a whole which this chapter has explored is the tension between specificity and continuity in the writing of colonial health history. This has involved holding the tension between the similarities in the development of health policy across the British Empire, and the specificities of its development in different country contexts. As mentioned in the introduction, it cannot be escaped that there are institutional ligaments which held (and in some ways continue to hold) the Empire together. This perhaps accounts, at least in part, for the strange sense of recognition one sometimes encounters when travelling in countries that – however different in other ways – were once a part of the British Empire. The point to be made here is that it is important to focus on a specific context – as this chapter has shown there were important differences between the Gold Coast and India – but also that these specific developments should be seen in the wider context of the Empire of which they were a part.

The detail contained in this chapter is, however, incomplete for the purposes of this thesis. The health policies and regulations discussed here, especially those that developed in the later colonial

years, in large part developed around an idea of work that was masculine. They focused on populations of workers made up predominantly of men, and on occupations that came to be coded as male occupations. The fact that compensation legislation was originally termed "work*men's* compensation" is indicative of this. Health policies and regulations, being both produced by and productive of social relations, were and still are centrally involved in the gendering of work and the workplace. Exploring further this gendered aspect will be the subject of the following chapter which looks at women, work, and health during the colonial period.

Chapter Three: Women, Work, and Health in the British Empire, 1900-1945

Introduction

The previous chapter provided a history of colonial health policies in India and the Gold Coast, focusing specifically on the place of the worker. It detailed the changing political economy of colonial rule over a period of 70 years, how this impacted on the shape and form of health policies in the colonies, and how different modes of governing opened up or closed down possibilities for resistance from below. This chapter, which looks at roughly the same time period and follows the same line of enquiry, has a similar aim to the previous chapter in that it provides the necessary background on which the rest of the thesis is built. However it takes a gendered perspective, looking specifically at the place of the woman worker – the woman as economic agent – in relation to the citizen within colonial health policies in both the Gold Coast and India. In doing so it introduces the gendered lens which runs as a theme through the following chapters and adds further depth and complexity to the history related in the previous chapter. Allman et al., (2002: 6) argue that historical accounts of women's lives "complicate the binaries and disrupt the chronologies that have tended to frame African colonial history more broadly." This chapter explores this blurring of boundaries that occurs when women are placed at the centre of an historical account.

Sangari and Vaid (1990: 3) state that:

> *… historiography may be feminist without being, exclusively, women's history … A feminist historiography rethinks historiography as a whole and discards the idea of women as something to be framed by a context, in order to be able to think of gender differences as both structuring and structured by the wide set of social relations.*

Gender here is seen as a social relation – something that is produced through the interactions of men and women, rather than about women alone. It is about the way that policies and practices interact with society to produce particular power dynamics and social outcomes. Drawing on this, this chapter should not be seen as a complete break from the previous chapter, where the focus was largely on the production of class and difference within a sphere largely designated as male, but as a deepening of the analysis so that an additional component of these power relations comes to the fore. Although the focus of this chapter is on women, this focus is used as "an entry point into debates about power … [rather than being] … the end point of the analysis" (Devenish, 2014).

A dominant theme within feminist critiques of social policy and administration has been the "public/private divide." The public/private divide refers to the development within liberal society over the course of the 19th century of dichotomous socio-political structure, in which there exists a 'public' sphere where rights and duties, including economic rights, are articulated and lived largely by men. The 'private' sphere, defined in opposition to it, is the sphere of affect, morality, and individual freedom. It is, as a number of feminist scholars have pointed out, also the sphere of women and children and the family (Lister, 1997). Women in pre-industrial England often occupied a central role in the public sphere of production – in agriculture, but even sometimes in the urban trades that existed simultaneously with their domestic roles (Berg cited in Rose, 1988). The Industrial Revolution and Victorian morality served to confine women more firmly in the private sphere of the home. Whilst her husband earned the family income in the public sphere, she provided the care necessary to reproduce the labour force in the private sphere; social policy from the Victorian era onwards became increasingly oriented towards supporting this family structure. This restricted women's opportunities in the labour market and left many of them economically vulnerable, particularly those who were for whatever reason unmarried (August, 1999). The reasons why this division occurred in the way that it did have been much debated and discussed (Hartman, 1976; Humphries, 1977). Whilst some feminists have argued that this was the result of capitalist social relations, others such as Pateman (1988) have argued that it is the result of the system of patriarchy (male dominance) that has existed throughout human history. At present there is a growing consensus that the public/private divide, and the resulting economic marginalisation of women, is the result of an articulation between capitalism and patriarchy (McDowell, 2008).

Health policies have been deeply implicated in the propagation of the public/private divide, and in the economic marginalisation of women workers (Harrison, 1991; 1995). Medical discourses on where it is healthy for women to work, and what work it is healthy for women to do have been central to the exclusion of women from workplaces all over the world. Within Britain and its Empire, these medical discourses contained two major strands. The first related directly to work and women's supposed inability to perform heavy manual labour. This meant that women could either be excluded from certain occupations altogether, or would be allocated to lighter (and inevitably less well paid) jobs within the workplace. The second was related to productionism, and involved a discourse on "proper nurturing motherhood"(Allman, 1994). Within productionism, women's most important role was as carer to the next generation of workers. The concern then turned to the reproductive health of women (which was also sometimes used as a justification for the exclusion of

women from workplaces), and to the "proper care of children" which centred on women as reproductive, rather than economic, agents.

A number of works of feminist historical scholarship, in both the British and colonial contexts, have examined the way in which health policies have justified the progressive exclusion of women from the world of formal labour and encouraged their position in the private sphere (Harrison, 1991; Allman, 1994; Sen, 1999; Lahiri-Dutt, 2001; Mills, 2008). This work has been important in exposing the manner in which women's economic roles were undermined by state policies and will be reviewed at some length in this chapter. However, a central argument of this chapter is that this story of *exclusion* cannot be the whole the story when it comes to women, work, and health policies, particularly in the colonial context. Here it is important to borrow a concept that has been elaborated on most notably by Du Toit (2005). Du Toit (2005) argues that, whilst *exclusion* may give important insights into the dynamics of "power and powerlessness," the concept of *inclusion* also provides a powerful analytical tool, particularly when it comes to the analysis of policy. Du Toit (2005) focuses specifically on what he calls "adverse incorporation," which refers to the ways in which people are included into systems in a manner which serves to disempower them. Rather than simply seeing exclusion, argued du Toit (2005), one is able to understand more precisely the multiple ways in which disempowerment is produced in the real world.

Allman et al., (2002: 6) state in relation to colonial histories that in the:

> *… prevailing binaries – rural/urban, private/public, peasant/proletarian, production/reproduction, formal/informal, resistance/collaboration, citizen/subject – either women occupy half of the "dichotomy" or their experiences are erased altogether … But women's diverse historical experiences defy such static representations.*

Women's erasure from colonial labour histories is obvious – there have been very few such histories written (although there are notable exceptions which will be discussed in this chapter). In part this is because of the predominant ideological framework in which labour histories have been written. As both Robertson (1988) and Battacharya (2006) have argued, Marxist analysis has assigned great significance to the working class (defined as waged workers in formal employment), while assuming that self-employed workers such as market traders, hawkers, and workers in home based enterprises (many of whom were women) were part of a "lumpenproletariat with no clear revolutionary role to play" (Robertson, 1988: 180). There is also the fact that men tended to control trade union leadership, so that women's role in formal trade union struggles is often invisible.

This trend from within labour history, combined with the focus on exclusion from within the gender and health literature, has tended to obscure the ways in which women *as workers* were incorporated into health systems. This was often through the urban health and sanitation systems which regulated the homes, market places, and streets where many working class women in Britain, as well as large numbers of women from all social groups in India and Ghana. As this chapter will show, in the few histories that have been written about women's economic role during the colonial period, the importance of understanding the ways in which women traders and other workers interacted with local sanitation systems becomes very clear (Clark, 2010). As many women continue to work in a similar manner in countries like India and the present day Ghana, this has important implications for analysing the place of the woman as worker in contemporary health policy.

As with the previous chapter and for similar reasons to do with understanding what David Scott (1995) calls the "rules of colonial difference" which means understanding policies in their original context as well as the colonial context to which they have been transferred, this chapter will begin with an overview of the place of women workers in health policy in 19th and early 20th century Britain. It will then move onto an analysis of the situation in India and the Gold Cost. Indian and African women were positioned differently within the world of work, and the two will be treated differently. In India there was a small, yet significant, population of women workers who worked on the plantations and mines, and in the large textile factories. Many more worked in the so-called "unorganised industries" – small home based workshops, small scale agriculture, or in small industrial concerns. By focusing on the story of the small number of women who worked in formal industries, the Indian story presented here bears some resemblance to the British one – it is a story of exclusion. That health regulations played a role in the exclusion of women from the workplace in India is an important part of this story, despite the arguments made earlier, because it reveals the gendered nature of these regulations. The section on the Gold Coast, on the other hand, looks at the alternative view – the story of inclusion. Seen together, the two main parts of this chapter are able to give a comprehensive picture of women, work, and health during the colonial period, one which brings each side of the story into a relational whole, and one which seeks to both build on and challenge conventional views on this subject.

Women, Work, and Health in Pre-welfare State Britain

The Industrial Revolution in Britain had a very specific impact on women's employment. Prior to the late 1700s, when production was based on a domestic system of agriculture and handicraft production, women worked mainly in the home as assistants to their husbands and contributed in this way to the "family wage" (Pinchbeck, 1930; Hartman, 1976). The separation of the workplace

and the home that was such a central feature of the Industrial Revolution changed this structure, forcing women who needed to earn a wage out of the home. This challenged the patriarchal system under which women had previously operated, giving them greater individual freedom. At the same time, however, it also made them more economically vulnerable.

Ivy Pinchbeck was an economic historian who taught social studies and economics at the University of London from 1929 to 1961. In her classic work of economic and social history, *Women Workers and the Industrial Revolution, 1750-1850,* she argues that in the long run the Industrial Revolution up until 1850 had opened up economic and social opportunities for women, proving to be a liberating force (Pinchbeck, 1930). However, this did not mean that certain opportunities had not closed down, or that women's lives were immediately improved. Pinchbeck (1930: 2) notes, for example, that under the domestic system women's labour had been subsidiary to that of their husbands' but resources had belonged to the family as a whole, rather than to the husband alone. However, "as soon as women became dependent on their own exertions the hardship of their position was at once apparent." Traditionally women had been excluded from technical training and apprenticeships and their wages pegged at a supplementary level. This continued to be the case as women moved out of the home and into the modern workplace. Furthermore, as more complex machinery was introduced into factories, occupations that had previously been considered women's work (such as spinning cloth), became the province of men who had been trained in the use of machines (Pinchbeck, 1930).

The deleterious effects that this had on women's social and economic position is described graphically by Pinchbeck (1930). This was particularly the case for women who, for whatever reason, could not supplement their wages with their husband's wages. Pinchbeck (1930) reports, for example, that the death rate of widows increased dramatically during the 18th century and in London, where the unemployment amongst women was particularly high, "crime and prostitution, and not infrequently starvation and suicide, followed inevitably in the wake" (Pinchbeck, 1930: 5). Importantly, many women were also forced into casual employment, domestic work, home based outwork paid at low piece rates and street trade (August, 1999), a point which will be discussed in more depth later in this chapter.

Nevertheless, there were also counterforces which continued to push women into the new industrial workplaces. Pinchbeck (1930) notes that the idea of the father earning the wage for the family, whilst women and children remained unemployed at home, did not initially sit well with people who

had become accustomed to the family wage system. While this later became the model for the growing middle class, it was not something that working class families were able to rely on and women from these families often had to earn an income, as did the single women who had children to support. There were also other economic reasons for this. During periods where labour was scarce or when the introduction of new technology (such as steam) required more hands, employers tended to ignore the conventions around women's employment. For example between 1812 and 1815 during a boom in the ribbon trade, employers who had previously disallowed women from working on the new Dutch Engine Loom (which required a period of apprenticeship) placed large numbers of women on apprenticeships which allowed them to work on the looms (Pinchbeck, 1930).

By the time that the nineteenth century revolution in state regulation had begun, there were several competing tendencies when it came to the issue of women's employment. On the one hand there were the inherited "traditions" of limiting women's access to apprenticeships and therefore to skilled trades that Pinchbeck (1930) points to as a major reason for women's subordinate position in the labour market. Then there were the employers, many of whom were happy to employ women and children because it meant more hands for lower wages. There were male-dominated trade unions who protested vociferously against the employment of women in factories as it threatened the wage levels of male workers (Rose, 1988). There were also increasingly prominent reformers such as Lord Shaftesbury and Lord Ashley who were concerned with the terrible conditions in which women and children were employed (Henriques, 1979). Yet until the 1840s the predominance of *laissez-faire* meant that little was done by the state to regulate women's employment (Pinchbeck, 1930). The 1833 Factory Act, for example, which was the first to limit employment of children, actually improved the chances for women as employers replaced child labour and "the field of employment for women was enormously increased" (Pinchbeck, 1930: 184).

The previous chapter has already shown that the strength of *laissez-faire* began to be challenged from the 1840s onwards, and through the course of the 19th century the state became increasingly involved in the propagation of so-called "protective legislation" which governed working hours, compensation, and conditions of work, including health and safety. The growth of state regulation of labour had important implications for women's employment. The acceleration of the social reforms after the 1880s coincided with the increasing prominence of a Victorian moral code, which stressed the importance of working class morality in the building of the nation, and placed women at the centre of this (Harrison, 1991). In many ways it was during this period that the public/private divide was codified as an unspoken moral law in British society. The respectable woman was one who

remained largely confined to the domestic sphere. Working women, as Pinchbeck (1930: 196) argues, disrupted the boundary and were defined as a social problem who, it was suggested, were "causing the complete break up of home life amongst the working classes." The new morality was complimented and reinforced by an evolving medical opinion which concerned itself particularly with the reproductive health of women, who, within the logic of productionism, were the bearers and carers of the next generation of the nation's workers. Within the Victorian imagination, this conflicted with the image of the working woman. "The health of the nation was inseparable from the morality of the working class," argues Harrison (1991: 472), and as the 19th century drew to a close, medical opinion justified the regulation of hours of women's work, restricted their work in dangerous trades and processes, and concerned itself greatly with the impact of work on reproductive health. In some cases these concerns improved the general working conditions in factories and mines, in other cases it left conditions unchanged with women, particularly those who were married, forced out of better paid but more dangerous employment (Mark-Lawson and Witz, 1988).

The first instance of workplace health and safety regulation which banned women's employment in a dangerous trade outright occurred in the British coal mining industry, where women worked underground in the rural areas of Lancashire, Cheshire, West Riding, South Wales, and in the East of Scotland (Pinchbeck, 1930). The 1842 Mines (Regulation) Act barred women and children from working in the coal pits for reasons ostensibly to do with protecting their health (Harrison, 1991). The traditional hypothesis for the origins of the Act is that it was a consequence of agitation from male unionists wishing to exclude women in the context of high competition for jobs. However Mark-Lawson and Witz (1988) argue that the reasons were in fact far more complex. For one thing the banning of women and children's labour underground was a way to undermine the system of family labour which had up until then operated in the industry. A male worker would be contracted by employers, and he in turn would employ his wife and children to assist with the mining. Working conditions may have been awful, but the system did ensure a certain amount of autonomy for male workers, who could decide on the time and pace of the work. According to Mark-Lawson and Witz (1988: 167), the system "clashed at every point with the rationale of new coal companies with their focus on work discipline and company paternalism." Excluding women and children from the system was therefore also a way for the emerging large coal companies to gain full control of the labour process.

At the same time, however, the justifications for the Act were framed by increasing middle-class outrage at the conditions of underground work, for which the "delicate constitution" of women and children were considered to be unsuited (Mark-Lawson and Witz, 1988; Mills, 2008). Commissioners appointed to consider the Act were clearly appalled by the working conditions faced by women, who in general worked either as "hurriers" (conveying coal from the workings to the bottom of the shaft) or as "coal bearers" (carrying baskets of coal on their backs out of the mine). One Commissioner described the women hurriers he encountered as "black, saturated with wet, and more than half naked, crawling upon their hands and feet, and dragging their heavy loads behind them." To him, their "appearance [was] indescribably disgusting and unnatural," and they presented a picture of "deadly physical oppression and systematic slavery, of which … none unacquainted with such facts would credit the existence in the British dominions" (Pinchbeck, 1930: 249). The effect of women's underground work on their children was also noted, with a Dr. Makellar giving the opinion to the Commission that "the effect of exhausting labour of females in coal pits has a marked influence over the physical developments of the infants at birth" (Pinchbeck, 1930: 261).

It took longer for the "protective principle" to take hold in the factories. Although the "desirability of limiting women's employment" first appeared in the discussions leading up the 1833 Factory Act and women and children's hours of work were limited by the 1844 Factory Act, it was only in 1875 that "the protective principle was firmly established" (Pinchbeck, 1930: 199; Harrison, 1991). Shortly after the passing of the 1875 Act, women were excluded from night work, and by the advent of the 20th century an "expressed public and official desire to restrict the labour of women" in factories was discernible (Harrison, 1991: 472). Once again, discourses surrounding women's health intersected with an economic rationale – the Depression of the 1890s and the subsequent problem of unemployment that arose meant that restricting women's employment was also a convenient way to ensure that men had greater access to the available employment opportunities.

Through its *de facto* exclusion of women from the workplace, protective legislation such as the Factory and Mines Acts "confirmed the sphere of domestic labour as the primary sphere of labour for women," argues Harrison (1991: 485). The 1911 National Insurance Act, the last major piece of social policy legislation that was enacted before the two world wars, continued this trend through its insurance policies, which covered only working men. During World War Two women took the place of fighting men in traditionally male occupations, but as soon as men returned home the status quo was reinstituted. The implementation of the welfare state after World War Two further entrenched the gendered division of labour through its male breadwinner family model (Fraser, 1989; Nelson,

1990; Lewis, 1992; Orloff, 1993; Sainsbury, 1999), although many women remained in domestic service, which was considered a suitable female occupation. The welfare state brought many benefits for women of all classes: free health care, education, school meals, and subsidised housing. It did not, however, see women as economic agents or as family breadwinners. The world of wage employment outside of the home remained largely a male one.

Women, Work, and Health in Colonial India

In India the gendered politics of workers' health was in some respects quite similar to that in Britain, but in other respects was very different. Here there is a story of exclusion to be told, although it differs in certain crucial respects to the British case, and in some industries occurred much later, as the confluence of political reforms and economic imperatives made its impact on the Raj. The story of Indian women's exclusion from the workplace through protective labour legislation has been told by Sen (1996; 1999), who has focused on the Bengal jute industry, and the tea plantations, as well as Lahiri-Dutt (2001) who has analysed this process in relation to India's coal mines. The following section will add to these analyses with a more specific focus on how health regulations played into this exclusion.

It should, however, be remembered that women working in the large formal industries were a small minority of the women working overall in India. As Janet Kelman noted in 1923: "There are more than 319 million people in India. In the year 1921, 102 049 women were working in cotton and jute mills and 91 949 in mines. When these figures are considered, it will be realised what a very slight impact on the life of the women of India organised industry has made as yet." Indeed, Roy's (2000) economic history of India argues that most Indian women worked either in small-scale rural agriculture, or in the small-scale urban industries located in homes and residential areas which fell outside of the Factory Acts. Nevertheless, it is these workers who are the focus of the following section. As argued in the introduction to this chapter, the story of women's exclusion from the formal workplace through health regulation is important to understand, and it is only through the story of formal workers that this story can be told.

Bannerjee (1990) argues that colonial rule in India played a central role in the marginalisation of women's economic position. Women in India had traditionally worked in three different types of occupations. Firstly they were involved in craft production for sale to markets locally and abroad (mainly cloth), either as assistants to their husbands or as self-employed operators. Secondly, they worked in caste-specific occupations such as washing clothes, sweeping, and making pottery. Thirdly, and most importantly according to Bannerjee (1990), they produced "subsistence crafts" for

the household or for sale to local markets. This included making and selling butter and ghee, collecting and processing forest produce, and making and/or preparing various types of food products such as puffed rice, vegetable oil, and rock salt, as well as making plates, baskets, mats out of natural materials, and religious adornments (Bannerjee, 1990: 284).

The expansion of colonial industry and of transport networks which connected ports to the interior, compromised the productivity of women's occupations. The Indian textile industry of course suffered badly from the competition of Manchester and this had implications for women producers many of whom had made a cash income from cotton spinning (Bannerjee, 1990). More importantly, however, women's work in the production of basic necessities was threatened by improved transport networks and increased competition from goods produced outside of a specific locality against which small producers found it hard to compete (Bannerjee, 1990). This was a particularly significant blow for women because traditional restrictions on women's movements outside the home meant that many had little option but to engage in home based production (Bannerjee, 1990). At the same time policies which upheld familial "claims to women's labour and sexuality" were implemented by the state, including the upholding of male privilege in marriage and inheritance laws, as well as regulations which placed strict restrictions on women's long distance migration to plantations and urban areas (Sen, 1996).

As a result of both the increased economic competition faced by women, as well as their limited ability to engage in modern industry, the share of women working in agriculture (often unpaid) increased noticeably during the late 19th century and continued to do so well into the 20th century (Bannerjee, 1990). Yet, as in Britain, the story of women's employment in large industries was slightly more complex. As both Sen (Sen, 1996; 1999) and Lahiri-Dutt (2001) have shown, there were times during certain periods of colonial rule when women made up a significant portion of the workforce in factories, mines, and plantations. That this was linked to economic factors is beyond doubt – when there were shortages of labour, or when certain industries were booming, women were employed more readily, and their "delicate constitutions" faded into the background. In the factories, these were often women who did not have family ties to keep them in the rural areas, single women trying to support themselves, or women who had been cast out from their homes for whatever reason (Sen, 1999). On the mines and plantations, systems of family labour meant that women had always participated in these occupations.

Particularly striking was women's involvement in coal mining as both underground and surface workers. In Bengal, the centre of the Indian coal mining industry, women were a central part of the labour system. In 1901 women made up 47.6 percent of the coal mining labour force. By 1921 – after the demand for coal during the World War One had led to a boom in the industry in India – women made up just over 61 percent of the labour force (Lahiri-Dutt, 2001). The local labour was, at least in the early years of the industry, dominated by very poor *adavasi* workers, also known as "tribals" or "aboriginals" (descendent of the pre-Aryan original inhabitants of the area) (Alexander, 2007). The mining technology in use was basic, and women occupied a variety of different roles, although were perhaps most involved in the movement of coal from the face to the surface[61], earning them the title of 'gin-girls,' after the winding machine (gin) used to lift baskets from the pit bottom to the surface (Lahiri-Dutt, 2001).

The first legislation to regulate the Indian coal mines was passed in 1901. Although women's labour in coal mines had long been banned in England itself, the 1901 Indian Mines Act had nothing to say in terms of the regulation of women's work, and sought only to regulate the age of working children (who helped their mothers to load and carry coal). While coal mining had been considered too dangerous for English women and children since 1842, Indian women, children, and men in mining continued to face the most appalling conditions of work. Reports from the Chief Inspector of Mines paint a chilling picture of health and safety conditions:

> *Strange as it may appear, there are many mine managers who do not know how to ventilate a mine … The bad effects of such ventilation are added to by the smoke from the kerosene-oil lamps [used to give light] … some of these lamps give off large quantities of smoke and soot. The smoke fills the galleries to such an extent that it is impossible to see, and the want of sufficient air and the effects of other emanations are sometimes so bad that a light will not burn and a man feels that he cannot live long in such a place.*[62]

Another striking excerpt from the Chief Inspector's reports is one from 1908 which addresses what was obviously a fairly common practice of women bringing their babies down into the mine shaft with them:

> *A baby lost its life underground. The mother had placed it on a ledge 3 feet high while she loaded her tub. Suddenly a fall of roof took place in a gallery about 20 feet away and the blast blew the child off the ledge and killed it. Taking children and particularly babies into mines cannot always be avoided, but it should never be encouraged. It is not a matter of surprise that the roof fell as the gallery was 18 feet wide and unsupported by timber.*[63]

[61] BL, IOR/V/3065, Report of the Chief Inspector of Mines, Government of India, 1899.
[62] *Ibid*.
[63] BL, IOR/V/3065, Report of the Chief Inspector of Mines, Government of India, 1908.

By 1908 in Britain it would have been unthinkable to take a baby into a coal mine – basic safety standards, Victorian morality, and medical opinion had by that time firmly removed women and children from dangerous occupations such as underground work. The fact that the Chief Inspector of Mines referred quite casually to the occurrence in India as something which could not "always be avoided" reveals the very different systems of thought operating in relation to women workers in England and India at the time. In India conditions were such that this practice, although not entirely acceptable, was nevertheless allowed to happen. This was certainly related to the need for labour at the time – particularly in light of the competition the coal mines were facing for labour from the South African mines. Women were needed as workers, and this inevitably led to babies and infants being on the mine as well. Yet it also says something about the state of the colonial political and social project of the time: that the regulation of family life in relation to work that was later institutionalised in the welfare states of Europe, had not yet fully taken hold of colonial labour policy in India.

This was not true for all economic sectors though, a fact which also reveals the importance of economic concerns in guiding the institution of health policies in relation to workers. In the textile industries in India, for example, women's work had been restricted from the first Factory Act of 1891, and health and welfare reasons had been used as a rationale for this from the outset. The Act restricted the hours of work for women and children to eleven hours a day on the same grounds as were used to make these restriction is Britain for the same groups. This was a predictable outcome as this initial piece of Indian factory legislation was a result of pressures from the Manchester textile mills, which by the 1890s were facing strict regulation of women and children's work hours, and an early reformist movement which drew inspiration from the regulation of women and children's labour in Britain.[64] This meant that women's participation in factory employment was always lower than that in the mines and plantations; according to Sen (1999) by the early 1920s women made up between 15 and 20 percent of the workforce in textile mills, which was about half the proportion of women working in the mines and plantations.

Even then, however, these restrictions were contested – largely by Indian factory owners who resented the restrictions being placed on them which impeded their ability to compete with the Manchester mills. Knowing by this stage that the cooperation of Indian elites was central to the sustainability of the Raj, the Government of India was forced to concede in a limited way. In 1908 the restriction of women's hours of work came up for debate again during the sitting of the Factory

[64] Kydd, J.C.1920. *A History of Factory Legislation in India*. Calcutta: University of Calcutta.

Labour Commission. Indian manufacturers argued to increase the restriction on women from 11 hours to 12, and to decrease the time allowed for breaks from 1.5 hours to 0.5 hours.[65] Interestingly, this argument was also framed in health terms; "the women working in the factories seemed to me to be a particularly healthy lot, and quite capable of working the same hours as I have suggested for young persons" argued LC Mactaggart, the Chief Commissioner. Indeed, the Factory Commission had investigated the health of women factory workers and found it to be "uniformly excellent"[66] (although no data on how this conclusion was arrived at was made available in the Commission's report). Consequently, it was a majority opinion of the Commission that women's hours be increased and their breaks shortened.

This caused some consternation amongst reform minded commissioners, particularly those concerned with the health of women workers. Dr. Nair, the Madras Municipal Commissioner, protested vigorously against the proposed amendment, claiming that it was "based on a new discovery and an old argument."[67] The new discovery, he argued, was that factory women in India "are all of good physique." However, he continued, "the excellent health of women factory operatives in India at the present time is the result of the short hours they are now worked." Increasing their hours would most likely see this good health deteriorate. The "old argument" he referred to was one which claimed that restrictions on women's hours gave men an unfair advantage in the labour market. This was not relevant in the Indian context, argued Dr. Nair, because men and women did very different jobs in the factories and were therefore not competing with one another for employment.[68]

The Commission did however take steps to restrict women's labour in other ways. The particular vulnerability of women working near "openers" (used to clean cotton) in cotton presses was described in vivid and horrifying detail by the report.

> *All the accidents due to fires occurring at the opener are of practically the same character. The men generally escape without injury, other than superficial burns; the women, in most cases are killed. The reasons for this are that the instantaneous flash bewilders the women, they become panic stricken, and rush into danger while seeking escape. Further, the form of garment is such that they attract much more cotton fluff than the men, who usually work with no covering but a small loin cloth. This fluff is at once ignited…the feeling that their clothing is on fire further bewilders and terrifies the female workers. Lastly, the amount of dust and fluff from cotton thrown out from the opener is so great that women are said frequently to cover their faces completely with a portion of their garments in order to escape*

[65] BL, IOR/V/26/670/6, Report of the Indian Factory Labour Commission, 1908.
[66] *Ibid*.
[67] BL, IOR/V/26/670/6, Dissenting Minute, Report of the Indian Factory Labour Commission, 1908.
[68] *Ibid*.

> *the irritation and annoyance which the fluff and dust cause. It is obvious that in these circumstances, they have but little chance of escape should a fire occur.*[69]

As had happened earlier in Britain, this finding did not lead to a recommendation for a general improvement in the working environment near the openers, but rather for a full ban against women and girls working "in that portion of a cotton-press factory in which an opener is at work."[70]

By the 1920s and 1930s, however, a more concerted effort to limit women's employment in large industries became discernible. Again, this was related to economic factors – the Depression of the late 1920s meant that unemployment had become a problem, and colonial administrators saw the need to create jobs for men first and foremost. Productionism as well was an influence. As the previous chapter showed, for male workers, productionism resulted in an increased emphasis on health as a means to improve productivity. For women on the other hand it emphasised their reproductive roles as mothers to future workers and soldiers, and in India, intersected with a growing concern about very high rates of maternal and infant mortality (Sen, 2008). According to Sen (2008: 82):

> *Factory women were increasingly regarded not as workers with particular problems calling for separate remedies, but as special kinds of mothers and wives – ones who also worked. Alongside debates about whether they should work or not were questions about the adverse impact of work on housewifery, child bearing and rearing.*

These concerns belonged not only to colonial administrators, but also to the Indian nationalist movement. Janet Kelman writing in 1923 noted that the 1919 Washington International Labour Conference had an important influence on nationalist leaders in relation to the regulation of women's work, quickly leading them to realise "the value to the nation of increased health amongst its women and children," prompting them to "demand an extensive programme of change in order to secure in rapid ways higher standards of vitality for the nation" (Kelman, 1923: 167).

The inevitable result was the gradual exclusion of women from the formal workplace. It should be noted that this did not occur on the plantations where the settlement of entire families continued to be encouraged, and where women's "nimble fingers" were highly valued for the picking of tea leaves (Sen, 1996). The steepest declines in women's employment occurred in the coal industry. From a high of 61.1 percent female labour in 1921, numbers of women started to drop steadily – in 1935 they made up 55.5 percent of the labour force, and by 1951 comprised only 35.4 percent (Lahiri-

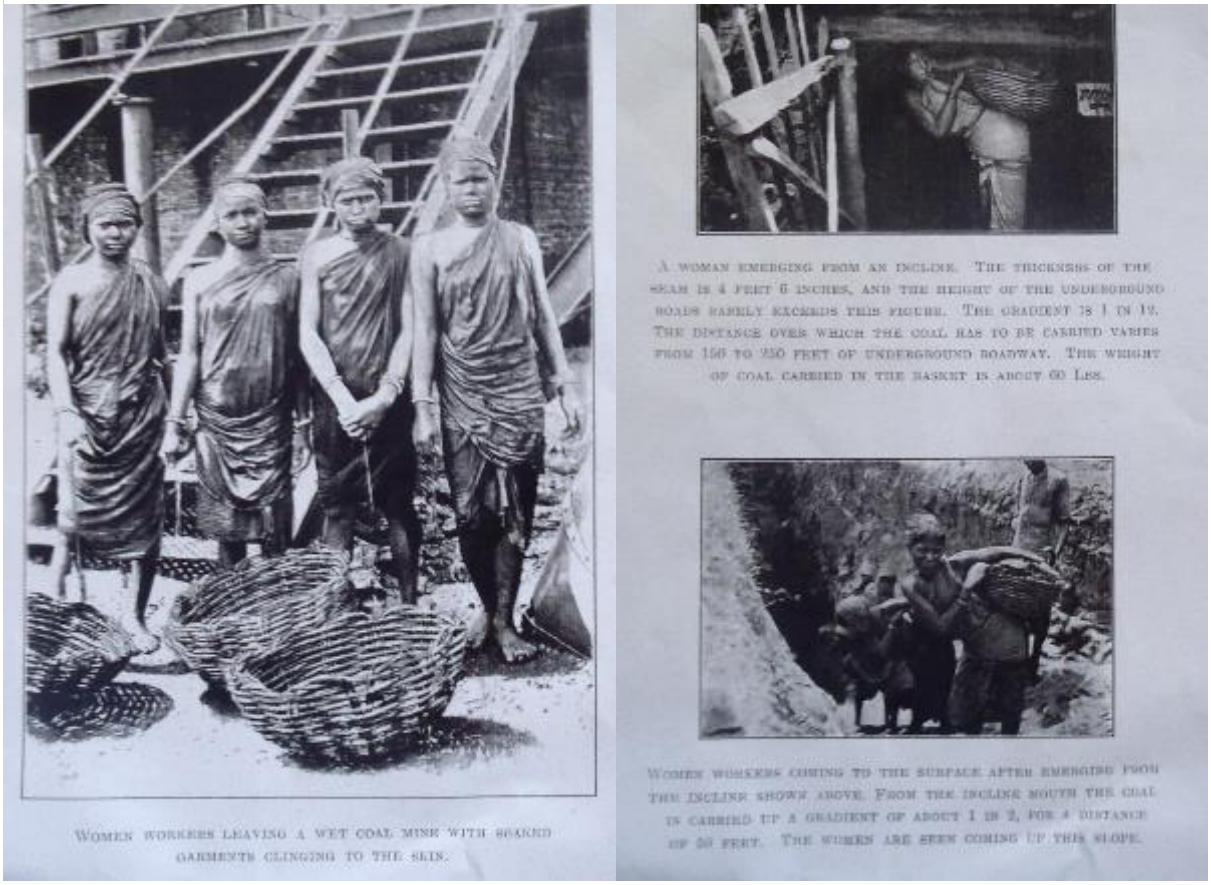
[69] BL, IOR/V/26/670/6, Report of the Indian Factory Labour Commission, 1908.
[70] *Ibid*.

Dutt, 2001). Simeon (1996) argues that increasing mechanisation was responsible for the decline in women's employment. However, both Lahiri-Dutt (2001) and Alexander (2007) argue that the decline was a result of various legislative measures which restricted women's employment, including the 1935 ILO Convention which banned women's underground work, and the prior Indian Mines Act of 1929 which also banned women's underground work, giving employers a 10 year period in which to phase it out. The ban was lifted in 1943 due a boom in the industry during World War Two, but imposed again in 1946.[71]

The 1929 Act was the result of a long legislative process which had begun in 1923 with a lobby group, representing the "respectable opinion," who successfully advocated for a ban to be placed on children's underground work (Alexander, 2007). Women's work was also a target of this group who considered women's underground work as an outrage against "morality, civilisation and womanhood." Women were not included in the 1923 legislation due to the opposition of employers, who still considered the family labour system as working in their interests. However by 1929, this moral opposition had gained strength. Increasing competition amongst coal companies, as well as an improved labour supply from other parts of India, meant that the old system of family labour (which was considered less efficient than modern work discipline) was no longer in favour (Alexander, 2007). Health concerns were entwined within this moral opposition. In 1927 the Chief Inspector of Mines reported that the owners of small collieries were opposed to the proposed ban on women's underground employment, and had "contended that work in coal mines is healthful and easy." The Chief Inspector stated that he was opposed to this view, providing photographic evidence (reproduced in Figure 1 below), to demonstrate the harsh conditions under which women laboured.[72]

[71] BL, IOR/V/1676, Report of Enquiry into Conditions of Labour in Coal Mining Industry in India by SR Deshpande, Director, Cost of Living Index Scheme, Goverment of India, 1946.
[72] BL, IOR/V/3069, Report of the Chief Inspector of Mines, Government of India, 1927.

Figure 1: Photographs of Women Coal Miners inserted into the 1927 Report of the Chief Inspector of Mines, Government of India. Reproduced with the permission of the British Library.



Captions:
Photograph (left): Women workers leaving a wet coal mine with soaked garments clinging to the skin.
Photograph (top right): A woman emerging from an incline. The thickness of the beam is 4 feet and 6 inches and the height of the underground roads rarely exceeds this figure. The gradient is 1 in 12. The distance over which the coal has to be carried varies from 150 to 250 feet of underground roadway. The weight of the coal carried in the basket is about 60 lbs.
Photograph (bottom right): Women workers coming to the surface after emerging from the incline shown above. From the incline mouth the coal is carried up a gradient of about 1 in 2, for a distance of 50 feet. The women are seen coming up this slope.

According to the Chief Inspector the women in the photograph on the left hand side of Figure 1 had been working in a mine where the humidity was at 97 percent. The photographs on the right hand side provide details and evidence of the heavy loads of coal which women carried up long and extremely steep paths. The underlying implication of these photographs was that women's work underground was undesirable and the upcoming ban was justified for health reasons. Certainly, the health arguments against women's work were strong. In 1931 The Royal Commission on Labour in India, which demonstrated a progressive concern with the economic consequences of women's

exclusion from the mines, was forced to address the health issue head on when countering the suggestion that the ban on women's employment be extended to quarries as well.

> *Our view is that the existing regulations involve a great disturbance of the economic position of women in the coalfield as is desirable at present, and we are not in favour of their extension to quarries on any grounds other than those of health. We think that arguments based on health considerations would be met by limitation of the permissible load for women … The exact standards are a matter for expert consideration and we would leave them to be fixed by the Mining Boards on the advice of their technical and medical experts.*[73]

The report did go on to note, however, that the "family lives" of male workers were likely to improve with women excluded from the workplace.[74] Presumably this was because women would be able to give more attention to living arrangements, food preparation, and childcare.

Whether underground work was objectively more dangerous for women than men is hard to tell. A 1946 report on working conditions in the industry made an attempt "to investigate whether work underground led to greater sickness than on the surface," but noted that "no conclusive evidence could be obtained on this point nor were the doctors in charge of hospitals and dispensaries able to say anything definite on the subject."[75] However, fatal accidents were certainly a regular occurrence.[76] An important consequence of the large numbers of women working in the coal mines was that accident records were disaggregated by sex, although this was not always consistent over the years. Table 1 below shows the fatal injuries rate for men and women per thousand working underground in coal mines falling under the Indian Mines Act.

[73] BL, IOR/V/4/SESSION 1903/1 Vol 11, Report of the Royal Commission of Labour in India, 1931.
[74] *Ibid*.
[75] BL, IOR/V/1676, Report of Enquiry into Conditions of Labour in Coal Mining Industry in India by SR Deshpande, Director, Cost of Living Index Scheme, Government of India, 1946.
[76] BL, IOR/V/3065, Reports of the Chief Inspector of Mines, Government of India, 1899-1936.

Table 1: Underground fatal injuries per thousand in the Indian coal mines disaggregated by sex[77]

Year	Men	Women
1908	2.3	1.3
1910[78]	1.7	0.65
1926	1.55	0.91
1927	1.71	0.78
1928	1.82	1.16
1930	1.57	0.96
1931	1.34	1.96
1933	1.06	1.25
1934	1.3	1.1
1935	1.97	2.51
1936	2.71	10.82
1937	1.59	2.57

The numbers here present an interesting story, one which on the surface suggests that women may well have been more at risk underground. Between 1931 and 1937 the fatal injury rate of women exceeds that of men, except in the year 1934. In 1931 the Chief Inspector remarked on the high death rate amongst women, which was "double that of the previous year."[79] To analyse the cause, it is useful to look more closely at the accident reports. In 1931 the death rate for women was inflated by an accident in which "tribute" miners (who were essentially self-employed miners who sold their coal on independently) had illegally undercut a side wall, which then collapsed, killing 14 women. In 1936, where the death rate of women is exceedingly high at 10.82 per thousand, 99 were killed in an underground explosion. From the accident report it seems that in the majority of cases, women were killed in accidents involving collapsing roofs and side walls.[80]

The reasons for the higher fatal injury rate amongst women are not clear, and questions about the reliability of the methods and reporting must be raised. The incident records show that for each accident in which large numbers of women workers died, men died in much greater numbers,

[77] *Ibid*.
[78] Figures for 1910 were not disaggregated into below and above ground, and the figure provided here represents a combination of the two and is therefore not strictly comparable with the other figures. However as most accidents tended to occur below ground, it is likely that most of the deaths represented here did occur below ground.
[79] BL, IOR/V/3065, Reports of the Chief Inspector of Mines, Government of India, 1899-1936.
[80] *Ibid.*

although perhaps proportionately less so.[81] Nevertheless, the fact is that during the inter-war period coal mining became much more dangerous for all underground workers as the production process in the Indian coal mines changed considerably in response to increased demand from industry. Deeper shafts replaced the previously shallow mines, there was increased mechanisation of the work process, and miners were forced to exploit coal seams more intensively, leading to collapses as supporting walls were compromised (Alexander, 2007). Once again, though, the answer to this was seen to be a ban on women's employment, rather than a general improvement of working conditions.

As in the mining industry, during the 1920s and 1930s women's access to factory employment was also compromised. Amendments to the Factory Act providing for maternity leave and other special benefits for women, although progressive in one sense, were not backed up by general legislation that protected women's employment. Knowing that they may have to provide maternity benefits meant that employers were often less inclined to employ women workers in the first place (Sen, 1999; Roy 2000). The Royal Commission ultimately decided not to restrict women's hours of work as it was "firmly in favour of increasing economic opportunities for women."[82] However, it was noted in the report that there had been a strong lobby (absent at the time of the 1908 Factory Labour Commission) in favour of a reduction in women's hours of work. What is particularly noteworthy is that the justifications for this reduction were framed less in terms of the direct effects of factory work on women's health, as they had been earlier, and instead focused on the fact that "women have domestic duties to perform, and that they find the long hours a greater strain."[83]

According to Sen (2008) between 1930 and 1940 there was a 2 percent drop in women's share of employment in the Bengal Jute industry, and the reports of the Chief Inspector of Factories show a 3 percent decrease in women's employment in industry overall between the years 1928 and 1939.[84] After the passing of Maternity Benefit legislation in Bengal in 1939, women's share of employment in industry "dropped radically" (Sen, 2008). The fall in women's employment in Indian industry between the years of 1928 and 1940 is likely to have several underlying reasons. It was certainly impacted by the depression, and the need to find employment for increasing numbers of male migrant workers from the rural areas whose cash crop production had been severely affected by the

[81] *Ibid.*
[82] BL, MSS EUR F174/1031 A, Report of the Royal Commission of Labour in India, 1931.
[83] *Ibid*.
[84] BL, IOR/V/24/1619-1621, Statistics of Factories subject to the Indian Factories Act XII of 1911 together with a note on the workings of the Factory Act during the year, 1928-1939.

economic downturn. Nevertheless, as Sen (2008) argues, this intersected with the increasingly maternalist view of women's role in society which was also an important factor.

Within the official historical records, it is difficult to find information on whether and how women engaged with the new debates on labour rights which came to exist the mid to late colonial period. The Maternity Benefit Act of 1939, for example, provided protections to women, but also played a role in their exclusion from the workplace. This was not because the Act was intrinsically exclusionary – it became exclusionary because of the context in which it operated, one where forces both social and economic converged towards the exclusion of women from the workplace. Sen (1999) has discussed the introduction of the Maternity Benefit Act of 1939 in the Bengal jute industry, but gives little indication of how women themselves reacted to the legislation which simultaneously provided labour protections, and worked to exclude them from the labour market.[85] Women's organised activism in India started to take shape in the 1940s with the growth of communism and the relief work taken on by women during the 1943 Bengal Famine (Devenish, 2014). However it was only in 1954 that the National Federation of Indian Women (NFIW) was established and a national women's agenda formed through struggles around the Campaign for the Hindu Code Bill, which sought to codify and reform Hindu personal and family laws (Devenish, 2014).

Even if it was too early for organised opposition from women during the 1930s, it seems likely that there may have been a nascent opposition to restrictions on their employment, or at least an attempt by women to use the new regulations to suit their interests. In the earlier period of factory legislation women were able to use limits on their hours of work to their advantage, to "come and go as they pleased" during the working day,[86] allowing them time to care for their children and the ability to earn an income. Women also took part in strikes and other labour disturbances, organised through trade unions. One account of a *khadi*[87] workers strike in Bihar shows how aggressively women could participate in such events:

> *In one of the interesting incidents of Khadi workers agitations, women workers collected huge amounts of sewage from septic tanks in buckets and not only littered it on the floors of the establishments but threw it upon the faces of the policemen who had come to arrest the leaders of the striking employees.*[88]

[85] The Act was not amended at central government level until 1961, so it is also difficult to tell within this time period what women's reactions were to the Bill.
[86] BL, IOR/V/26/670/6, Dissenting Minute, Report of the Indian Factory Labour Commission, 1908.
[87] Khadi is a traditional woven cloth.
[88] Archives of Indian Labour (hereafter AIL), Oral History Project: The Trade Union Movement in various Industries.

The Archive of Indian Labour's (AIL) oral history project contains a report of interviews conducted with Indian trade unionists, including women. A particularly striking theme within the testimonies of the women trade unionists is the insistence that they "were prepared to forego their family interests in favour of their primary interests in the factory."[89] This in itself may be seen as a form of resistance against a dominant idea – perpetuated by male trade unionists no doubt, as well as medical professionals and welfare experts – that women's proper place was in the home. It should also be noted that the emphasis on women's place in the home coincided with, and through its embodiment in official policy, reinforced a separation which had long existed in Indian society, between *ghar* (home) and *bahir* (outside world), which kept many Indian women confined to the domestic sphere, particularly those of a higher social status (Chatterjee, 1990). In this environment, British maternalism found fertile ground in which to develop.

In some ways, then, the story of workers' health legislation and women's work in India mirrors that of Britain – it is a story of women's progressive exclusion from the public sphere of work. However, as mentioned earlier, it is not the full story. In the 19th and early 20th century there were also many working class women in Britain who did not work in conventional workplaces. August (1999) has detailed the numerous and diverse ways in which poor British women made their living in urban areas. Residents in poorer areas often provided goods and services to those in the neighbouring richer areas. Markets and streets were home to hawkers and sellers of all sorts of fresh foods and household goods. Other women worked in their homes, taking in washing and stitching, and doing outsourced piece rate work for textile manufacturers (Pinchbeck, 1930). As August (1999: 15) argues, for many poorer women, "the streets, public spaces in their neighbourhoods belonged as much to them as their husbands. Poor women asserted their interests aggressively and publicly, whether bargaining with street sellers or shopkeepers, arguing with their husbands, or battling the police."

Yet, as August (1999) goes on to point out, these women in Britain were often left out of official census collections, their economic contributions largely invisible to national policy makers, and their presence as workers in public spaces generally considered a social problem that required a solution. Indeed as the 20th century progressed, the Factory Acts came to regulate small home based workshops where many women, excluded from employment in larger factories, worked. This, combined with more rigorous zoning and town planning regulations meant that by the mid-20th

[89] *Ibid*.

century the separation of workplace, home, and public space (and the separation of functions within those spaces) was more clearly demarcated.

In India, this demarcation did not progress in the same manner. Roy (2000) argues that the development of industry in Britain and India was different in that in Britain large industry developed out of small home based industries. In India on the other hand, large scale industry developed in parallel with the small home based industries. The Factory Acts in India were never expanded to include the home based production units, an important source of employment for women which continues to be so to the present day (Bhatt, 2006). The story of these women, so much more numerous than those who worked in the larger scale factories and mines, is not one that is often told in India's labour history (Battacharya, 2006). This is not surprising; in Britain they were left out of official records and reports, and the colonial commissions were more interested in their roles as mothers and upholders of a particular moral order, not as workers. Yet, if one takes a creative approach, it is not impossible to find information on these women workers in the public record. Specifically, as the following story of women's work in the Gold Coast shows, the records of local government public health and sanitation departments often contain important stories related to women's work outside of formal workplaces – stories that are left out when it is labour records that are predominantly consulted.

Women, Work, and Health in the Gold Coast

The landscape of women's employment in the Gold Coast (as well as many other African colonies) was very different from that of either Britain or India. As in India this had a lot to do with existing social structures and how they interacted with the arrival of colonial industries. In the Gold Coast women as a rule did not participate in the waged labour force. In the context of Southern Africa, Bozzoli (1983) has refuted the argument that the work was considered too arduous for women, positing instead that it was women's relative importance in agricultural production that kept them in the rural areas. Cooper (1996) supports this argument for Africa as a whole, although Alexander (2007) puts more weight in the somewhat different South African context on the legal restrictions on women's movement. In the Gold Coast, Bozzoli's (1983) argument certainly carries some truth. As mentioned in the previous chapter, the main focus of the West Africa policy was to encourage the development of indigenous cocoa production. Grier (1992: 320) states that "from the very beginning, the labour of women and girls was critical to the production of cocoa." By the time the Gold Coast mining boom of the 1890s had started, women's largely unpaid contribution to family production in cash crop agriculture in coffee, cocoa, palm oil, and peanuts was already firmly

established, and it is understandable that chiefs, fathers, and colonial administrators would have been hesitant to release women for work in the mines (Grier, 1992; Austin, 2005).

Nevertheless there were few explicit regulations banning women from waged employment, and there were some exceptions to this rule. For example, archival records do suggest that when labour was short on the mines women were employed as surface workers – Major Orde Browne, Labour Advisor to the Colonial Office noted in 1944 that this practice was taking place on some of the Gold Coast mines. [90] In fact Mining Regulation 15 of 1940 had explicitly allowed for the employment of women over 14 years of age in surface works.[91] However, as in both Britain and India, the economic downturn of the later 1930s, coupled with the new problem (in the Gold Coast at least) of unemployed wage workers, meant that this practice became heavily discouraged. Orde Browne argued that the practice should be discouraged "since ample male labour" was available. Arthur Casswell Spooner, a Labour Inspector whose personal papers reveal a man with little sympathy for the cause of either "natives" or women,[92] agreed with this assessment stating that "women would be better at home looking after their menfolk."[93]

An incident which illustrates how these restrictions played out in reality for women occurred in the mining town Tarkwa in 1943. It came to the attention of the colonial officials that a group of 22 women were employed by the Tarkwa Town Council as sanitary labourers. At least 17 of the women were sole breadwinners, either being widowed or unmarried, and were aged between 16 and 45 years.[94] Two of the women had been employed in this capacity for as long as 15 years, and they had formed an association known as the Tarkwa Town Council Women Labourers.[95] Their positions as labourers had been deemed appropriate up until the point when it became necessary to make jobs available for male mine workers laid off during the downturn. At this point the Tarkwa Sanitary Committee decided to retrench the women. The decision was appealed, the women workers arguing that despite "the scanty salary" they received, they had "been executing [their] bounden duties to the entire satisfaction of the Local Authorities."[96] They further argued that their sole breadwinner status should protect their employment:

> *…it is by this work that we poor women both husbandless and fatherless are able to maintain*

[90] Order Browne, G.St-J.1944. *Labour Conditions in West Africa.*
[91] NAG, CSO 21/8/44, Note on the Regulation of Female Employment on the Gold Coast Mines, 1944.
[92] RH, MSS.Afr.s.2438, Correspondence and papers of Arthur Casswell Spooner.
[93] NAG, CSO 21/8/44, Note on the Regulation of Female Employment on the Gold Coast Mines.
[94] NAG, CSO 20/5/34, Western Province Commissioner to Colonial Secretary, 4th March 1943.
[95] NAG CSO 20/5/34, Ambiah Tawiah and Effuah Essumanbah to Colonial Secretary, 3rd February 1943.
[96] *Ibid*.

> *our poor mothers and children. Without which we shall not be able to meet up the demands of our children's schooling which now-a-days entails heavy expenditure.*[97]

The women did not receive a sympathetic response from colonial officials who considered it "undesirable for public authorities to employ women as sanitary labourers," and they were retrenched with 2 ½ month's notice and a gratuity.[98]

So while there had been (small) gaps that women were able to exploit and gain entrance into the world of waged employment, these gaps tended to close more rapidly than they were opened. As in Britain and India this trend was reinforced by a medical/welfare discourse which emphasised women's role as mothers above their role as economic agents. Indeed, as Jean Allman (1994: 25) has shown, this discourse which aimed at "constructing proper nurturing motherhood … out of biological maternity," although rooted in European middle-class values, was a global one "which impacted upon women living in communities as far apart as the working class districts of Liverpool and London and the farming villages of West Africa." From the late 1920s and into the 1930s, "mothercraft," including hygiene and nutrition became a central aspect of health policy in relation to African women, just as it had in India. Baby shows, infant health inspections, and child welfare centres were all initiatives that emerged in the Gold Coast as a result (Allman, 1994).

According to Allman (1994), the emphasis on women's role as mothers in the Gold Coast specifically (although no doubt this is also true for Britain and India) was an attempt on the part of the colonial authorities to assert a particular moral order, one which had become necessary because of a shift in gender relations. Economic opportunities for women may have been shutting down in the world of formal waged employment, but they were opening up in other areas – particularly that of "middle women" in the trade in food, cloth, and other basic goods. According to Robertson (1984) Ga women in Accra began to enter into trading in large numbers in the third quarter of the 19th century, and particularly after the imposition of formal colonialism in 1874. Prior to this men and women had worked in complementary, but segregated occupations (for example, men would catch fish and women would process and sell them). Once colonial government and business arrived, many men moved into waged employment in government or in the private sector, leaving women to take on a greater role in production, transportation, and sale of goods (Robertson, 1984). Here women were not confined to the private sphere, but occupied and used public space in a way that often frustrated and confounded the British authorities: hawking goods on the roadside, setting up corn

[97] *Ibid*.
[98] NAG, CSO 20/5/34, Western Province Commissioner to Colonial Secretary, 4th March 1943.

mills and cooked food outlets in residential areas, and in general blurring all the boundaries of urban space set up by British town planners.

As Robertson (1984) points out, women were enabled to do this by the particular Ga social structure, which was segregated along female and male lines, and which gave women a certain amount of independence, and some power over their social and economic position – a very different context from both Britain and India. Although the female line was politically subordinate to the male line in the family hierarchy, economically women could be independent. Powerful older women in particular had control over all junior females, which meant that they were able to mobilise labour through the system of female apprenticeships. Cultural norms also allowed women to conduct economic transactions on their own, and to own property separately from their husbands (Roberston, 1984). As the economy of the Gold Coast began to shift in the 19th century, with an increase in British produced goods in the colony so that production became less important, women were able to use this independence to carve out a specific economic niche for themselves as traders. They were so successful in doing so that, by the time the Gold Coast government had begun to discuss workmen's compensation legislation in the late 1930s, some officials were able to argue that such protections were in fact not necessary because African women were able to support themselves financially in the event of a male breadwinner dying or losing the capacity to work.[99]

There were then a significant number of women in the Gold Coast operating as economic agents during the colonial period. However, they operated outside the world of formal waged employment. Since the 1980s there has been a concerted effort from within labour history to write the story of African women as economic actors. Notable studies in the West African context have come from Robertson (1984), Grier (1992), Mann (1991), and Clark (2010). These have focused primarily on women's labour and accumulation processes, but have also paid attention to the institutional context in which women workers operated. Both Robertson (1984) and Clarke (2010) provide a number of examples which highlight the relationship between traders and the colonial institutions and policies which most affected their working conditions: municipal public health and sanitation regulations.

Indeed, it is from the administrative department concerned with municipal sanitation that we see one of the only pieces of statistical information available on the risks posed to the health of women

[99] NAG ADM 1/1/474, Input of the Joint West African Committee, Report of a Sub-Committee of the Colonial Labour Committee appointed to revise the Model Workmen's Compensation Ordinance, 1937.

traders as a result of their economic activities. In 1924 plague broke out in the Asante capital, Kumasi. Percy Selwyn-Clarke, then still a young Medical Officer of Health for Kumasi, wrote a report on the outbreak. He concluded that the "conditions under which food was sold in the market and in which water for drinking and washing purposes was obtained both constituted contributory causes to the outbreak."[100] Perhaps to emphasise his point, Selwyn-Clarke recorded the occupations of the deceased. The resulting tabulation indicated that petty traders (considered a woman's occupation) were the worst affected with 43 cases of plague. "Married women" and "labourers" were next on the list with 19 and 17 diagnosed cases of plague, respectively. In conclusion, Selwyn-Clarke stated that, while occupation seemed to have little impact on the survival rate of the infected, "petty traders and market women stood a greater chance of becoming infected than others."[101] The reason for this, he went on to argue, was that they stored edible goods (later to be sold) in their own homes. This attracted rats – the source of the fleas which spread the plague.

The development of municipal health systems in the colonies has long been a point of interest for historians of health, as well as those interested in local government. Although largely neglected in the African colonies until the early 1900s, Joseph Chamberlain's insistence on the importance of sanitation led to major sanitary reforms in the major cities of the Gold Coast – Accra, Cape Coast, Kumasi, and Sekondi. In both India and the Gold Coast the introduction of sanitary regulations was a highly charged political affair. In Accra, for example, the provision of sanitation infrastructure often required the appropriation of land owned by Ga chiefs and their subjects. In some cases the local people were compensated for this, but this was not always the case, and often led to protracted wrangling over the control of urban space (Parker, 2000). Moreover, the monitoring of sanitation meant intrusions into private dwellings – something which the sanitation court records show was not welcomed by the inhabitants of the city.[102]

These overt political struggles over sanitation have been discussed by a number of historians: specifically Arnold (1993) and Harrison (1994) in India, and Patterson (1981) and Addae (1996) in the Gold Coast. Sanitation as a political and historical subject has not only been examined from this institutional perspective, however. A number of studies have applied a Foucauldian lens to the study of sanitation, focusing on the moulding of colonial subjects through the administration and practice of hygiene (Anderson, 2006). Perhaps most famous, however, have been the studies which have

[100] NAG ADM 14/1/44, Gold Coast Sessional Papers 1925-1926: Report on the Outbreak of Plague in Kumasi, Ashanti, Gold Coast Colony by P.S. Selwyn-Clarke.
[101] *Ibid*.
[102] NAG SCT 17/5/293, Accra Sanitation Court Records.

argued that the provision of such services (or lack thereof) were a means by which to reinforce racial and class divisions within colonial society – the so-called *cordon sanitaire* which marked in urban space the difference between black and white, and between the middle and lower classes (Swanson, 1977, Curtin, 1992).

However, few, if any, of these studies have looked at the relationship between municipal level sanitation systems and the economic activities of women workers operating in public spaces. In the West African literature, Gracia Clark and Claire Robertson, writing as they do from an Africanist feminist perspective, are alone in linking these two subjects, although their focus is not primarily on health and sanitation, but on women as economic actors. The fact that their attention turns to sanitation at all is a reflection of the impact of these regulations on the ability of women to work.

Although a Towns, Police, and Public Health Ordinance had been in existence since 1878 in the Gold Coast, concerted efforts to regulate sanitation and public health in Accra began only in 1910 after several outbreaks of plague had turned the attention of the Colonial Office to the appalling state of sanitation in the colony. A particular focus of the new administrative department concerned with sanitation was the regulation of food[103] – where and how it was produced, where and how it was sold. In this respect, sanitary inspectors in the Gold Coast were following a universally accepted understanding that food, as a common breeding ground for disease, was in need of careful regulation. As it was women who by and large were involved in the production and sale of food in Accra, it was their work which fell under scrutiny.

It cannot be disputed that food production is in need of hygiene regulation. However, the framing of Accra's sanitary regulation was problematic when it came to the women workers who produced and sold the food. The colonial city administration's relationship to these workers was an ambiguous one. While officials understood and recognised the value and importance of this source of affordable food for its urban population, and importantly, for its waged labour force, they also viewed women workers both as a threat to the public health, a threat to their control of urban space, and ultimately a threat to their vision for the future of African society as a whole. The sanitary regulations which were developed reflected strongly these biases. Unlike the regulations relating to the health of the mostly male waged labour force, sanitary regulations were little concerned with protecting the health of women workers operating in public space. Instead the focus was protecting citizens from

[103] TNA CO 98, Gold Coast Medical Reports: The preoccupation with the regulation of food was such that the Gold Coast Medical Department reports contained a separate section dedicated to 'Food in relation to health and disease.'

the effects of spoiled and unhygienic food. The regulations positioned food producers and sellers as producers of disease and treated them punitively rather than supportively. The Accra District Court records are filled with the names of women food sellers brought in on charges of sanitary offences.[104] In fact Robertson (1984) points out that so many women came before the district sanitation court that the standard use of "he" within the court transcripts was finally changed to "she."

Perhaps most striking was the way in which women workers were blamed as individuals for the spread of preventable diseases, whilst the poor sanitary environment in which they operated was often ignored or glossed over. Even with the enhanced focus on sanitation from 1910, the health of Accra was generally regarded to be very poor. In one Town Council meeting, Councillor De Graft Johnson, an African 'unofficial' member of the Council "called attention … to the breeding of flies in the quarry near the Adabraka Market and suggested that steps should be taken to fill up the quarry with swish[105] instead of rubbish in order to protect the foodstuffs sold in the market."[106] The response from the Council was that it would be too expensive to fill the quarry with swish, "but that if women sellers would protect their foodstuffs as required by the bye-laws, there would be nothing to complain of."[107]

Sanitary regulations also reflected the need for colonial officials to control and regulate the use of urban space. Cooper (1983: 612) has argued that "of all the ways that space can be divided … one of the most critical in Africa is the division between legal space and illegal space. This is a distinction that reveals the uncertainty of who can define urban society and how." Sanitary regulation in particular was used to define and reinforce the division between legal and illegal space, which had important repercussions for traders operating in the public spaces of the city. Street trading was a target of Accra's Medical Officer of Health who argued in 1935 that "from a health point of view," street trading was inadvisable. Not only was food sold on the streets "unhygienic," but it also "harboured rats."[108] This added the weight of medical opinion to an attempt by the Town Council to regulate and restrict street trade and to encourage the formation of designated market areas. The Town Councils of the Gold Coast had since the 1920s begun to recognise the importance of the revenue gathered from municipal markets, and were eager to have traders located in bounded,

[104] NAG SCT 17/5/293, Accra Sanitation Court Records.
[105] Used with adobe to build a basic house structure.
[106] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 12th May 1930.
[107] *Ibid*.
[108] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 9th September 1935.

controlled areas where the collection of various fees, licenses and taxes would be most simple. Public health and sanitation provided a means to justify this, and it was the Medical Officer of Health for Accra who was finally appointed to lead the first "Committee to Deal with Street Trading in Accra" in 1935. The resulting regulations included the following stipulations, all of which were framed in terms of 'protecting the public health':

1. No article, which is likely to be used in the state in which it is exposed for sale, shall be sold without adequate protection from dust and flies.
2. No sale shall be allowed within a radius of 50 yards of public latrines or dust bins.
3. No sale shall be allowed on pavements or streets … during market hours.[109]

Cooper has noted that the need to control and regulate urban space was linked strongly to the British colonial administration's vision for the African working class. During the course of the 1930s, British colonial administrators had come to the realisation that "the way Africans lived and the way they worked were part of the same problem" (Cooper, 1996: 117). Discontent in the workplace was linked to discontent in the urban areas where the workers lived and raised their families. As a consequence, British policy turned not only to dealing with the labour question directly, but focused as well on urban infrastructure and planning. The vision of an African working class was matched by a vision of the African city as a space ordered along the lines of working class cities in Britain.[110]

Not part of this vision were the aspects of African urban society which transgressed the social and spatial categories imported from Britain. In this respect not only were women working in public space an anomaly, but the fact that their work often blurred the boundaries between workplaces and living spaces – what Cooper has termed the "spaces of production" and the "spaces of reproduction" – was also problematic to the officials concerned. In Britain these spaces had long been separated, particularly after the Factory Acts forced the closure of small home based industry. Once again sanitary regulations were used to enforce this distinction. A particular target in the Gold Coast was the bakeries located in or near the homes of the bakers who were all women. In 1930, for example, the Cape Coast municipality passed a sanitary by-law stating that "no living room, sleeping room, or other room can communicate directly with the bake-house"[111] In Accra the MoH was incensed by the practice of turning "stores into dwelling rooms" at night. After an initial inspection

[109] NAG CSO 20/1/1, Accra Town Council Meeting, 8th July 1940.
[110] A good example of this urban vision from the Gold Coast is found in NAG CSO 20/1/77, Report of the Accra Rehousing Committee. The committee was tasked with the redevelopment of Accra after the 1939 earthquake, and included the development of a self-contained housing estate in Kaneshie for African working class families.
[111] NAG CSO 20/4/7, Cape Coast Town Council Meeting, 27th August 1930.

by the health authorities, the MoH called for a thorough re-inspection of all stores in order to put an end to the practice. [112]

Rather than protecting both the health and economic activities of women workers, then, sanitary regulations instead punished them on a regular basis whilst failing to address the generally poor state of health and sanitation in the city. Sanitary regulations were also used to control the movement of women, and in doing so significantly impacted on their ability to work. However, something which requires emphasis in the telling of this story is the fact that, far from accepting their fate, women workers in Accra regularly engaged with the municipal authorities around the regulation of health and sanitation, as well as safety and security. Indeed as Gracia Clark has argued (2010), the commodity associations which are now such a feature of market life in modern Ghana were first developed as a way in which to strengthen the bargaining position of women traders in relation to the municipal authorities. Clark (2010), in her discussion of women traders in Kumasi, notes that the first record of such an engagement was from 1915 when Fante fish sellers met with city officials to discuss the sanitation and overcrowding of the main market. This engagement did not end well for the fish sellers; instead of rebuilding or expanding the market, city officials chose to re-site the market outside of town, away from customers, in a reclaimed swamp (Clark, 2010).

Yet other engagements did result in some gains for the market women. As mentioned earlier, the colonial government had a somewhat ambiguous relationship with traders, and sellers of food in particular. Traders transgressed and blurred all kinds of boundaries that colonial officials wished to impose. At the same time they provided an important service which colonial officials knew they could not do without, and they contributed significantly to the revenue of the Town Council. This ambiguity allowed traders a certain amount of leeway, and at times they were able to gain concessions from the local authorities. In 1938, for example, a petition from traders protesting against the poor state of the shelters in Selwyn Market resulted in a commitment from the Town Council to reconstruct the shelters and plant shade trees within the market so as to provide protection from the elements.[113] In 1943, again in Selwyn Market, Madam Mary Tetteh had her goods stolen and she petitioned the Town Council "asking for compensation and the free use of her stall on compassionate grounds."[114] This was allowed – Madam Tetteh was given free rent of her stall for three years as a result.

[112] NAG CSO 20/1/1, Accra Town Council Meeting, 13th July 1942.
[113] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 12th December 1938.
[114] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 8th March 1943.

Moreover some of the actions taken by local government turned out to be very popular with women workers. One such example was that of the "Chop Kiosk." Having decided in 1942 that open air cooking was unhygienic and a public "nuisance," the Accra Town Council embarked on an experiment in providing "suitable" built structures for food sellers to operate out of, naming them "Chop Kiosks."[115] Due to tight financial constraints, a very limited number were built by the Council. They were so popular by 1945, however, that Councillor Dinah M Quist (the first woman councillor on the Accra Town Council), charged with Chop Kiosk allocation, was overwhelmed by the number of applicants.[116] Councillor Quist was in fact forced to answer charges of corruption placed against her by certain people whose applications had been rejected. The result was the formation of a Chop Kiosk Committee, which would undertake the work of allocation. The establishment of the Chop Kiosk could well be seen as another exercise in defining legal and illegal space – those who operated within the bounds of the Kiosk operated legally, those who operated outside operated illegally. However, it is also important to acknowledge the popularity of the Kiosks – food sellers wanted them because they offered a safe, convenient, and hygienic place to sell food. Moreover, women in Accra have continued to use this concept – what are now known as "Chop Bars" are no longer built by the municipality, but there is one (and sometimes more) on almost every street corner of any reasonably sized town in Ghana.

The point here is not to try and paint colonial local government in a glowing light – in large part, colonial sanitary policies and regulations were highly oppressive and discriminatory to women traders. The point is to emphasise that, because of the leeway opened to them, traders were able, and with limited gains for themselves, to engage with the institutional machinery around them, and in so doing "shape their colonial world" (Allman, 1994). They took what they wanted and needed, and resisted what they didn't. There are several examples of market women refusing to use designated markets because they were sited in inconvenient locations. In several cases, the Town Council was forced to lower the market fees in order to attract sellers to the markets.[117]

One of the real missed opportunities of the postcolonial period was that women workers, working in public spaces, were not given a statutory right to bargain with local government over their conditions of work, and that urban health regulations in particular, were not reformed towards being more supportive of traders. As Robertson (1984) points out, after 1952, women's social and economic position weakened relative to men's in the Gold Coast. The means of gaining political

[115] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 22nd March 1943.
[116] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 17th July 1945.
[117] NAG CSO 20/1/1, Accra Town Council Meeting Minutes, 1938-1945.

power and wealth had become land ownership (dominated by men), and formal education from which many women had been excluded. Increasingly Ghanaian men "found women's economic autonomy threatening," and repressive measures taken against traders – often carried out by municipal governments – has been a feature of life in Ghana since Nkrumah's rule (Robertson, 1984). As will be discussed further in Chapter Four, this prejudice was also bolstered by the fact that small scale self-employed workers were the ideological antithesis of the modernist industrialisation which postcolonial governments in general committed to following.

Finally, does the story of health regulations and women's work in the Gold Coast have anything to say about women's work and its regulation in India? On the one hand, it is clear that the economic structure was different. Cultural norms combined with the wider economy of India meant that women were largely confined to the home in urban areas or the home and small farm in rural areas. Women in the Gold Coast had much more freedom in the public sphere and their presence as workers was more visible, particularly in urban areas. Yet homes, even if they were private, also fell under urban sanitary regulation. Women working in the small home-based industries of India would certainly have come into contact with these regulations. Indeed the Self-Employed Women's Association (SEWA) in India, which is the largest trade union of self-employed women workers, and which will be the subject of Chapter Six, continues to place emphasis on the sanitary upgrading of slum areas in order to enable greater productivity amongst its home based workers (Bhatt, 2006). It is possible that an examination of municipal sanitary records from India may be able to add to the story of health regulation and women's work in colonial India.

Conclusion

The arrival of the National Health Service in Britain after World War Two is often seen as a high point in the history of health, signalling the moment when health became a right for all. Yet there has always been an undercurrent of criticism directed at the fact that, in centralising the health services, the link between health services and local government was severed (Doyal, 1979). The result was the marginalisation, within the health services, of the Chadwickian environmentalist approach to health, which Percy Selwyn-Clarke, in his later years as head of the Association of Medical Officers of Health, decried:

> *The National Health Service, in the opinion of many, had been weakened by splitting off Housing and Local Government from the Ministry of Health, thus over-emphasising curative medicine at the expense of the preventive aspect. The move was said to have been engineered by Dr. Hugh Dalton, who seemed to have more influence with Prime Minister Attlee than did that splendid firebrand Aneurin Bevan, who had done so much to create the*

Health Service but resigned over the Labour Party's decision to charge a fee for prescriptions.[118]

This criticism has become part of the wider debate about the relative merits of basic preventative health versus curative care, and has been particularly fierce in relation to the developing world where large amounts of money have been spent on building hospitals, whilst basic sanitation and primary health care have been relatively underfunded. The lamentation over the separation of local government from national health services tends not, however, to acknowledge the fact that there may also have been something problematic about the fact the local government was also separated from national level labour departments – something which meant that the institutionalisation of workers' rights was fundamentally divorced from the state institutions with which many women workers had the closest interactions.

This is perhaps not surprising because this close interaction is only visible when the definition of work is expanded to include the often unrecognised sectors of the economy in which women proliferated rather than the more traditional formal workplaces on which labour (and health) history – with some notable exceptions – have tended to concentrate. As this chapter has argued, when one looks at the full range of women's work during the colonial period and its relationship to health regulation, it is necessary to add an extra dimension to the story. As the Indian example shows, health regulations, as in Britain, were used to particularly exclude women from the workplace. This is certainly an important part of the story to tell. Yet, as the case of the Gold Coast shows it is also important to tell the counterpart story – the part which looks at where women were included into health regulations and looks critically at the terms on which this inclusion was based. It is this second part of the story that has not been emphasised enough in either colonial histories of labour or health. In failing to do so, this body of work has reproduced the marginalisation of forms of work which differ from those that governed the colonial imagination.

As will be shown in future chapters, this blind spot – of policymakers, academics, and experts – has had very real implications for informal workers in relation to health regulations to the present day. International and national level health public and occupational health policies which aim to include informal women workers such as traders, rag pickers, and home-based workers, are undermined by unreformed municipal health policies which play a role in limiting the good health and economic potential of these workers. On a broader level though, one which resonates with one of the main

[118] RH MSS.Brit.Emp.s.470, Papers of Sir Selwyn Selwyn-Clarke, Footprints: The Memoirs of Sir Selwyn Selwyn-Clarke (Percy Selwyn-Clarke).

themes of this thesis, this chapter has revealed an important aspect of difference. Institutional patterns which developed in the metropole were juxtaposed onto a world onto which they did not map perfectly. This is not a superficial difference – it reflects a profound mismatch between ideas and reality. As Chapter Six will show, this has implications for a more inclusive social democracy – one which is able to institutionally recognise different forms of work, but which maintains essential social democratic qualities.

Chapter Four: Occupational Health Stillborn: The Late Colonial & Post-independence Period and the Limits of Engagement, 1945-1970

Introduction

The immediate post-independence era ushered in a shift in health policy and the terms on which former colonial populations were to be included within it. The new international language of universal human rights and universal citizenship, permeating from the international organisations founded after World War Two and eagerly taken up by post-colonial governments, now framed social policy more generally. At least in theory, health was now a service for all, rather than something to be extended to special groups in the interests of increased productivity. It was prospective *citizens* who were now the central concern of health policy, not workers, and post-independence governments, aimed at the provision of a truly universal notion of citizenship, took up the call to see health as a "responsibility of government and a right of citizenship," (Amrith, 2006: 2).

As a consequence of this wider focus, workers' health issues became a specialised area of health policy and administration. Administrative departments concerned with workers' health increasingly fell under labour rather than health ministries within the British colonial institutional mould. In the Gold Coast a Factory Inspectorate was established in 1951 to monitor workers' health.[119] In India, where workers' health had always been monitored jointly by the Medical Department and the various labour inspectorates, this shift in emphasis manifested with the establishment of the Industrial Health Advisory Committee in 1945, set up to advise the Government of India on all matters to do with the health of workers. Although the Indian Medical Service was represented on the Committee (by the Deputy Director of Social Insurance), the labour department was the dominant administrative authority, represented as it was by the Chief Labour Commissioner.[120]

These administrative shifts reinforced, and in turn were reinforced by, the move within the medical profession to build a separate area of specialisation for workers known as Occupational Health (OH). By the late 1940s doctors in Britain had for many years been working in the field of industrial health. Work on the effects of industrial poisons (such as phosphorus) on humans had commenced in the 19th century, and dust diseases in miners had also been investigated since the turn of the 20th century (Harrison, 1995; Bartrip, 2002; Mills, 2008; Melling, 2010). Industrial health had, however, been thought of as having little relevance to the colonies apart from India and some of the settler

[119] TNA CO 98/97, Gold Coast Labour Department Report, 1951.
[120] BL, IOR/V/26/840/16, Minutes of the meetings of the Industrial Health Advisory Committee, 1945.

state such as Australia and South Africa. Even in India, however, little had been done to foster the development of the discipline. As the Chairman of the Industrial Health Advisory Committee (appointed in 1945 by the Government of India) commented, "The only apology for medical inspection and control in respect of factories and mines, if it can be called control at all, is the appointment of certifying surgeons of the provincial governments."[121]

By the late 1940s and early 1950s, however, the old concept of "industrial health" was being overtaken, in the international discourse at least, by the new and more inclusive conception of "occupational health." In 1950 occupational health was defined by the first sitting of the Joint International Labour Organisation/World Health Organisation Committee on Occupational Health as:

> *…the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological capabilities, and to summarise, the adaptation of work to man and of each man to his job.*

This definition represented a landmark in the history of workers' health – it was an official declaration that that the industrial focus of industrial health was to be shifted in favour of the understanding that work-related health problems could occur in all spheres of work, rather than just in the so-called 'hazardous trades' of industry and mining. The implications for the newly independent countries was clear: whether or not they were industrialised, occupational health was still a relevant domain with which to engage.

For this new vision of occupational health, the immediate post-independence period provided potentially endless opportunities for growth and development of the discipline in contexts far removed from where it originally developed. Moreover the political and economic context seemed to suggest that the discipline might have an important and worthwhile contribution to make to developing countries. As the high tide of modernisation theory started to unfold, there was a faith that industrialisation was and should be a major part of the development of newly independent countries. Occupational health was an approach to health based on scientific and technical principles – this was generally favoured by modernisation theorists and post-independence governments – and was concerned not only with the health of workers but also with increased productivity, another key concern for these new governments. The promise of technological innovation was matched by a political environment which, although not always favourable to workers' organisations, was based

[121] *Ibid*.

on the model of late colonial policies in which concerns about urban workers still in reality dominated social policy, despite the rhetoric of universal citizenship. No wonder then that in 1961 Dr. Stuart Hall of the Ross Institute's East African Branch[122] felt confident enough to put in an application to the Nuffield Foundation to establish an Occupational Health Unit at Makerere College in Uganda.[123] Similar excitement was being felt in India, where, on the eve of independence, an Industrial Health Research Unit was set up in 1948 under the aegis of the Industrial Health Advisory Committee (which still held onto the industrial focus), as well as a Medical Branch of the Factories Inspectorate.[124]

Yet occupational health did not take off in the way that was expected. Despite periodic (and generally brief) flurries of attention in Africa as well as India, occupational health services failed to attract much interest from governments, donors, or even worker organisations. The Ross Institute's application to the Nuffield Foundation was turned down;[125] in Nigeria the Hot Climate Research Institute established by the colonial government at Oshodi, and which had started to offer occupational health services, noted in its 1954 annual report that:

> *In spite of widespread publicity and personal contacts with various Departments and even other West African Governments, there are still no signs that the services of this Unit as an adviser on practical points of Industrial Hygiene and Physiology are either appreciated or desired.*[126]

An ILO mission to Ghana in 1966 painted a pathetic picture of the state of occupational health administration in the country with minimal funding, no equipment and scarce expertise;[127] a 1972 WHO mission described a situation in which little had changed since the ILO report six years earlier.[128] Even in India, where the health of workers was arguably a more salient concern, occupational health specialists were still complaining about the lack of resources given to the discipline almost 20 years after the Industrial Advisory Committee had gathered for the first time.[129]

---

[122] The Ross Institute, named after Sir Ronald Ross, was affiliated with the London School of Hygiene and Tropical Medicine, and provided hygiene and health advisory services to tropical industries. It operated mainly in India and East Africa, but also received subscriptions from large colonial concerns in West Africa as well.
[123] London School of Hygiene and Tropical Medicine Archives (hereafter LSHTMA), Ross Institute (herafter RI), 10/04/08.
[124] Gupta, M.N. 1954. 'Industrial Medicine and Hygiene,' in *Proceedings of the Society for the Study of Industrial Medicine (Jamshedpur),* Vol 6 (2).
[125] LSHTMA, RI 10/04/08.
[126] International Labour Office Archives (hereafter ILOA), SH 32-2-202, Occupational Safety and Health Research Institutions in Nigeria, 1955-1965.
[127] ILOA, TAP 0-196-5 (1), Expanded Programme of Technical Assistance: Ghana OSH, 1966.
[128] World Health Organisation Archives (hereafter WHOA), AFR/SOH/4, Occupational Health in Ghana, Report of a Mission, 8th October-30th December 1971.
[129] Bhatia, G.D. 1974. 'Presidential Address,' in *Indian Journal of Occupational Health (Bombay),* Vol 17 (6).

This chapter is concerned with understanding why this happened. What can only be considered as the “still birth” of occupational health in the post-independence period has left a legacy which continues to affect workers in developing countries to this day, including the exclusion of women and other workers who were not employees in large formal enterprises, from occupational health. It is the contention of this thesis that this current situation is directly linked to institutional processes that occurred during the immediate post-independence period, and for this reason it is a period that deserves close scrutiny.

Here again there is a need to balance specificity with the general picture. As would be expected, India and Ghana after independence continued to be very different societies and economies, with very different politics. Nevertheless the ligaments of the British Empire continued to have an influence and, when it came to occupational health, there were definite continuities. In both countries, occupational health failed to flourish (a condition experienced by many countries outside the industrialised world); in both countries there was an institutional legacy inherited from Britain which maintained a strong hold over the imagination and politics of scientists, policy makers, and citizens. For this reason the chapter, although moving into the period after independence, maintains the style of the previous chapters, and continues to look at the institutional template laid out by Britain. It uses this template as the basis for a discussion on what was different about the post-colonial landscape. In both India and Ghana the relationship between trade unions and the state also became increasingly fraught after independence (although this was more the case in Ghana than in India). The intention of this chapter is not to flatten out the complexities of post-independence life in these countries. At the same time this, and the following chapter, seek to explore what happened to OHS outside of the industrialised world in fairly broad terms. It therefore looks to emphasise similarities rather than differences, although where differences do exist, these are pointed out.

Whilst the chapter is primarily focused on occupational health, it follows the theoretical focus of the thesis as a whole by placing occupational health in relation to the wider context of general health service provision. In doing so, it highlights the very real tensions that existed during the post-independence period between inclusion based on status as a worker, and that based on status as a citizen of a newly independent country, and also allows the author to map the shifting nature of state vis-à-vis employer responsibility for health provision. There is, however, still a need to distinguish between health in pure work situations – occupational health – where employer responsibility was more easily defined, and provision of general health services where employer

responsibility and state responsibility was a highly contested arena. Its core focus is, however, on the relationship between the two.

This chapter will argue that a specific confluence of political economy (the interactions of state, labour, and capital) and science underlay the marginalisation of occupational health. The following sections will attempt to justify this statement through an analysis of the key actors in the political economy and the science of occupational health and the role these played in maintaining occupational health as both a marginal administrative department within the state, amongst workers, and within the medical profession itself. In doing so the chapter incorporates both a materialist analysis and one which considers the question in more discursive terms – trying in this way to think further about the ideas and visions which underpinned the science of occupational health as well as the way in which this was influenced by the political-economy of the time.

As with previous chapters, this chapter seeks to elaborate on Cooper's (1996) theory of engagement. Here though, the focus is a more critical one than in previous chapters. If, as Cooper (1996) argues, the process of engagement by the labour movement was instrumental in the development of late colonial social policy, then the failure of occupational health to evolve during a subsequent period may provide insights into the limits of that engagement. This chapter therefore seeks to explore situations in which engagement was limited, and to think further about why this may have been the case.

Workers, Trade Unions, and Occupational Health

Vicky Long's recently published book, *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain, 1914-1960 (*2011*)*, is the first full-length historical work to explore the politics of industrial health in post-Victorian Britain. Long (2011) focuses on the development, and later the decline, of the idea of the workplace as a site of health promotion and production amongst the workforce. Central to her argument is the idea that trade unions, Britain's Trades Union Congress (TUC) in particular, played a central role in the development of industrial health services in the country, by her account a "fraught and contested field" at the time (Long, 2011: 17). In doing so she challenges an assertion by Weindling (1985) that British trade unions tended to focus on wages, and were not especially interested in engaging with government and employers on the subject of workers' health and safety. To support this argument Long (2011) provides a plethora of information on the TUC's active participation on the various committees and boards which debated the future of occupational health in Britain.

If the engagement of trade unions had been an important factor in the development of OHS institutions in Britain, and if, as Cooper (1996) argues, the engagement of trade unions was instrumental in the development of labour institutions more generally in Britain's African colonies, it is the activities of trade unions (and the limitations thereof) which provide a starting point for an analysis of why occupational health institutions did not evolve as they could have during the post-independence period. In both Ghana and India the post-independence period heralded in a change in the relationship between trade unions and the new nationalist governments. Governments now found themselves in potentially adversarial relationships with their previously strong allies. Taken together with a need for industrial peace, this provoked a tendency towards government control of trade unions – something which hindered effective engagement and negotiation on behalf of workers.

In Ghana, for example, the post-independence period was a difficult time for trade unions. As Damachi (1974: 1) notes, the transition from colonial territories to independent nations precipitated "a crisis in government-trade union relations" all over Africa, but most notably in Ghana. It was noted in Chapter Two that the relationship between the GTUC and the United Gold Coast Convention (UGCC) and later Kwame Nkrumah's Convention People's Party (CPP) was a tense one. A tenuous alliance between the CPP and the GTUC had developed by 1950 when workers staged strikes in sympathy with Nkrumah's Positive Action Campaign (Jeffries, 1978). However, this alliance was always a fragile one, and Ghana's post-independence politics strained it to breaking point (Jeffries, 1975; Jeffries, 1978; Crisp, 1979; Kraus, 1979; Crisp, 1983). Upon assuming power in 1957, Nkrumah and his Convention People's Party (CPP) moved towards what Kraus (1979) has called the "corporatist nationalist non-democratic type" of state-trade union relations. Emphasis was placed on the importance of industrial peace for development; government and trade unions had to cooperate to build the new country (Damachi, 1974).

To encourage this obedience on the part of trade unions, the CPP passed the Industrial Relations Act of 1958. The Act gave legal recognition to only one union federation – the Ghana Trades Union Congress (GTUC), and forcibly grouped workers in the country into 24 federated unions. In 1959 an amendment to the Act was passed which dissolved any existing union other than those scheduled under the 1958 Act. This gave the CPP government enormous influence over the labour movement (Trachter, 1962). Realising that this did not comply with ILO standards, the then Secretary-General of the GTUC, John Tettegah, argued that Ghanaians did not need to "be bothered with Cambridge Essays on imaginary ILO standards with undue emphasis on voluntary association" (Damachi, 1974:

10). The state also imposed a compulsory mediation-arbitration procedure which essentially made strikes illegal (Kraus, 1979).

By the early 1960s, however, even Tettegah had been detained for interrogation in 1962,[130] and was no longer safe from Nkrumah's increasingly repressive regime. The Ghanaian economy, dependent on cocoa, had suffered during the cocoa price slump of the late 1950s, and the country's first ten year development plan had failed to yield the intended results. Workers became restless with the worsening socio-economic conditions, and in 1961 the country's transport systems came to a standstill when the railway and dock workers embarked on a full scale strike which spread from Sekondi-Takoradi and Kumasi to the whole country (Damachi, 1974: 49). The economic slump powerfully reinforced the state's need to rein in workers' demands, and in an attempt to impose order on what was becoming an increasingly disordered political and economic situation, Nkrumah implemented repressive measures, pushing through a motion that made him president for life. The police also had their powers of detention increased to 26 days, and the imprisonment of suspected dissidents became common practice. The outspoken Tettegah was removed from the leadership of the GTUC and replaced with the "government stooge" Kwaw Ampah, thereby sealing the alliance between the GTUC and the CPP government (Damachi, 1974). In 1965, Dr. Nowacki, the Polish occupational health expert sent on a two year technical assistance mission to Ghana by the ILO, noted that the GTUC had begun to operate as the *de facto* Labour Department, the department itself having been weakened to such an extent that it was now "merely attached as an appendage to the more important ministries."[131]

Although the GTUC regained a certain amount of independence after Nkrumah's ousting in 1966, the new military regime was hardly sympathetic to labour's cause. Damachi (1974: 63) notes that "labour had no real power to influence economic decision making [during the military regime] ... on important boards it usually had only one representative, with at least two from the employer's association, and the rest government." This provides a possible explanation for the failure of occupational health services to develop in Ghana. If the ability of trade unions to engage meaningfully with labour policy was a necessary condition for the development and expansion of those institutions, one explanation could be that trade unions in Ghana had a limited ability to push for this – either because they had been made too weak, or because they had effectively been incorporated into the government itself.

[130] ILOA, Z 3/196/1, Director General's Mission to Ghana, November-December 1962: Background Note on Ghana.
[131] ILOA, TAP 0-196-5 (1), Expanded Programme of Technical Assistance, 1966: Ghana OSH, Notes.

A comparable argument could also perhaps be made in the case of India, where the Indian National Trades Union Congress (INTUC), although not facing the same restrictions to freedom of association as in Ghana, was intertwined with Jawaharlal Nehru's ruling Congress Party. Writing in 1958, Ralph James observed that in certain states INTUC unions were "essentially instruments of their respective state governments." By this time India was experiencing setbacks in its Second Five Year Plan – Nehru's strategy of large scale industrial development was not materialising in the way it had been hoped, and, in a bid to maintain industrial peace, the Congress Party utilised "the device of monopoly power" in a recognised union (James, 1958). The smaller rival union federations – the Hind Mazdoor Sabha (HMS) and the All India Trade Unions Congress (AITUC) – were also described by James as "instruments" of the political parties with which they were aligned (James, 1958). Moreover, divisions and tensions within and between unions and their federations were high, and their commitment to the welfare of rank and file members had been repeatedly called into question during the colonial period. In 1945, for example, the Dalit activist and political leader B.R. Ambedkar had criticised the unions, calling their policies "really nothing else but a policy of organised loot, the first man trying to take whatever he can from the Government of India leaving the rest of the people uncared for."[132] There was little indication after independence that this had changed in any significant way.

In this context it is difficult to imagine trade unions actively campaigning against the government and employers to expand occupational health services. This is particularly so considering the government's clear sensitivity to criticism about workers' health from outside India, as demonstrated by the Government of India's defensive reaction to an unfavourable ILO report published in 1963 on Industrial Physiology in the mining industry. Arguing that the report was likely to be misconstrued "to indicate that the job of Indian miners is very hard and they all suffer from fatigue during their routine work," the Government of India wished to make it clear that:

> *… the real picture [was] … quite different … There is no gainsaying that the requirements of some occupations were such that they showed evidence of producing fatigue when judged by one criterion … amongst many others in use, but the miners had complete freedom and opportunity to recover fully by resting at an acceptable environmental condition before starting a fresh work cycle.*[133]

The Government of India went on to submit an official request for these points to be emphasised and "elucidated upon" in the final report.

[132] BL, IOR/V/9/181, Legislative Debates, 28th February to 13th March 1945.
[133] ILOA TAP 0-33-5 (L), Expanded Programme of Technical Assistance, India OSH: Industrial Physiology (Mining Industry), 1963-8.

Yet this argument, based as it is on the inability of trade unions to distance themselves sufficiently from governments, does not fully stand up to scrutiny. The labour movement may have lacked independence in both Ghana and India, but it still had a certain amount of leverage, and, while there were few advances made in occupational health, there were certainly gains made during the post-independence period for workers in terms of work related social policy more generally. In Ghana, for example, Nkrumah's regime implemented a national social security scheme (pensions and provident fund) for formal workers. Nkrumah officially announced the scheme during his speech at the inauguration of the new Trades Union Hall in Accra in 1963, and it was passed into law by parliament as the Social Security Act of 1965.[134] The colonial Workmen's Compensation Ordinance of 1942 was also upgraded in 1963 to the Workmen's Compensation Act, which for the first time included a schedule of occupational diseases.[135] As Damachi (1974) points out, these advances were an attempt by Nkrumah to control the labour unrest in the country which was spiralling out of control at the time. While he had initially reacted to this unrest with force in 1961 when he ordered police to open fire on strikers in Takoradi, his action had alienated many of his allies, and, as his colonial forerunners had done before him, he began to see policy change as a more acceptable and legitimate means with which to stem the tide of worker resistance.

It should be mentioned that this labour unrest had little to do with the trade union leadership, who were situated firmly under the direction of government. Rather it emerged from rank and file workers themselves. Nevertheless, this created enough of a disturbance that Nkrumah was forced to respond. What is interesting though – and certainly a point for further analysis in this chapter – is the fact that Nkrumah chose to focus his attention on social security legislation, doing nothing to bolster the institutions governing the workplace, other than to add occupational diseases to the Workmen's Compensation schedule. Before moving onto further discussion about this point, it should be noted that a somewhat similar turn of events had also occurred in India, although under different circumstances.

In India, the state felt a need to maintain an industrial peace seen as crucial to the nation's development, and this impacted on the shape of health policy (Nanda, 1998). It no doubt gave further impetus to the strength of the Employee's State Insurance Scheme (ESIS), which was aimed specifically at a small group of formally employed industrial workers, over the more universal recommendations of the Bhore Committee Report. The ESIS, which was passed into law in 1948 but

[134] ILOA TAP 0-196-4-1, Expanded Programme of Technical Assistance, Ghana Social Security Reports 1963-1965, Excerpt from Ghana Parliamentary Debates, 16th February 1965.
[135] NAG, Laws of Ghana, vol 7, 2004 edition, Note attached to the Workmen's Compensation Act of 1987.

was only implemented in 1953, was financed through employee, worker, and state government contributions. Although the original report emphasised the importance of preventive health work in industry,[136] occupational health services were excluded from the scheme as they were viewed as supplementary to health insurance, rather than as an integral part of it.[137] This completely ignored the proposals contained in the Bhore Committee Report. The original intention behind the ESIS was to slowly expand health insurance provision from a core group of industrial workers to the wider population, once India was "ready" for such a move.[138] In reality, however, the scheme was from the very first beset by administrative and political difficulties as exasperated reports from the ILO's Technical Assistance team reveal.[139] In the end it remained a limited one (and still is to this day), available only to a select few industrial workers. So while the rhetoric of health in the post-independence period had certainly emphasised the citizen, in reality the Indian government continued the late colonial tradition of extending "universal citizenship" to a limited number of formal workers, whose cooperation in developing the nation was felt to be important.

It is important to note here that there were some exceptions to this rule in India. Worker's Welfare Boards had first been set up in 1934 in order to provide social and labour protections to dock workers (Agarwala, 2013). The welfare board operated at state level and was funded by an additional tax on employers, state and national government and membership fees from workers. In 1966 the Beedi and Cigar Worker's Act was passed, which established health and labour protections for these home based workers, although its provisions were not enforced until 1974 (Bhatty, 1987). In 1976 the welfare board model was used as a basis for the Beedi Workers Welfare Fund and Cess Act, which placed a "cess" (additional tax) on beedi sales which contributed to the funding of a welfare board to regulate health, welfare and working conditions for Beedi workers.

The point to emphasise here is that workers in both Ghana and India (even some of the more vulnerable workers), despite the problematic relationship between trade unions and governments and the closing of spaces for engagement, were still able to influence to some degree at least the trajectory of health, social security, and labour policies. Both countries had adopted a macro-economic policy of industrialisation, and organised workers remained a critical force in the post-

[136] BL, Adarkar, B.P. 1945. Report on Health Insurance for Industrial Workers. Labour Department, Government of India.
[137] Das, S.K. 1954. 'Employee's State Insurance Scheme and the Future of Occupational Health in India,' in *Proceedings of the Society for the Study of Industrial Medicine* (Jamshedpur), Vol 6 (2).
[138] BL, Adarkar, B.P. 1945. Report on Health Insurance for Industrial Workers. Labour Department, Government of India.
[139] ILOA, TAP 6-33-2-1-0, Technical Assistance Programme, India Social Insurance, Reports from Ian Robertson (controversy with M.M. Merani and Katial), 1955.

independence period. The state was forced to respond when workers displayed their unhappiness with the status quo. What did not seem to be high on the agenda, however, was occupational health – not for governments, and not for workers themselves. When occupational health services were excluded from the ESIS in India, it was not worker organisations that led the somewhat muted protest, it was industrial doctors.[140] Reports from the ILO's Delhi Office, covering the years 1929 to 1965 show that the majority of official trade union disputes were related to wages and bonuses, or personnel issues.[141] In Ghana Dr. Nowacki, the Polish occupational health expert from the ILO, stated (somewhat despairingly) that if occupational health services were to develop in the country it would be necessary for the GTUC to show "much more interest in the occupational safety and health of their members."[142]

Of course the distance between trade union leadership and rank and file members in both countries means that that interests of trade union officials did not always match the needs and concerns of their members (Crisp, 1984; Karlekar, 1998). The complexity of the situation in India was revealed in an informal interview with Jagdish Patel, the Executive Director of the People's Training and Research Centre (PTRC), an Indian research and advocacy organisation focused on struggles around occupational diseases. Patel argued that, while Indian trade unions had done little over the years to push the occupational health agenda, certain groups of workers had independently (and with the help of allies such as the PTRC) waged successful battles against industry to improve health conditions and pay compensation to affected workers.[143]

The fact that workers may have been fighting health related battles outside of the trade union movement during the 1950s and 1960s is certainly an important point to consider. That these are unlikely to have been recorded in official documents makes these activities easy to gloss over. Even so, this still does not really answer the question of why occupational health failed to take off during this post-independence period. If anything, it deepens the mystery surrounding the failure of the labour movement to pick up and engage with it (even if isolated groups of workers were managing to make gains), or why governments, while implementing labour related social policies, continued to ignore occupational health services. The following section attempts to explore these questions

[140] The Journal "Proceedings of the Society for the Study of Industrial Medicine (Jamshedpur)" contains several examples of such protests from industrial doctors.
[141] ILOA, Reports from the India Delhi Office, 1929-1965. These reports have been digitised in collaboration with the University of Goettingen and are available at: http://www.uni-goettingen.de/en/324221.html
[142] ILOA, TAP 0-196-5 (1), Expanded Programme of Technical Assistance, 1966: Ghana OSH, Notes.
[143] Interview with Jagdish Patel, 5th April 2013, Delhi, India.

further by looking more closely at the state's role in defining the agenda around occupational health in Britain, India, and Ghana during the late colonial and post-independence period.

The State and Occupational Health: Late Colonial and Post-Colonial Welfare Regimes[144]

In thinking further about why post-independence governments showed a distinct lack of interest in promoting occupational health, it is useful to start with an analysis of the structure of the post-World War Two welfare regime in Britain because it ushered in far reaching changes in the nature of the state and its relationship to its citizens. At the centre of these changes was an understanding that the state would provide certain basic welfare guarantees to all citizens – the social citizenship to which T.H. Marshall (1965) referred. To the intellectual supporters of the welfare state this was the key point to emphasise – if the reduction of social inequality was the aim, then there had to be state provision for all rather than limited provision for a few defined groups. Richard Titmuss (1958: 54), for example, argued vociferously against additional occupational benefits provided by employers for those working in "good jobs," which he claimed "divided loyalties, nourished privilege, and narrowed the social conscience." Titmuss's faith lay in the state as provider, and the state alone. [145] It was this faith in the state, and the importance of citizenship as the basis for entitlements, that would have important consequences for the position of occupational health services in Britain.

In 1940 there had been hope that the end of the war would allow for the establishment of a state run national industrial health service in Britain, "when the appointment of industrial medical officers under the 1940 Factories (Medical and Welfare Services) Order promoted a model of industrial medicine characterised by medical supervision of the worker in the workplace" (Long, 2011: 65). By the time the National Health Service (NHS) White Paper was released in 1944, however, these hopes began to fade (Long, 2011). The White Paper explicitly excluded industrial health services from the proposed NHS. According to Long (2011), although Bevan did not necessarily disagree with the proposal to include industrial health services, he felt that the NHS Bill could not tackle "everything at once." His position was attacked by both the TUC and the British Medical Association (BMA) who continued to lobby for the NHS to recognise workers as citizens with special needs. By 1951,

[144] In this chapter, the term "welfare regime" rather "welfare state" is used following Gough and Wood (2004). The welfare apparatus adopted in both Ghana and India was too limited in scope to qualify as a welfare state even though it espoused an ideal of universal citizenship. The more appropriate term therefore is "welfare regime" which acknowledges the presence of social policy, and of certain rights of citizenship, whilst also acknowledging the limited scope of these social rights.

[145] An important footnote to this is that Titmuss's last major work, *The Gift Relationship* (1970), stressed as well the importance of citizens' voluntary donations to the state and society. He saw these as an absolutely vital demonstration of the "contract" between citizens themselves, and between citizens and the state.

however, Bevan had become more steadfastly opposed to this idea and a later proposal to establish a parallel national industrial health service was also met with opposition. There was a strong feeling that the development of a national industrial health service would compete with the NHS for resources and manpower. Furthermore, it presented the possibility of increasing the scope of occupational benefits, and in doing so undermining citizenship as the basis of the entitlement to health care (Long, 2011). Added to this was the Ministry of Labour's insistence that industrial health remain under its stewardship. The result was that industrial health services remained connected to the Factories Inspectorate, falling under the Labour Ministry and isolated from mainstream health services.

Similar arguments had also been made in relation to workmen's compensation legislation and social security. Titmuss was very against workmen's compensation because it provided favourable treatment to workers over and above citizens, and because of the practical difficulties involved in distinguishing between ill-health caused by work and that caused by general living conditions (Titmuss et al., 1968). Beveridge too was against the system, his main reasons being the cost of litigation, the uncertainty of benefits, and the fact that it did not actually encourage safer practices in the workplace (Bartrip, 1985). Nevertheless the opposition of the unions to the dissolution of workmen's compensation led to a compromise position where the legislation was incorporated into the national insurance system, so that workers retained preferential treatment under it (Bartrip, 1985).

Long's thorough and fascinating account of the "rise and fall" of occupational health services is somewhat flawed by her failure to situate these processes adequately within the wider political economy of the British welfare state. Although she touches on it, she misses the point that the institutional politics gave rise to a certain bureaucratic structure in which industrial health was always going to be marginal. Esping-Anderson (1990) has argued that one of the central features of the welfare regimes of Europe is the fact that "they systematically kept the bureaucracies and administration of social protection and labour market sharply separate." The origins of this administrative separation emerged from classical liberal theory and its assumptions about the "equality-efficiency-trade-off," or the idea that the state's attempts to maintain equality and/or justice within the labour market would inevitably compromise on economic efficiency and productivity (Esping-Anderson, 1990: 147).

Even before Esping-Anderson had developed his typologies, however, the socialist critic of the welfare state, Claus Offe (1984), expressed the view that this division has the effect of separating social life into two separate spheres – what he refers to as "the sphere of work" and "the sphere of citizenship." The sphere of work he associated with the economy, production, and primary income distribution; the sphere of citizenship was associated with the state, reproduction, and secondary distribution. The welfare state grants and regulates rights of citizenship, Offe (1984) argued, but because of its orientation towards the freedom of the labour market, does much less to grant and regulate workers' rights in the sphere of production. In this way the welfare state emphasises *reproduction* over *production.* Offe (1984) interpreted this as a mechanism of "political-ideological" control. By granting citizenship rights in the sphere of reproduction, the state works against the expansion of workers' rights by making "people ignore or forget that needs and contingencies which the welfare state responds to are themselves constituted, directly or indirectly, in the sphere of work and production." The social programmes required to address these needs and contingencies are then paid for by taxpayers. The point of this, argued Offe (1984), is that the capitalist status quo remains unchallenged. Offe's interpretation of the political economy of the welfare state has been heavily criticised. Esping-Anderson (1990) has pointed out that, despite the bureaucratic division of social policy and labour market institutions, there are actually many ways in which social policy interacts with the labour market. For example, policies around childcare can make a big difference in the number of women who enter the labour market. Furthermore, as critics of Offe point out, his perspective – which ultimately suggests that "citizenship rights are merely a bourgeois façade concealing class-based relations of exploitation which perpetuate capitalism," (van Niekerk, 1999) – does not account for the potential that "citizenship rights have to work in the interests of the working class" (Doyal and Gough, 1991). Certainly it would be difficult to argue that the formation of the NHS was in any way a negative development for workers in Britain.

Nevertheless Offe's point about the impact of the separation between social policy and the labour regime does provide an important insight into the position of industrial health in Britain at the height of the welfare state. Within Offe's framework, industrial health fell uneasily between the spheres of production and reproduction – it was something that was, and still is, intimately linked to the production process and the production environment; it is *of* the sphere of production. Preventive measures related to the types of machinery to be used, how they were to be used, and allowable limits on the potentially poisonous by-products of industrial processes had an impact on not only the processes being used, but also the costs associated with them. The fact that it was the state which monitored and regulated this allowed it a certain degree of control over the sphere of

production (which employers have been notoriously sensitive about, as seen in Chapter Two), and within the context of the welfare state, created a somewhat anomalous situation. In this context the decision of the post-World War Two government to de-emphasise rather than emphasise its direct role in regulating the production process by maintaining industrial health as an isolated and fairly marginal government department, and concentrating instead on a new health scheme which would operate exclusively in the sphere of reproduction, becomes intelligible in political economy terms.

In Britain's liberal welfare state, industrial health and the physical control of the workplace largely became the province of employers. As Sturdy (2000: 224) argues, there had been a move in this direction since the end of World War One when governments decided that "in the difficult political and economic circumstances they were largely happy to leave such matters in the experienced hands of employers themselves." It is important to note as well that the particular structure of the British welfare state was only one aspect which influenced this. Constraints on state spending after the war was another. There was also the old principle of "the polluter pays" or the liability of employers (rather than the state) to pay for the social problems that they caused directly. The confluence of these factors meant that after World War Two very little was done by the state to bolster industrial health services, and Britain failed to sign on to a number of international directives concerning occupational health. In 1962 when the European Commission recommended setting up occupational health services in all workplaces with more than 200 employees, Britain was one of the four out of twelve member states which refused to implement this directive (Schilling, 1998).

This neglect of industrial health was inherited by the welfare regimes of Britain's ex-colonies. The late colonial welfare regimes had followed a similar philosophy – interference in the workplace was to be minimised in favour of policies which addressed conditions in the sphere of reproduction.[146] As Chapter Two has already shown, there was always a tension between the colonial state's need to reap the rewards of British overseas investment, and the need to maintain a particular social order which included the regulation of working conditions. In the Gold Coast, this tension was reflected in the progressive Governor Gordon Guggisberg's complicated relationship with the mining sector, which tended to waver between acceding to their demands and attempting to place heavy restrictions on labour recruitment and workplace practices (Crisp, 1984). Ultimately though, interference in workplace matters was kept to a minimum. In a letter home Arthur Spooner, an officer in the Gold Coast Labour Department, revealed the power of the mine managers over the

[146] In Ghana the Mining Health Areas Acts had distinguished between the actual workplace, which the mines were held to be responsible for in terms of maintaining health and safety, and the 'mining health area,' a three mile radius surrounding the mine for which the government would be responsible.

institutions of the colonial state: “Mine Managers are very busy and rather touchy individuals so far as Government is concerned. If you get up against them you cannot get a damn thing done and they are liable to bring pressure to bear and to have individuals removed so I am frankly a little frightened of butting in.”[147] Here the tension is evident between a theory of state which required the regulation of the economy and the reality that, in practice, capital was quite easily able to bypass any protective initiatives.

Cooper (1983; 1986) argues that a central feature of the British colonial welfare regimes was the attempt that they made to link the spheres of reproduction and production, in the hope that by improving living conditions, workers would be less inclined to participate in the strikes and disturbances that began to threaten the stability of the British Empire from the 1930s onwards. It could, however, be argued that these colonial regimes did not only link together the spheres of production and reproduction, but they also actively emphasised reproduction over production, at least when it came to protective social regulation. The minutes of the Colonial Labour Advisory Committee are filled with discussions relating to housing and social security; relatively scant attention is paid to workplace regulation.[148] This was reflected in the research carried out by the social scientists whose work informed colonial policy. As Cooper (1996) himself points out, despite the plethora of social surveys and research carried out amongst urban workers in the late colonial and post-colonial period in Africa, very little was done on the actual working environment and the work process.

Post-independence governments did little to alter this state of affairs. For both Nkrumah and Nehru the drive towards large scale industrialisation was a predominant goal. While methods to improve worker productivity were certainly welcomed, state interference in the production process was not a priority for these governments in their attempts to attract capital and keep it there. In India industrialists were particularly wary of state interference – the British textile industry had waged war against its Indian counterpart using the Factory Act as a means to drive up the costs of production, leaving a bitter taste in the industry’s mouth when it came to that particular piece of legislation. In Ghana, Nkrumah had originally tried to extract concessions from foreign companies operating in the country, but this was seemingly limited to the provision of housing and medical facilities for workers. Even then his success was limited. When in 1958 his government put pressure on the Ashanti Goldfields Corporation to extend their housing provision for workers, the reply from the Chairman,

[147] RH, MSS.Afr.s.2438, Papers of Arthur Casswell Spooner, August 2nd 1939.
[148] TNA, CO 888/2 Colonial Labour Advisory Committee Minutes.

General Sir Edward Spears, was not encouraging. “We must assume the Government will provide its citizens with houses as every other Government does. The public entrusts us with money for mining and not to enter into large building schemes,” responded Spears.[149] Considering these difficulties, Nkrumah and his colleagues may well have felt that it would be more trouble than it was worth to interfere in the production environment of large international corporations.

The political economy of the post-independence state, its attendant bureaucratic structures, and its ideological underpinnings, produced an environment in which occupational health institutions remained isolated from other health institutions and therefore marginalised. This particular confluence of forces may also provide some insight into the lack of engagement by workers’ organisations with occupational health. Engagement, as Cooper (1996) describes it, which is the ability of civil society to take advantage of policy gaps and widen them, can only occur after a policy space has opened up. While these spaces may initially open up because of pressure from below, the precise form of that opening is still determined by those in power. Social policy in the sphere of reproduction was a point on which the state was willing to engage, while occupational health in the sphere of production much less so. This in turn may well have influenced the strategies of worker organisations in terms of which engagements they decided to focus on and which to leave alone.

Employers: “Getting Out From Under”

There were, however, other important reasons why trade unions and workers found it difficult fully to engage with occupational health. Large industries also had a role to play. Here it is necessary to acknowledge an important difference between Britain and its colonies. In Britain the Factories Inspectorate remained a marginal department, but it was still relatively well resourced, and operated within the context of a strong welfare state and social contract which had at least some respect for the idea that the needs of capital should not compromise the health of workers. As Long (2011) has shown, there was still a state apparatus which workers could leverage, even if the gains that resulted were small. This was not the case in the ex-colonies, where the vast majority of resources which went into occupational health actually came from employers themselves.

Cooper (1996) has highlighted the inherent contradiction of the liberal reforms of the late colonial period; while the Colonial Office wished to create a limited version of universal citizenship, it most certainly did not wish to invest the resources necessary for even this limited vision. As a

[149] Cambridge Churchill Archives (hereafter CCA), Spears Papers, SPRS 3/1/267, Spears to Brown, 24th November 1958.

consequence the Colonial Office tried to shift as much responsibility as it possibly could onto employers. This was codified into policy by the Colonial Labour Advisory Committee in 1947 when it stated that:

> *After full consideration of the various aspects of the problem we recommend that in general the provision of social services, such as health and education facilities, and the maintenance of standards of housing should be the responsibility of Colonial Governments; but that in the early stages of industrial or agricultural development, and pending the establishment of permanent centres of population, this responsibility can, in the case of larger concentrations of labour, reasonably be laid upon employers.*[150]

While the principle of state provision of social services was upheld, the reality of resource limitations was clearly acknowledged. This acknowledgement was not limited to the Colonial Office. In 1952 the ILO passed its Convention on Minimum Standards of Social Security (No. 102), which covered nine contingencies,[151] but asked that new member states (the newly post-colonial states such as India), only cover three out of the nine (Rodgers et al., 2009). This was the first acknowledgement by the organisation that labour conventions may not apply universally, and that the special circumstances of developing countries had to be acknowledged.

As has already been discussed in Chapter Two, the attempt to pressure employers into providing such services had mixed results. On the one hand in India some large employers like the Tata Steel Corporation, which had already prospered during World War One, invested a great deal in the health and welfare of their workers. At Jamshedpur, where Tata Steel was headquartered, the steel works provided a number of social and welfare services, including "first class organisations on modern hospital lines for giving curative medical aid including antenatal and post-natal clinics for women workers."[152] In Ghana, Ashanti Gold had also provided doctors, piped water supplies, a dispensary, and a hospital for workers. As Chapter Two pointed out, the motives were more closely related to profit than to altruism; many large mines and other colonial industries were located in rural areas where the colonial state hardly reached. In order to keep workers fit enough to produce the necessary output it was obligatory to provide for health and housing. This was as true outside the British Empire as it was inside it. In Liberia, for example, the US based Firestone Tire and Rubber Company maintained a fairly sophisticated network of hospitals, clinics, and dispensaries on their plantations where approximately 30 000 worked (Lumumba-Kasongo, 2001). In 1950 it employed an

[150] TNA, CO 888/5, Colonial Labour Advisory Committee Papers and Minutes 1947/8, Africa Sub-Committee: Examination of the Report by Orde Browne on Labour Conditions in East Africa.
[151] The contingencies covered were: medical care, sickness, unemployment, old age, employment injury, maternity, invalidity, survivors and family allowance.
[152] Dastur, H.P. 1949. 'Medical Supervision in Indian Industries,' in *Proceedings of the Society for the Study of Industrial Medicine (Jamshedpur),* Vol 1 (1).

expatriate medical staff of 13 in addition to 244 Liberian employees, of whom 89 were nurses, 15 were laboratory technicians, and 36 were involved in sanitary work.[153] This was a ratio of one health professional to 200 workers, which, although not ideal, was a better ratio than was found elsewhere in the country.

While many of the large international or multinational firms had seemingly accepted their role in the provision of basic health services, after independence there was change in the air. In 1950 the WHO had announced that health was a right for all and a responsibility of government. The implication of this for their responsibility for employee health service provision was not lost on industry, particularly as medical technology became more complex and expensive. The ensuing debates and deliberations played out particularly clearly at the conference on Industry and Tropical Health. This conference had first been organised in 1951 by the Harvard School of Public Health, which, together with the Rockefeller Foundation, had interests in both tropical medicine and industrial health, and continued on a four yearly basis until 1970. The conference combined insights on industry and tropical health from health professionals and representatives from large international firms such Anglo-Iranian Oil, Standard Oil, Shell Petroleum, Firestone Rubber and Tire Company, KLM, the United States Fruit Company, Iraq Petroleum, and several other still recognisable names.

From the very first a significant contingent of the industrial representatives began to argue for a withdrawal from the provision of general health services such as clinics and hospitals. Robert Collier Page from the Standard Oil Company led the charge in 1951. He argued that the costs associated with such provision had begun to far exceed the benefits to companies:

> *In 1940 the total medical expenses for the Latin American affiliates of the Standard Oil Company were a little less than 3 million dollars. Now in 1950 the total is over 9 million dollars and in spite of curtailment, operating expenditures are still going up…And so we see that a practice which was considered expedient in the early days has gone almost beyond control. Through commitments of all kind, the Company with which I am associated is responsible for, in a medical way, approximately 200 000 people, of whom only 34 000 are employed by it and its affiliates. This must mean that much of management's investment for medical services to employees is being misdirected.*[154]

Not only did the costs of health provision mean it was no longer "good business" to provide health services, but provision of such services also represented "paternalism to the nth degree,"[155] argued

[153] Wellcome Trust Archives (hereafter WTA), Proceedings of the Conference on Industry and Tropical Health Volume I, 1951.
[154] WTA, Presentation by Robert Collier Page, Standard Oil Company, Proceedings of the Conference on Industry and Tropical Health Volume I, 1951.
[155] *Ibid*.

Collier Page. The WHO had proclaimed that health services were a responsibility of government, and if industry continued to provide in its place, governments would never learn to provide on their own. Industry could provide a certain amount of support, providing scholarships for "nationals to study medicine abroad" and temporary partnerships to deal with certain pressing problems, but no longer should comprehensive health services be seen as the responsibility of industry.[156] This was to be a consistent theme throughout the twenty years of the conference's existence.

Not everyone agreed with this. At the 1954 session of the conference, Dr. Luis Dao, a Venezuelan working for the SA Petroleum Company in Las Mercedes, Venezuela (a very poor country at the time), questioned the position of Collier Page and others:

> *I think the oil companies should give medical assistance … in places where no medical facilities exist but there is a company doctor. This is different in places where the government – the community – has a hospital. The company can differentiate and say, "we don't accept such and such a patient, you have to go to the government hospital." But in out of the way places where they don't have medical facilities, I think it is good policy – a point of humanity – that all should help the poor people.*[157]

When challenged on this opinion Dao responded that he considered it "an ethical obligation of the profession to take care of poor people."[158] This rhetoric (one which came more naturally from a doctor than a corporate executive) did not sit well with the general direction of the conference and a challenge like that was not to be raised again during the conference's lifespan. Instead, the focus turned, in Collier Page's term, to ways in which to "get out from under."[159]

"Getting out from under" essentially meant thinking of ways to free industry from its prior commitments to general health service provision – not an easy process where health service provision was a result of union bargaining. Yet it was reasoned that as long as the WHO's drive towards state provision of primary health care continued, it would become easier and easier for business to withdraw. Within the move to get out from under, occupational health began to assume an importance not perhaps seen before. If health service provision was to be renegotiated between the state and business, then business would still need to be seen to be viewed as giving some concessions. This could involve corporate subsidies to local community health clinics, conceded Collier Page, but the responsibility of business should rightly be on "preventive and constructive

---

[156] *Ibid*.
[157] WTA, Comment by Dr. Luis Dao, Chief Physician-Surgeon, SA Petroleum, Venezuela, Proceedings of the Conference on Industry and Tropical Health Vol II, 1954.
[158] Ibid.
[159] WTA, Presentation by Robert Collier Page, Standard Oil Company, Proceedings of the Conference on Industry and Tropical Health Volume I, 1951.

medicine in contradistinction to curative medicine," and should involve itself only with workers and not their families.[160] The provision of occupational health services – with a focus on prevention – could be the bargaining chip for industry to use to free itself from the expensive and complex provisions of general curative medicine.

Of course this did not mean that large corporations all over the developing world dismantled their corporate health services and set up occupational health services in their place. Certainly many, like Tata Steel, continued to provide general medical services, as well other welfare services like housing and child care facilities – the age of industrial welfare was by no means over. It did, however, signal the beginning of a significant shift in thinking about the responsibility for health service provision – who was to be included and on what terms. Where colonial governments had leaned, as far as they could, on large industries to provide services, such as housing, pumped water, and health care, for their workers and their families, the rhetoric of universal citizenship meant that it was harder for post-independence governments to maintain that pressure on industry.

What it also meant was that some of these large industries began to plough more resources into occupational health. While this may certainly have had benefits for workers working in those industries, the benefits to occupational health as a discipline were more questionable. Occupational health was not a science that came cheaply. It required specialist training for doctors and engineers, and expensive equipment. For post-independence governments already battling to balance the budgets and provide basic social services, occupational health research must have seemed more of a luxury than a necessity. When the ILO sent a technical assistance mission to India in 1965 to study industrial physiology in the mining industry, the expert arrived to find that no equipment was available at the Regional Labour Institute. After much negotiation with various institutions including the All India Institute of Hygiene, the Regional Labour Institute, Calcutta, and the University of Calcutta, he managed to procure one piece of the necessary equipment and described the results of his efforts as "very poor."[161] Dr. Nowacki, working in Ghana, had had a very similar experience, arriving to find that not only did he not have a local counterpart with whom to work, but that his office was a "higgledy-piggledy" old army barracks "enough to demoralise any expert," and that he had insufficient equipment with which to conduct his research.[162]

[160] *Ibid*.
[161] ILOA, TAP 0-33-5 (L), Expanded Programme of Technical Assistance, India OSH 1963-8: Fedlesak to Jain, 24th November 1965.
[162] ILOA, TAP 0-196-5 (1), Expanded Programme of Technical Assistance, Ghana OSH 1966.

For better resourced corporate entities, however, the costs associated with occupational health were far less than those of providing curative health facilities for tens of thousands of people. It is not surprising then that the professional associations and research institutes which began to emerge looked to procure corporate sponsorship for their activities. The Indian Association of Occupational Health, the Indian affiliate of the International Commission on Occupational Health (ICOH), began its life sponsored by Tata Steel and operated out of its headquarters at Jamshedpur. The doctors who presented papers to its journal and who participated in its annual meetings were overwhelmingly employees of industrial concerns, rather than representatives from state institutions or universities.[163] In Ghana, outside of the large mining houses, the only doctor who had training in occupational health was Dr. LKA Derban from the University of Ghana's Medical School, whose training had been facilitated by an ILO fellowship in 1965.[164]

The fate of the Ross Institute's work in East Africa reveals some of the difficulties this reliance on corporate funding could create. The work of the Ross Institute, an offshoot of the London School of Hygiene and Tropical Medicine (LSHTM) which had originally been set up to advise colonial industries on health matters in the tropics, had always been funded by subscriptions from large colonial industries. By the 1960s, however, it was looking to develop in a direction congruent with newly independent Africa. The young and enthusiastic doctor in charge, Stuart Hall, proposed to use the Institute's funds to establish an East African occupational health unit which would be situated at Makerere University College in Uganda. The response from his superior at the LSHTM, Professor George MacDonald, was far from encouraging. MacDonald argued that industries would likely be unhappy to see "their contributions go at least in part … to Makerere."[165] If Hall wished to continue with his proposal he would have to seek alternative funds. Hall's attempt to procure funds from the Nuffield Foundation, mentioned earlier in this chapter, was an effort at moving away from the limitations of corporate funding. After the rejection of his proposal, however, it became clear that corporate subscriptions were likely to continue to be the underpinning of any further work, although a smaller grant from the Munitalp Foundation did at least allow Hall to take up a lectureship at Makerere's School of Public Health between 1965 and 1967.[166]

In this way, occupational health became largely the domain of industry and the doctors who worked for it – much more so than it ever was in Britain where the state's resources were relatively better

[163] See Proceedings of the Society for the Study of Industrial Medicine (Jamshedpur).
[164] ILOA, TAP 0-196-5 (c) FS-4 Labour Conditions and Administration Fellowships, Mr LKA Derban, 1965.
[165] LSHTMA, RI 10/04/08, MacDonald to Hall, 8th November 1963.
[166] LSHTMA, RI 10/04/05, MacDonald to Hall, 15th June 1966.

developed and where trade unions had a long history of involvement in campaigns for industrial health. This was never going to be a context in which worker's voices would be prioritised or even encouraged, or where it would be easy for worker organisations to engage with the profession and those who controlled it. Particularly problematic was the fact that this also excluded the large majority of workers in countries like Ghana and India – particularly women workers – who did not work for a recognisable employer, or in a formally recognisable place of work. With occupational health being the domain of employers, in a context where the state structures were weak, workers who worked outside of formal waged employment had no chance of accessing such services.

The exclusion of women workers specifically from occupational health services was of course not only a problem in Ghana and India. Chapter Three highlighted the gendered foundations of the British welfare state, with women confined (in ideal terms) to the private sphere and men dominating the public sphere and the sphere of work. In this context women's health (which continued to follow the productionist emphasis on reproductive health) and occupational health occupied very separate places within health disciplines.

Karen Messing (1998), an occupational health scientist from Canada, has detailed the ways in which women's occupational health concerns have been marginalised by state institutions, the corporate sector as well as mainstream occupational science in economically developed Anglophone countries. If this has been the case in the developed world, it is something that was magnified in countries like Ghana and India. As noted in Chapter Three, one of the features of the post-independence global health movement, and one which retained a continuity with colonial health, was the emphasis that was placed on women's reproductive health. In doing so health policies tended to position women as mothers first and foremost, and as workers second. This was reinforced by the fact that post-independence governments, with their minds on industrial modernism, actively did not wish to consider the occupations in which so many women worked, as occupations. In Ghana, for example, Clark (1994) has argued that market women were a threat to the male dominated post-independence government because of the ways in which their presence as small, private operators in the economy challenged the ideology of state socialism. Yet as Messing (1998) argues the dominance of the corporate sector in funding occupational health services has also been central to the exclusion of (particularly) self-employed women workers.

However, whilst workers outside of the formal sector have little chance of connecting with occupational health services, even formal workers were often excluded. The lack of worker

representation and input at any of the large meetings on occupational health so far discussed in this chapter is quite striking. Only once in twenty years was a worker representative invited to speak at the Conference on Industry and Tropical Health. Mr Rudolph Fuapi, the International Representative of the International Association of Machinists, started his speech with the following words: "Some people might think it unusual, or perhaps even downright inappropriate, to find a trade union representative present at a discussion of this highly technical problem."[167] Yet many of the discussions at the conference could hardly be considered as highly technical and/or scientific. Whilst doctors were certainly well represented, and scientific papers were presented, there were also many non-medical representatives from industry and even government who spoke on social issues relating to the health of workers. This was certainly not such a technical conference that it should have been so unusual for a worker representative to speak at it.

The *Proceedings of the Society for the Study of Industrial Medicine* in India also reveals a very limited engagement with workers during their conferences and gatherings. An unusual 1953 volume did however carry two short contributions from workers which presented a fairly damning portrait of the collusion between doctors and employers at the expense of workers. Mr Kubul, a foreman at a textile mill, complained that:

> *The number of factories whose Medical Officers are really conscientious and willing to render humanitarian service are few. MO's are generally appointed on a part time basis. They come to the factories, and in the short time they are expected to spend there, their time is spent in meeting the Directors, Managers and other officials to enquire after their health, and then at the factory dispensaries where they examine a few patients, give a few hurried instructions to the compounders and then leave.*[168]

Even today the Indian Association of Occupational Health (IAOH), which emerged out of the Society for the Study of Industrial Medicine and is still made up largely of doctors employed by industry rather than the state or tertiary educational institutions, faces accusations of being influenced by industry. In a letter to the 2008 edition of the International Journal of Occupational and Environmental Health, Dr. TK Joshi, a member of the IAOH, accused the association of accepting sponsorships from corporate entities associated with the production of substances harmful to human health on a *quid pro quo* basis (Joshi, 2008). This was hotly denied by the IAOH who subsequently expelled Dr. Joshi from the association (Shanbag, 2008). It does not, however, seem

[167] WTA, Presentation by Mr. Rudolph Faupi, International Association of Machinists, Proceedings of the Conference on Industry and Tropical Health Volume IV, 1961.
[168] Kubul. 1953. 'A Worker's Point of View.' *Proceedings of the Society for the Study of Industrial Medicine (Jamshedpur), Vol 5 (4).*

unimaginable that a professional association which continues to "seek sponsorship" from corporate entities may be unduly biased towards their sponsor's interests.

Industry control over occupational health, the employment of physicians, the sponsorship of associations and conferences, and the financial resources to invest in expensive technical work, certainly furthers the understanding of why workers in countries such as India and Ghana would find it difficult to engage with the profession and turn it to their advantage. This explanation also sits well within a materialist framework – the control of scientific knowledge as a consequence of the wider control over the means of production. However, as scholars of colonial health and medicine such as Arnold (1993) and Anderson (2000) have shown, the politics of science and medicine is intelligible on several different levels. While the struggle for the control over the means of production is certainly one important level, there are other ways of understanding these politics which incorporate a more ideal level of analysis, and which also have important implications for understanding the limits to engagement. The following section delves deeper into the politics of medical knowledge and the medical profession itself in order to draw out further complexities in the relationship between occupational health and workers in developing countries.

Science and the Limits to Engagement

Linked very closely to the rise of the welfare state in Britain and the emphasis on citizenship as the basis for entitlements was a change in the ideological underpinnings of health provision itself. The emphasis that productionist logic had placed on the production of strong, healthy workers had shifted, after the World Wars, in favour of what Pickstone (2000) refers to as the "communitarian" model of health. In line with the aims of the welfare state, the emphasis was now on the provision of health care as a means by which to enhance social inclusion and national solidarity – the "social medicine" which Dorothy Porter (1997; 2006) and others have examined in such fine detail. While efficiency and productivity were still a concern, they were no longer necessarily considered to fall under the health services. Moreover, the focus on productivity was a limited one which focused on certain population groups (workers, mothers, infants), whilst social medicine was a practice of health that aimed to be inclusive of all.

This change in ideology was transported to the colonies and reinforced by the various health commissions which sat at the time and determined health policy. The Maude Commission Report, released in 1952, directed health policy in Ghana for the first ten years of independence (Addae, 1996). Maude's recommendations were based on the standard prescriptions of the age of social medicine: a focus on primary health care centres accessible by all citizens, both rural and urban.

Significantly, and in line with the new focus on citizenship, Maude called for the abolition of the Mining Health Areas, against which Percy Selwyn-Clarke had fought so vociferously, calling instead for a universal Public Health Ordinance.[169] The Mining Health Areas had represented a health policy which had focused attention on workers at the expense of the rest of the rural population. In the age of social medicine – a practice of medicine based on the principle of universal citizenship – these areas were considered exclusionary and untenable.

Yet the battle against the Mining Health Areas was only one front in the larger war that Selwyn-Clarke and his colleagues fought against the exclusionary orientation of colonial health policy. In 1936 the Colonial Secretary for Mines undertook a tour of the Gold Coast. In his report, he complained that no attention had yet been given by the health department to the occupational disease of silicosis, whilst too much had been given to the "general health of miner's sanitation and to tuberculosis."[170] He cautioned about the experience of South Africa, where the government had been forced to pay out millions in compensation to silicosis sufferers and underlined the need for a silicosis survey in the colony and the deployment of a medical officer with knowledge of the disease.[171] Despite his reformism in relation to health policy in general, Selwyn-Clarke was deeply unhappy with this. His chief interest had been in the upgrading of housing and sanitation as a means by which to control the high and rising levels of tuberculosis in the Colony.[172] He admitted that whilst silicosis may be present amongst miners, tuberculosis was still the main disease to be tackled. Silicosis, he and his colleagues Drs. Duff and Howells argued, was only important "insofar as it was an aggravating factor in the development of tuberculosis."[173] The doctors in fact refused to refer to silicosis independently of tuberculosis, preferring instead to use the term silico-tuberculosis "with an emphasis on tuberculosis." [174]

The reason for Selwyn-Clarke and his colleagues' reluctance to acquiesce to the silicosis survey was rooted in the same way of thinking which catalysed his protest against the Mining Health Areas, and which had inspired the rejection in Britain of a proposed national industrial health service. It was likely also the reason which underlay the Maude Commission Report's failure to consider the place and scope of occupational health within the health services. A focus on industrial diseases removed the focus from the health of the general population, away from citizenship as the basis for claims to

[169] TNA, CO 98/102, Report of the Commission of Enquiry into the Health Needs of the Gold Coast, 1952.
[170] NAG, CSO 11/14/237, Secretary of Mines to Colonial Secretary, June 1936.
[171] *Ibid*.
[172] RH, MSS.Brit.Emp.s.470, Papers of Sir Selwyn Selwyn-Clarke, Health and Housing in the Tropics.
[173] NAG, CSO 11/14/237, Howells to Colonial Secretary, June 1936.
[174] *Ibid*.

health. In this way the tension within the welfare state between health provision for workers and citizens was reflected in the medical profession itself. As Dorothy Porter (1996: 295) has argued social medicine represented "the rising tide of corporate welfarism" – it was medicine for the people, for *all* the people. Industrial health on the other hand represented the health needs of a privileged "special population" of workers.

Yet not all proponents of social medicine considered the two to be mutually exclusive. As Amrith (2006) points out the members of the Bhore Committee contained some of the leading left wing thinkers on social medicine (unusual for such a committee), including John Ryle who was the first professor of Social Medicine at Oxford University and Henry Sigerist, a champion of the Russian model of socialised medicine. The Bhore Report was exceptionally progressive in taking a holistic view of health and Chapter Ten (X) is dedicated to occupational (rather than industrial) health services.[175] It recommended that an occupational health organisation be set up and

> *… integrated with the work of the general health services in each local area under the national health schemes, including those provided by the general practitioners, the hospitals and any specialised units which are available for the treatment of occupational diseases and research and teaching in this subject.*[176]

As with the rest of the Bhore Report, these recommendations were never to be implemented. Nevertheless, the report does highlight the heterogeneity of positions that existed even within social medicine during this period. One reason that occupational health may have featured in the Bhore Report, but not in other similar reports of the period (such as the Maude Commission Report in the Gold Coast and the Gluckman Commission Report in South Africa), was that Ryle and Sigerist played a prominent role on the Bhore Commission.[177] Both these men identified themselves as socialists and looked to the Russian public health system, in which workers' health played a prominent part as model.

There is, however, an additional factor to consider. Percy Selwyn-Clarke, so vehemently opposed to a focus on workers within the public health system, had worked for a long time in the colonies and had borne witness to the way which health services had been skewed in favour of workers. Despite Ryle and Sigerist's involvement in the Bhore Committee, they were not doctors operating in the

[175] Report of the Health Survey and Development Committee Survey, 1946.
[176] *Ibid*.
[177] Bill Freund (2012) provides an interesting discussion of Ryle in South Africa. Although not a member of the Gluckman Commission, he did visit South Africa during the proceedings of the Commission and provided a trenchant critique of what he saw to be a health system that was meant to uphold racial divisions.

colonial medical services and their experience of colonial health policy was limited. They were putting forward an admirable ideal for an integrated health service which catered to the needs of citizens both at home and at work, but they had limited knowledge about the context and history of the country into which they were trying to insert it. Selwyn-Clarke on the other hand was steeped in colonial experience and had battled for years to make the colonial governments realise that it was not only workers who had health needs. His antagonism towards occupational medicine is perhaps therefore understandable.

It was the vision and rhetoric of men like Selwyn-Clarke that predominated in the era of "health for all" after independence, even if the reality of health provision on the ground remained stubbornly similar to its colonial predecessor. In this way the structure of the state and the predominant ideology of health reinforced one another in a manner that served to marginalise occupational health. However, this is not the only politics of science that impacted on the trajectory of the discipline. There is something as well about the origins of occupational health as a science, its orientation as a high modernist discipline, and the transferral of that to an environment where this modernity existed only in limited form.

One gets an odd feeling when looking at the occupational disease schedule attached to the Workmen's Compensation Act in Ghana – that it is meant for another country entirely. In Ghana, where the vast majority of workers worked in agriculture, or on the sides of roads and in market places, and where workers tended to suffer most acutely from diseases of the environment, the schedule maintained a focus on diseases acquired in industrial settings (industrial poisonings dominated the schedule), and was derived almost word for word from the ILO's model occupational disease schedule, which had been criticised several years earlier by the Colonial Labour Advisory Committee in London as "particularly related to conditions in Europe … taking no account of the problems we meet in the colonies."[178]

In his history of radiography and silicosis treatment in Britain during the early to mid-20th century in Britain, Joseph Melling (2010) argues that historical narratives which place too much emphasis on the contribution of worker's struggles to the development of the science of industrial medicine are overly simplistic, and even misleading. "British evidence," he argues, "suggests rather the importance of links forged amongst general practitioners, local tuberculosis officers, expert researchers, and campaigning bodies concerned with public as well as occupational health in these

[178] TNA, CO 859/1174, Occupational Health in the Colonies, 1957.

decades" (Melling, 2010: 430). So, as with the earlier discussion on the impact of workers' struggles on occupational health institutions more generally, the question of whether workers were really able to engage with the science of occupational health even in Britain is raised. Melling (2010) and Melling and Sellers (2012) put forward convincing arguments that it was, and still is, the connections between scientists in the "invisible colleges" of international expert groupings that are the real driving force behind knowledge creation and development within the discipline.

However, even a brief look at the TUC archives reveals a decided interest in using the science of occupational health to further workers' struggles in this area. In 1930 the TUC appointed Sir Thomas Legge, the Home Office's first Medical Inspector of Factories, as Medical Consultant and Advisor. A later memorandum on Legge's "invaluable" contribution to the TUC (written after his death in 1932) noted the ways in which his expertise had been used to expand the list of compensable occupational diseases scheduled within the Workmen's Compensation Act; "Dr. Legge was, of course, expert in industrial diseases and he knew exactly what was required to get over the objections and criticisms of other medical men and the employers."[179] Arguing in favour of the appointment of a new Medical Adviser, the memo went on to say that "our agitations backed up by irrefutable facts presented in a scientific way has resulted in a very great progress in the last few years and it would be a great pity to say the least of it, if that work were to be lost."[180] This suggests that not only was the TUC heavily involved in the political machinations surrounding the administration and development of occupational services as Long (2011) argues, but they were also deeply concerned with the science itself – using professionals to engage with other professionals in the interests of developing a science which could be used for the interests of workers. In later years the TUC was even to make a financial contribution to the Centennial Institute of Occupational Health at the LSHTM which opened in 1968, and which became a driving force in spreading the science of occupational health to the developing world (Schilling, 1998).

While the influence of workers' struggles on the development of occupational health science is perhaps therefore still debatable in the British context, it is certainly much less so in its old colonies. As with political engagements around workers' health, the available evidence suggests that workers in such places as India and Ghana failed to substantively engage with the science itself – it was an area of knowledge driven by experts sitting in Geneva, London, and in various prestigious universities in the United States. Ultimately this contributed to a conspicuous collective failure of the

[179] Modern Records Unit, Warwick University (hereafter MRU), TUC Collection, MSS.292/140.9/1, TUC Council Memo, 1933.
[180] *Ibid.*

profession to think really creatively about how the discipline could and should develop within contexts very different from the ones in which it originally arose.

This was of course partly due to the influence of industry over the profession, as shown in the previous section. Industry had no interest in the widening of the field – it was in its own interests to keep it as narrow as possible. The intersection between occupational health and tropical disease was an area of particular concern because industries were certainly not interested in having to pay compensation for diseases like malaria and schistosomiasis – it was much less of a risk in this regard to keep tropical medicine a very distinct discipline from occupational health. However, not all those who controlled the discipline were linked to corporate interests. As already mentioned in the introductory section of this chapter, the ILO and the WHO had by this stage begun to play an important role in defining the occupational health research and policy agenda, particularly in developing countries. Their entrance into this domain, and the subsequent tensions created by two powerful actors operating in the same policy space, will be discussed in more detail in the following chapter. For now it is important to note that even where scientists were not directly beholden to corporate interests – such as those working in the ILO and WHO – their views on the direction and scope of occupational health science in developing countries remained somewhat narrow.

This suggests something internal to the scientific discipline itself was also implicated in the creation of a barrier to engagement. This brings to the fore questions about the relationship between power, knowledge, and engagement. Cooper (1996) argues that it was the "scientific language of labour" – a language that aspired to universalism – that allowed African trade unions to lead the demand for universal rights of citizenship in the colonial territories. That it was a universal language, not a particularistic language of "the other," was key to this because it gave workers the language to demand for themselves the same rights as those of metropolitan citizens. Yet it is possible to turn this around and argue that this universality also made it more difficult for workers to engage with certain elements of this "scientific language of labour," including occupational health.

In the immediate post-independence period, the exoticism and particularism of colonial medicine sat in fine balance with an attempt, particularly by the international organisations, to move towards a more universalistic approach to medical practice. Colonial medicine, it has been argued by authors such as Vaughan (1991), was both constitutive of and constituted by colonial power. As such it was deeply entwined with what Edward Said termed "orientalism": Europe's attempt to define itself in relation to the other cultures and peoples by setting them up as the "contrasting image, idea,

personality" of the European (Said, 1979: 1-2). Colonial medical practice tied colonial subjects to otherness – tropical medicine itself was constituted by this exoticism. Diseases of the environment which Europe had transcended, such as cholera and malaria, were designated as "tropical diseases" still to be overcome in the backward areas of the world. It was a medical practice based on difference – different races, different bodies, different environments, different diseases, different treatment (Anderson, 2000).

By the 1930s in the Gold Coast, and in other colonies, the particularism of tropical medicine had begun to be challenged by doctors like Percy Selwyn-Clarke (as well as those located in the metropole such as John Ryle) whose focus was on the more universal ideas which underpinned tuberculosis eradication measures. In the post-independence period these more universalistic ideas were given greater prominence as a new wave of medical practice was ushered in. Public health, now considered a universal human right, was internationalised through agencies such as the WHO. This was a medical practice which sought to separate itself from "colonial precedents, assumptions and interventions" (Amrith, 2006: 15). It did so by adopting what Amrith (2006) called a "techno-centric" approach, which in theory allowed it to transcend the colonial need to "intervene deeply in matters of 'culture' or social transformation" (Amrith, 2006: 17). However, as Amrith (2006) argues, this transformation from colonial to post-colonial medicine was an incomplete one. The attempt to use technology as a way in which to move away from colonial assumptions was always hindered by its inability to break from the "institutional, intellectual and epidemiological legacies of the colonial medical past" (Amrith, 2006: 15).

Occupational health was firmly located within this new techno-centric universalistic paradigm and unlike the public health discipline was able to firmly draw a line between the colonial and the post-colonial. Both Anderson (2000) and Arnold (1993) have argued that a defining feature of colonial medicine was the connection it had not only to the social, but to the environment of the places in which it operated, situated firmly within an understanding of the relationship between "tropical vegetation, tropical bodies and tropical mentality" (Anderson, 2000: 238). Occupational health on the other hand positioned itself in direct relation not to the tropical environment, but to the modern industrial workplace. In 1925 the International Labour Conference (ILC) passed Convention 18 concerning Workmen's Compensation for Occupational Diseases. The Convention essentially defined occupational diseases as those diseases or "poisonings" produced by the "substances set forth in the Schedule appended hereto": substances such as lead, benzene, mercury, and arsenic.[181] This

[181] ILOA, SH 1-3-25-6, Correspondence with the Trade Union Congress, London, 1953.

particular definition was to come under challenge in 1936 from the Miner's International Federation who wished to see ankylostomiasis (hookworm) added to the list of occupational diseases.[182] During the late 1960s and 1970s an increasing awareness of environmental concerns beyond the workplace, driven largely by the discoveries around asbestos, would challenge these assumptions further (Melling and Sellers, 2012). However at the time of independence, the focus on industrial processes as the basis for the definition of occupational disease was to remain dominant for many years to come. Occupational diseases were diseases which arose from man-made industrial production processes and environments – the processes and environment of modern industrial production, not from the natural environment.

Underpinning this drive towards high modernism was the need for what was ultimately a relatively new profession to establish its credentials within the medical field. When Sir Thomas Legge, at that time the editor in chief of the ILO's flagship encyclopaedia of industrial hygiene *Occupation and Health,* was asked in 1929 whether or not certain diseases of the natural environment which affected working populations could be included within the volume, his answer was an unequivocal no.[183] He argued that if such diseases were to be included, it would undermine the "sophisticated specialty" and unique contribution of the medical discipline of industrial hygiene which they "had all worked so hard to establish."[184] It is likely, as Messing (1998) has argued, that this sentiment was also behind the clear separation that was drawn between women's reproductive health and occupational health; a division, she argues, which has failed to understand the linkages between women's work and reproductive health.

If occupational health represented a highly modernist view of the relationship between the working body and disease, it was also constructed from a universalistic rather than a particularistic approach to medicine. It represented and reinforced the universal ideal of "industrial man" and exported it throughout the world. Again, the emphasis on "man" here was evident – work that women did, or those employed outside of large, industrial workplaces, were excluded. Stuart Hall at the Ross Institute, for example, was driven by the idea that "European standards of study and practice in occupational health should be introduced in Africa."[185] What created difficulties for Hall, however, was the fact that he was trying to do this in a place of what Anderson (2000: 243) calls "liminal

[182] ILOA, HY 553/4/01, Extracts from Mr. Marten's Speech to the Governing Body, 77th Session, 14th November 1936.
[183] ILOA, HY 103/6/25/1, Advisory Hygiene Committee, List of Unhealthy Trades, Correspondence with Sir Thomas Legge, 1923-1929.
[184] *Ibid.*
[185] LSHTMA, RI 10/04/08, MacDonald to Hall, 22nd July 1964.

modernities." European style modernity had arrived in the old colonies – the late colonial period had ensured that, but it was always limited in scope, and it always had to operate in conversation with the very different society and environment into which it had been inserted.

The fact was that most workers in tropical countries suffered more frequently and with greater intensity from diseases of the natural environment than they did from diseases related to industrial processes. The main health problems for workers in these areas, the Conference on Industry and Tropical Health concluded, was "the tropical cocktail," the term used to refer to "the load of schistosomiasis, hookworm infection [ankylostomiasis], ascariasis [roundworm], and malaria."[186] By abstracting itself from a consideration of these diseases, occupational health was confronted with the problem of remaining relevant in a very different context to that in which it had originally developed.

Documents from the WHO in particular reveal an interesting contradiction that emerged as the tension between the universal and the particular, the modern and the not quite modern, played themselves out. In an attempt to assert itself over the ILO, which remained relatively steadfast in its strictly industrial approach to occupational health, the WHO had positioned itself as a champion of occupational health in developing countries, arguing that the discipline had to consider the "total health" of the worker in such contexts where living and working conditions were difficult to separate, and supporting the integration of occupational health into primary health services as a "public health speciality" in order to reach workers working outside of large industrial concerns. A WHO report from India in 1955 even noted that:

> *The health problems of the industrial worker in India are very different from those in industrialised states, especially in Europe and Northern America, where occupational health has been studied for a long time and considerable experience is available. The difference will make it inadvisable and perhaps impossible for occupational health from these countries to be copied directly and applied efficiently.*[187]

Even so, the actual research promoted by the WHO into occupational disease and health in developing countries remained substantively the same as that which was carried out in Europe.

The big discovery in occupational health during the early 1950s in Britain had been the full classification of the disease 'byssinosis' – a respiratory disease related to continuous inhalation of dusts during the processing of organic materials such as cotton – by Richard Schilling and his

[186] WTA, Conference on Industry and Tropical Health, Volume 1, 1951.
[187] WHOA, SEA/Occ.Health/1: Report on Occupational Health in India, 1955.

colleagues at the University of Manchester (Schilling, 1998). The excitement over this discovery was quickly transferred via the WHO to developing countries, and was to influence the direction of the occupational health research it funded for many years to follow. A brief review of various technical cooperation documents from the early 1970s reveals a marked tendency towards funding research on "respiratory diseases resulting from the inhalation of vegetable dusts." While it is very likely that respiratory diseases which arose from the processing of raw materials were a cause of occupational disease in countries where this industry drove the economy, further research into this area during the 1970s was hardly pushing the boundaries of knowledge in a new social and economic context where so many workers worked outside of formal industry, or were not working in industry at all. Rather it represented the relatively standard replication of work that had first been carried out years earlier in Britain.

When Stuart Hall of the Ross Institute put in a funding proposal in 1963 to lead a study on "vegetable dust pneumoconiosis in East Africa" he was turned down by the Nuffield Foundation on the grounds that the subject "of respiratory diseases in people working in dusty conditions is one that has been fully explored."[188] Reportedly, their actual words were "flogged enough already."[189] In a letter to Hall shortly afterwards, his supervisor at the LSHTM, George MacDonald, stated that the Foundation was far more likely to fund an application "that has a local tang to it. That is, if you said you were going to study schistosomiasis or some other exotic condition, they would have been ready to support it."[190] The charge of exoticism, of "othering," could quite easily be made against the Nuffield Foundation here. Certainly it was not applying universal principles to its understanding of workers' health. At the same time though a certain common sense dictates that in areas where workers suffered in far greater numbers from schistosomiasis than they did from respiratory diseases related to vegetable dust processing, it was perhaps a better use of resources to focus on the former.

The response of the Nuffield Foundation to Hall's application in 1963 makes it even more striking that the WHO was still funding this type of repetitive research well into the 1970s. Part of the reason for this was undoubtedly Schilling's own influence over the particular professional milieu from which the occupational health specialists of both the WHO and ILO originated. After leaving Manchester in 1956, Schilling had taken up a position as Reader in the newly established Occupational Health Unit at the LSHTM. Here he developed a postgraduate teaching programme which attracted students

[188] LSHTMA, RI 10/04/08, MacDonald to Hall, 22nd July 1964.
[189] *Ibid.*
[190] *Ibid.*

from around the world – by the time he retired in 1976 almost half of his students "came from other countries, and more than half came from developing countries."[191] We were exporting occupational health … looking back at my career … this has been one of the things that I look back on with more pleasure – that I have friends from all over the world,"[192] said Schilling in a recorded interview held some years after his retirement. In exporting occupational health, Schilling was also exporting his passion for the study of byssinosis, which he fondly referred to in his memoirs as "the fourth Schilling child" (Schilling, 1998).[193]

However, at the heart of this was the idea that occupational health was a universal modern science which could be applied equally in all countries of the world. Consequently, it remained a highly specialised area of science. Research on vegetable dust – particularly that from cotton – may have had relevance to the relatively small proportion of workers in countries outside of Europe and the United States which had developed manufacturing capacity (largely in Asia). To the vast majority of workers, however, it held very little real relevance. During the 1950s and 1960s this seemed to bother the scientists very little – the focus was on establishing a new specialism which would eventually be appreciated by non-metropolitan countries as they moved towards industrial development. In later years however, as these countries failed to industrialise, it occasioned a crisis of relevance against which occupational health doctors in developing countries continue to battle.

In a brief characterisation of theoretical approaches to social understandings of medicine, Amrith (2006) argues that while the historiography of colonial medicine has been highly critical, that of the internationalised public health of the post-colonial era has been much less so. While Western medicine in the colonial context has been characterised as a constitutive element of colonial power, the dominant narrative on international public health has been one of "diffusion," and the progressive defeat of preventable disease (Amrith, 2006: 7). This chapter has focused not on international public health *per se*, but rather on occupational health where the dynamic was somewhat different.

This chapter does however suggest a critique of the approach to understanding colonial and post-colonial medicine described above – an approach which sees the former as entirely negative, and

[191] WTA, Richard Schilling, C.B.E interview with Max Byrne, 1987.
[192] *Ibid*.
[193] Schilling, as the international doyen of vegetable dust research, had undoubtedly influenced the WHO's Egyptian Technical Officer, M.A. El Batawi, whose research interest was listed as "vegetable dust" and who was certainly behind the drive to commission so many technical research agreements on the subject.

the latter as a progressive move forward, and which privileges universalism over the particularism in a blanket way. Tropical medicine was an integral part of colonial power, that in its particularism it 'exotified' and 'othered' colonial populations. For all these faults, however, colonial medicine at least engaged with the context in which it was situated – there was no other choice. Colonial medicine was used as a way in which to further a particular vision for colonial society, one which instilled certain norms and behaviours in subject populations. In order to do this it had to engage with people, and, as David Arnold (1993) has so convincingly shown, those people were able to resist and in so doing transform medical practice itself. As much as colonial medicine attempted to constitute colonial society, it was also constituted by it. The champions of tropical medicine were men who had spent many years in tropical countries, whose science had inevitably been influenced by the context in which they operated. This was never the case with the discipline of occupational health. In its inherent modernity and drive towards a universalistic modernism, occupational health remained distant and unengaged with the real needs of workers in developing countries. It was a science controlled from Geneva and London by scientists like Richard Schilling who, for all the good work they had done in their own countries, had a limited understanding of a world in which work and its relationship to human health operated very differently.

Conclusion

In concluding this chapter, three points should be emphasised. The first is that the answer as to why and how occupational health ended up as such a marginal service within post-colonial states is a multi-faceted one. A number of factors, including the political economy of the late colonial and post-independence period, the structure of the British welfare state that was inherited by its colonies, as well as the politics of occupational health science and research all contributed to the situation. Secondly, this chapter (and Chapter Two) have shown that, whilst workers in both newly independent India and Ghana were able engage with policy spaces that opened up for them within the provision of health services, there were limits to this engagement. In Offe's terms, health benefits in the sphere of reproduction were more readily granted than those in the sphere of production. When it came to occupational health, the political economy and the nature of the scientific project, which in itself failed to engage with a new context, were against it. Lastly, an important part of this chapter has been the relational approach taken to understanding the place of the worker and the citizen in health policy – looking at the way these two visions of health provision sat in tension with one another. This relational perspective has also illuminated an important aspect of the politics of health – one where the focus on workers and occupational health acted as a lever for large international and national corporations to extricate themselves from the commitment to providing large scale curative services in the tropical countries in which they worked.

In this way, Chapter Four introduces a tension between inclusion into health services based on citizenship, and inclusion based on status as a worker. It brings up questions of state responsibility versus employer responsibility – the shared responsibility of tax payers versus the responsibility of capital for health problems that are either directly or indirectly caused by the processes attendant on capitalist development. This is a tension which continues to be explored in Chapters Five and Six. Chapter Five moves the thesis from the post-independence period to the present, looking at how this tension has played out amongst the international organisations. Chapter Six returns to the national level, looking at how these international trends have translated into national level policies in India and Ghana, and how worker organisations have engaged with them.

Chapter Five: International Organisations and the Politics of Workers' Health, 1950-2012

Introduction

The previous chapter focused on the position of the worker in health policy during the immediate post-independence period. This chapter extends this analysis from the post-independence period to the present day. Although there is potential for repetition from the period 1950-1970, this is in fact not the case. While continuing to refer to some of the issues discussed in the previous chapter, this one focuses mainly on the policies of three of the multilateral international organisations which have been concerned with the place of the worker in health policy – the International Labour Organisation (ILO), the World Health Organisation (WHO), and in more recent years, the World Bank. The chapter also considers the present position of philanthropic foundations, which have come to play a significant role in global health through allocations far exceeding those which are available in the UN system.

Any study of social policy in the developing world necessitates the inclusion of at least some discussion of the influence of such international organisations. As Deacon et al., (1997) have argued, the international organisations have always had a much greater influence here than in industrialised countries and have been key sites of transmission for ideas about economic and social policy. This influence has been extended through direct technical assistance in the setting up of social programmes (for example, the ILO assistance with India's ESIS mentioned in the previous chapter). Importantly, it has also been extended through more indirect means – through research, knowledge generation, and dissemination, as well as the circulation of senior policy workers, which influence the terms on which policies are debated and formulated at national level (Béland and Orenstein, 2013). This has been particularly true for health policy. Amrith (2006: 19), for example, argues that he chose to focus his history of health policy on the Asian region as a whole because "so many 'local' sources I examined – books, pamphlets and newspapers in English and in Indian languages ... pointed back to the chambers of the UN, the WHO, as the ultimate authority deciding policies governing the health of millions."

Nevertheless, it is difficult to ascertain the impact of the international organisations on the ground. Certainly, the mass health campaigns led by the WHO in the 1950s did have a very tangible impact. In later years, and particularly in more recent times, these grassroots campaigns have given way to a greater focus on influencing policies and ideas. Partly this has been because of financial limitations

(especially recently), but as Amrith (2006) points out in relation to the WHO, the mass health campaigns of the 1950s had shown how difficult it was for the international organisations to influence national politics and local communities. For this reason this chapter is not a study of whether and how international organisations had an impact on the ground. Rather, it is a study of institutional discourse, albeit a discourse which reacts to real economic shifts.

The chapter spans a considerable length of time. The advantage of taking this approach is that it is possible to discern broad trends and changes in thinking which have occurred over this period, and allows for direct comparisons to be made between the post-independence era in which social democratic thinking tended to dominate the international organisations, the period in which neo-liberalism gained ascendancy, and the current era which has been labelled as "post-neoliberal" or "post-Washington consensus." Why is this an important comparison to make?

As this chapter will show, there is currently a heated debate over what post-neoliberalism actually means for previously marginalised groups. The policies of the post-independence social democratic era were concerned with questions of social justice and equity. As the previous chapter showed, in the ex-colonial territories the "terms of inclusion" in health policy were reconfigured towards universal citizenship. While this ended up being more rhetorical than real, this was a fundamentally different stance from the neo-liberal period which followed after the economic collapse of the late 1970s. The era of small government and the unrestrained movement of capital around the globe reconfigured the terms of inclusion again – but this time away from citizenship towards consumerism (Pickstone, 2000). Health care became something to be purchased – the introduction of user fees in health facilities, promoted heavily by the World Bank, became commonplace across the developing world. Those too poor to purchase health care were afforded targeted "safety nets" such as indigence exemptions. Now again the terms of inclusion are changing. The need to deal with the crises of production and social reproduction wrought by neo-liberal policies in a context of increasing poverty and inequality has led to a shift in position towards favouring state regulation in some instances. This has allowed for a renewed focus on social policy to emerge (Mkwandawire, 2004; Lund, 2009), with some arguing that a Polanyian "double-movement" which seeks "to re-embed the economy in society" has begun (Sandbrook, 2011).

Importantly, this "re-invented" social policy has opened up policy spaces which even in the post-independence/social democratic era, were closed off. In terms of the position of the worker in health policy, for example, there is a growing recognition that workers outside of formal

employment are also in need of health protections, and that the existing systems for providing these protections, based as they are on the European welfare state models, are inadequate. There has also been growing recognition of the role that women play as economic agents, as well as mothers and carers, and that their work-related health needs may differ from those of men. At the same time, however, there have been words of caution from a number of scholars who argue that while certain spaces have opened up, others, equally critical for the realisation of a just society, are closing down (Fraser, 2009; Lund, 2009; Bebington and Humphreys Bebington, 2011; Ballard, 2013). Indeed, the current conjuncture is one characterised by a tension between the reform of welfare regimes to be more inclusive of those previously excluded, and the danger that this reform is shaped in such a way that the very real gains of the social democratic period are lost. This chapter attempts to explore this tension within the health policies of the international organisations, and, following the main theme of the thesis, uses the changing place of the worker in health policy over the three periods in question as a point of focus. This historical approach allows for an analysis which is able to evaluate the gains and losses of the current moment as compared to previous conjunctures, and in doing so adds to the current debate on "post-neoliberalism."

In doing so this chapter becomes paired with the chapter that follows (Chapter Six). The theoretical framework of this thesis is one which sees policy emerging as a result of struggles between and within social forces. Yet, following Cooper (1996), it is also one which is centrally concerned with where and how workers have been able to engage with policy and to turn it to their advantage (or, as in Chapter Four, where and why this kind of engagement was blocked). In taking the thesis into the present, this chapter seeks to explore the current hegemonic position on health from a global perspective and to compare it to the past to see what has been gained and by whom, and what has been lost and by whom. It focuses therefore on the view from the top rather than the bottom, and seeks to explore debates that operate at the international level. In Chapter Six the thesis remains in the present, but takes a view from the bottom and looks at where and how organisations of informal workers are engaging with this hegemony at a national level. In this way Chapter Six grounds the debates discussed in this chapter in national experience.

A theme that runs through this chapter is the relationship between certain international organisations – particularly the ILO and WHO. As Saunier (2007) has argued, whilst there are a number of studies of these organisations, most have focused on single institutions rather than the relationship between them. Some important exceptions are those by Litsios (1997), Deacon et al., (1997), and Weindling (1995), but on the whole Saunier's (2007) point remains true. This chapter

therefore also contributes to the limited body of work on the relationships between international multilateral institutions. A central argument is that the tensions which emerged between the ILO and WHO, particularly around occupational health, were not only related to battles for territory, but also reflected the tension that existed within the social democratic model between the state-citizen relationship and the employer-worker relationship. It argues that the relationship between the two organisations has reproduced this tension in a manner which has negative implications in the present moment.

It is interesting to note that the tensions between the WHO and ILO seemed to exist mainly within the field of occupational health. The available evidence on the relationship between the two organisations show that there was very little tension over the question of health insurance systems – considered part of 'labour protections,' it was unquestioningly accepted by the WHO that in such matters the ILO was the lead agency. For this reason, the chapter focuses in large part on the tensions between the organisations on questions of occupational health. Yet, following one of the overarching themes of this thesis, it focuses on situating occupational health within the wider politics of health, highlighting important tensions between international organisations, between the different professional groupings within the health profession, and, perhaps, most importantly for this thesis, between different viewpoints on how the worker should be positioned within health policy more generally, and which can be applied to health policy more widely.

International Health Policy and the Worker during the Social Democratic Era, post-World War Two

Chapter Four highlighted the tension within the "terms of inclusion" in the post-World War Two period between workers and citizens, with a particular focus on how this tension played out in the newly independent countries of Ghana and India. In Britain, it was argued, the terms of inclusion had shifted towards citizenship and social provision by the state, with the NHS embodying this move within health policy. Whilst health as a right of citizenship had been considered an ideal by many developing countries, the reality was that health provision remained tied to employers.

Nevertheless, a point which is not elaborated in Chapter Four is that whilst social citizenship had become the defining welfare ideology in Britain, the employment relationship was still an important aspect of the British welfare state. As Lund (2009: 2) puts it:

> *Beveridge's model of the welfare state … was built on assumptions about family life and the role of employment in meeting families' needs: that most people would be married, that men would be the head of the household, that wages earned would be enough to cover the family, and that work would be the chief source of economic security over the lifetime.*

While the NHS was a service which any citizen could access, its very existence relied on the idea that there would be enough citizens earning high enough wages and paying enough tax to maintain the system. Social citizenship in Britain assumed a labour market where there was full, or close to full, employment and it was through employment that the benefits of economic growth would be distributed. So even within a system where the "terms of inclusion" were ostensibly based on citizenship, there was a need to maintain a focus on production – a situation which meant that social and economic policies were in fact highly interdependent even if the design of the administrative institutions governing them suggested that they were very separate (Heintz and Razavi, 2012).

The axis of responsibility that ran between the state and citizens for social provision was therefore complemented by an axis that ran between employers and workers (Lund, 2009). This second axis was downplayed by British social policy experts such as Richard Titmuss, who believed firmly that it was the state who should be the dominant provider of social services, arguing that benefits attached to the employment relationship served to increase social inequalities (Abel-Smith and Titmuss, 1987). Even then, however, there was an unspoken assumption that industries would be paying enough in taxes and wages to allow for redistribution through the state. The employment axis was of course far more visible in developing countries, where state provision of social services was often absent, particularly in rural areas, and where large employers in some cases (but certainly not all) provided in-house medical services to their employees.

It is important to underscore here that the axes of the welfare state – those of citizen-state and employer-work – were essential to the functioning of the social democratic model, but at the same time operated in tension with one another even in the industrialised world. This was particularly so when it came to the provision of social services. Whilst the tension in countries like Ghana and India was one between an ideal and the reality on the ground, in industrialised countries the tension was between the different positioning of the employment relationship with respect to social services. The battles that raged, for example, between the proponents of Bismarckian models of Social Health Insurance (SHI) found in most Western European countries, where contributions to the national health scheme were tied to the employment relationship, and the British model of publicly funded free health care was a case in point. Although, as mentioned in earlier chapters, the models were essentially underpinned by the employment relationship in that they both ultimately relied on the contributions of employers and workers, the fact that Britain's system was funded from general taxation did outwardly obscure the importance of the employment relationship to a certain degree.

These tensions also existed at the level of the international organisations, and emerged particularly prominently in the post-World War Two era within the United Nations (UN) system.

Within this international system, the International Labour Organisation (ILO) was the flagbearer for the employment relationship. Born during the period of social and economic turmoil which followed World War One, the ILO was originally established to work toward industrial peace in 1919 as an office of the League of Nations after the Treaty of Versailles. It was unique within the League, however, in that its governance structures gave equal status to representatives from government, labour, and employers. This tripartite structure was a consequence of the fact that, while European governments, particularly Britain, were interested in an international labour organisation which could impose labour standards on all member countries so that they could remain economically competitive, trade unions had by this stage also become an increasingly powerful and internationalised force who had themselves put forward a proposal for a tripartite international labour organisation. Although this tripartite structure did not find favour with all who sat on the commission which developed the plans for the ILO (particularly the American delegates), it was eventually adopted as "the first pillar of ILO ideology," which was seen as a victory for the voice of organised workers (Alcock, 1971). Equal numbers of representatives from government, labour, and employer organisations from each member country would sit on the Governing Body, and would be represented at the annual International Labour Conference where various labour standards in the form of Labour Conventions would be proposed and adopted.

As an unusual international organisation, the ILO was sometimes accused of "amateurism" by the pre-war League of Nations because of its association with trade unions, and struggled to assert itself within an organisation that placed emphasis on inter-governmental associations (Saunier, 2007). The organisation came under even greater pressure during the period of transition to the UN system in the 1940s and 1950s and the emergence of the new "international development agenda." The USA, now one of the dominant players in international politics, and wary of the European social democratic model, did not fully trust the ILO and its perceived workerist positions. In a major blow to the organisation, the ILO was not invited to the key post-war financial and economic planning conference held at Bretton Woods in 1944 (Maul, 2012).

Furthermore, the relevance of the ILO to newly independent countries was questioned. The organisation's tripartism had emerged from a distinctly European model of social organisation and although the ILO had dabbled in what it called "the non-metropolitan" territories during the 1930s,

its only members from Africa and Asia were India (a "special" member) and South Africa. It had also been criticised vociferously by Asian nationalist movements for taking an overly cautious stance towards the question of decolonisation, largely because it did not wish to lose favour with Britain (Maul, 2012). The 1944 Convention on Social Policy in Dependent Territories (The Declaration of Philadelphia), which proposed that colonial powers extend a limited version of social citizenship to their dependent states, represented an attempt by the ILO to expand its focus, and was considered a triumph when it was adopted at the International Labour Conference. The Declaration garnered criticism from the dependent territories themselves, who argued that the ILO was upholding a double standard by producing one set of social policy recommendations for industrialised countries, and another set for "the rest" (Maul, 2012). Nevertheless, the Declaration was important for the ILO because it carved out a clear role for the organisation in the development of international financial and economic development policy. Having achieved this success, it was indeed a grave blow for the organisation when it was not invited to Bretton Woods.

The ILO was eventually invited into the international fold because of the cooling of relations between the Soviets and the USA and Britain. The USSR had attempted to establish the World Federation of Trade Unions as a "countervailing force" to what it perceived as the western allied ILO (Maul, 2012). This gained the ILO the crucial support of the USA and Britain, and in 1946 it was invited to sign an agreement with the United Nations Economic and Social Council to become one of the UN's five specialised agencies, giving it official status as an international body. This agreement and the appointment of David Abner Morse, previously U.S. Under-Secretary of Labour, as Director-General in 1948 changed the position of the ILO considerably. Morse spoke the anti-communist language the U.S and Britain were happy to hear and saw the ILO's programmes as a way to reach out to developing countries and steer them away from Soviet influence. This vision for the ILO ran parallel to an aggressive and well-funded campaign by US and Western European "liberal" trade unions under the banner of the International Confederation of Trade Unions against the "communist" trade unions of the USSR and the WFTU (Garcia, 1973; Carew, 1996). It was also Morse who saw the real potential to integrate and promote the employment agenda within the wider international development agenda. Under Morse the ILO developed its Technical Assistance Programme (TAP) which provided assistance and training in developing countries and focused on employment priority areas such as manpower development and productivity (Maul, 2012). Yet even with Morse's steadying influence, the ILO still had to prove itself – to newly independent countries unsure of the relevance of European labour standards to their context, the USA still wary of

workerist politics, and to an international development community still not entirely convinced that the ILO belonged.

This basic insecurity is perhaps why the announcement in 1950[194] by another specialised agency – the WHO, that it was establishing a "Social and Occupational Health Unit" – was met with such consternation at the ILO. Before discussing this further, it is first necessary to provide some background detail on the health activities of the ILO. While the main purpose of the ILO was, and still is, the development of international labour standards, it also has maintained a number of technical departments, some pre-dating World War Two, which have not only guided the Technical Assistance Projects mentioned above, but have also conducted and compiled research in their respective areas in order to support various conventions and recommendations. One of the oldest of these technical departments was the Industrial Hygiene Service, established in 1920 to deal with the health of workers.[195] Prior to World War Two, the service concerned itself with developing health standards and maintained an advisory correspondence committee to oversee this process (first set up in 1924). This brought together leading minds from Europe and America such as Professor Alice Hamilton from Harvard University and Sir Thomas Legge who had retired as a distinguished Medical Inspector of Factories in the UK and had gone on to work for the British TUC.

By the end of the war in 1945 the Industrial Hygiene Service listed amongst its achievements the White Lead Convention, adopted in 1921, which prohibited the use of white lead in interior painting, and excluded women and children from painting with it at all. It contributed to two Conventions (1924 and 1935) and a Recommendation on Workmens' Compensation (the first of which contained the first international schedule on compensable industrial diseases), and had organised two major international conferences on silicosis (in Johannesburg and Geneva).[196] It was also Dr. Luigi Carozzi, the Italian who started the service in 1920 and headed it until 1940, who began work on the *Encyclopedia of Industrial Diseases,* the two volumes of which were finished in 1930 and 1934 respectively. The encyclopedia was aimed at "the enlightenment of the industrial world to occupational dangers and hazards, the technical education and training of medical men who have to combat occupational diseases, and to spread knowledge about industrial hygiene."[197]

[194] WHOA, Measures for Strengthening Occupational Health Activities, 1953.
[195] ILOA, SH-01-2-3, History of the Industrial Hygiene Section, 1920-1949.
[196] *Ibid*.
[197] ILOA, HY 104, Relations between Rockefeller Foundation and the ILO, 1923.

Weindling (1995) states that under Carozzi's leadership, the Industrial Hygiene Service of the ILO developed a highly scientific and very narrow understanding of workers' health which centred on the direct effects of industrial processes on the individual worker. The ILO had adopted an approach of "scientific universalism" in order to justify the various standards they developed. This was a way to bypass politics – to put the ILO's standards beyond question by employers and governments at the International Labour Conference. Yet, as Weindling (1995: 140) argues, it was a double edged sword because it meant that the understanding of the relationship between work and health was limited to "what could be proved in a laboratory."

This narrow focus was, however, also a consequence of the relationship between the ILO and the League of Nations. The ILO's mandate from the Treaty of Versailles had included the fairly general instruction to protect "the worker against sickness, disease and injury arising from his employment" (cited in Weindling, 1995: 139). At first the organisation had attempted to interpret this widely. Saunier (2007) has written a fascinating history of the ILO's endeavour to involve itself in the field of social housing in the interests of improving the living conditions (and through this the general health) of workers during the 1920s. While some inroads were made, ultimately the ILO was forced by British employer and government representatives on the ILO Governing Body to abdicate its position. They argued that housing was solely a state responsibility and therefore the business of an inter-governmental organisation, not a tripartite one. Pressure came also from the League of Nations Health Organisation which insisted on its authority on matters related to general public health (Weindling, 1995; Saunier, 2007).

As Saunier (2007: 34) argues, "In this sense, the end of the housing activities of the ILO and their development at the League were the symbol of the defeat of a coalition of socialist/municipal/voluntary associations by a liberal/state/government compact." With its wings officially clipped by the Governing Body in 1923, the ILO was forced to retreat into a narrow focus on industrial health. It was also allowed to continue its programme on the development and administration of national health insurance systems because they were considered to be "employment related" (Weindling, 1995; Saunier, 2007). With the unstable position of the ILO, in conjunction with the fact that its drive for a wider mandate on health had been denied, it was perhaps not surprising that the ILO would react with alarm when the WHO – an inter-governmental organisation – announced that it too would be working on industrial/occupational health. Furthermore, the WHO was a new organisation, confident in its role in the new international order. It promised to bring health to the citizens of the world; its mission was unquestionably relevant to

the wider developmental aims of the post-war period. This put it in a very different position from the ILO, whose structures and manner of working were deeply rooted in the European social democratic model and whose relevance to development was always questioned.

Officially the potential overlap in functions was resolved through the establishment of an ILO/WHO Joint Committee on Occupational Health in 1950, which officially announced that henceforth 'industrial health' was to be known as 'occupational health,' thereby widening its scope. However, what looked on the surface like a congenial collaborative relationship did not in fact mirror the reality of the situation, which was that the ILO was losing ground to the WHO.

> *Since the war marked changes have been taking place in Occupational Health, as a result of which the influence of the WHO has been steadily growing while that of the ILO has been diminishing. The present position is such as to give some cause for concern if the ILO is not to lose its former prestige even further,*

noted a report commissioned by the ILO in 1953.[198] Not only was the WHO encroaching on territory that had previously been the sole domain of the ILO, it was doing it in a way that fundamentally challenged the ILO's approach to the subject.

The rather lengthy definition of Occupational Health by the ILO/WHO Joint Commission, presented earlier in this thesis, and which is still used today, states that:

> *Occupational Health should aim at: a) the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; b) the prevention amongst workers of departures from health caused by their working conditions; c) the protection of workers in their employment from risks resulting from factors adverse to health; d) the placing and maintenance of the worker in an occupational environment adapted to his physiological and psychological equipment and, to summarise: the adaptation of work to man and of man to his job.*[199]

As the report commissioned by the ILO noted,[200] this definition was in fact a compromise between two divergent approaches to OH that were emerging during this period. The first approach, which was the one favoured by the WHO, saw OH as "a clinical approach to the total health of the worker."[201] From this viewpoint, it was argued that the main causes of illness and disease – and the consequent loss of productivity – were in fact non-occupational in nature; it was therefore important to see the health of the worker as part of the greater health problem, rather than attempting to compartmentalise it. The second approach – "the traditional attitude" – was one

[198] ILOA, Z 8/1/40, OSH Branch, Memo on the World Situation in Occupational Health 1953-1961.
[199] ILO/WHO Joint Commission on Occupational Health, 1950
[200] ILOA, Z 8/1/40, OSH Branch, Memo on the World Situation in Occupational Health 1953-1961.
[201] *Ibid.*

which saw it as a "specialised branch of preventive medicine applied to industry." It was typified by the British Factory Inspectorate system, which created a very definite division between workers' health and general health issues.[202] The report went on to argue that the WHO's approach, which viewed occupational health as "a small but integral part of the total health programmes," was favoured by the USA, Eastern European countries, and was "growing in popularity" in "many of the developing countries," despite the fact that it was really just "the application of general medicine to industrial settings."[203] It was the second specialised approach which was closer to the ILO's position, but even then, the report noted, it was becoming much wider and more complex than the ILO's narrow physiological approach as it began to integrate with environmental medicine through a focus on subjects such as aero-space medicine, atmospheric pollution, and agricultural medicine, and branch out into the new field of ergonomics.[204]

The attraction of developing countries to the WHO's model was particularly worrying in the context of the development agenda and the ILO's struggle to find a place for itself within it. As the report made clear, the ILO's position on OH was not one that bore much relevance to the needs of developing countries, and in that case it was no wonder that the WHO's approach was increasingly being seen as a more viable one. In addition, the report argued, the WHO had the advantage of being able to use "the emotional appeal of health care to gain the confidence of governments, employers and workers."[205] The choice was a stark one for the ILO – "either it must hand over its health functions to what many people consider to be the obvious and appropriate UN technical and professional agency, or it should develop its existing resources to keep pace with developments in the field."[206] By way of conclusion, the report recommended that the ILO attempt to maintain its position by forging a strong relationship with the WHO so as to be able to influence the "trajectory of WHO policy," and to turn its [the ILO's] attention to safety, particularly radiation safety, which was an area the WHO would have less competence to tackle.[207]

These divisions were of course not limited to the ILO and WHO. There were fierce battles raging at the time between the professional groupings concerned with OHS, and not only between the "traditional" practice of OHS and the clinical approach discussed above, but also between those concerned with the engineering aspects (industrial hygienists) and those concerned with the medical

[202] *Ibid*.
[203] *Ibid.*
[204] *Ibid*.
[205] *Ibid*.
[206] *Ibid.*
[207] *Ibid.*

aspects. In 1951, for example, M. Robert, head of the ILO's Safety Division (then separate from the Industrial Hygiene Division), forwarded an article to his Director-General by Allen D. Brandt, head of the American Industrial Hygiene Association, who argued that the medical aspect of OHS was on its way out, being replaced with a focus on engineering.[208] To support his argument he cited figures to show that the number of industrial physicians employed by the US Department of Labour had shrunk considerably, with the number of engineers increasing exponentially. This shift was corroborated in a correspondence between David Morse and his old colleague in the US Department of Labour, Clara Beyer (then Associate Director in the Bureau of Labour Standards), who wrote to advise Morse on ways in which to counter the WHO's encroachment onto ILO territory:

> *It seems to be that if the ILO is to hold its own with the WHO in the industrial health field, it must have particular competence in the engineering aspects of controlling industrial health hazards. You can always draw on the research of medical men in the purely medical aspects of the problem, but the job that the ILO and the labour ministries throughout the world must do – and must do well – is to apply the medical research to the industrial scene in such a way as to prevent the incidence of disease. This is primarily the job of engineers of one sort or another. 90 percent of the work of industrial hygiene units in this country is handled by engineers.*[209]

Of course what was not being accounted for by Brandt, but was brought up by Beyer as a worrying trend, was the fact that an increasing amount of the resources for OHS within the USA were being diverted from the US Labour Department towards the public health services. This trend culminated in 1970 with the creation of the National Institute for Occupational Safety and Health (NIOSH) which was located under the Centre for Disease Control as part of the health apparatus, and was later to become one of the WHO's OH Collaborating Centres.[210]

The advice to Morse from both the international ILO report and from Beyer corroborated the findings of an earlier commission of enquiry held in 1950 into the ILO's work in the field of safety and health. The commission, known as the Buckland Committee, was chaired by the Under Secretary of the Safety, Health, and Welfare Division of the British Ministry of Labour. In its report it made two key recommendations. The first was that the programme should be "practical and must apply directly to the needs of Member states," (which suited Morse's drive towards Technical Assistance Programmes), and secondly that the safety and health divisions should be amalgamated into one department.[211] Again, it emphasised the competence of the ILO in the field of engineering and industrial hygiene.

---

[208] ILOA, Z 8/4/9, Merger of the Industrial Health and Safety Divisions, Robert to Morse, 21st May 1951.
[209] ILOA, Z 8/1/21, Industrial Safety and Health Division, 1951-1952, Beyer to Morse, 5th August 1952.
[210] WHOA, OCH-02/370/15, WHO Programme on Workers' Health: General, 1987.
[211] ILOA, Z 8/4/9. Merger of the Industrial Health and Safety Divisions, Rens to Morse, 6th August 1952.

Consequently, under Morse the safety and health divisions were merged and given the name of Occupational Safety and Health (OSH). The positioning of 'safety' before 'health' was an indication of the relative priority afforded to safety as opposed to health within the new division – a move which has certainly had lasting effects, with the ILO's current OSH programme known now as SafeWork. However, even after this move, the new division continued to face challenges to its authority in the international sphere. There were clearly internal tensions between the doctors of the health division and the engineers of the safety division as they struggled to define their territory in relation to one another. Initially it had been decided that the doctors would deal with medical problems and the engineers with technical ones. This division was not, however, clear cut, and Robert wrote to the Deputy Director-General complaining that a "friction had developed … [which was] preventing the ILO from playing its full part in a field in which it has been active since 30 years ago."[212] Moreover, despite a formal agreement with the WHO on methods for information sharing and collaboration, the ILO was clearly feeling increasingly left out of the fold – particularly in Europe where the WHO's OH programme was most developed. By 1958 ILO officials were complaining that the WHO was not sharing information adequately and had, on several occasions, launched OH programmes of "direct and even primary interest to the ILO … without any prior consultation."[213]

Nevertheless, despite what could be described as early teething problems, an uneasy and fragile truce appears to have developed between the two organisations during the 1960s. By this time the ILO had become more confident in its international role. In 1960 it had encountered criticism from African delegates at the ILO Regional Meeting held in Lagos, who expressed doubts about whether such a fundamentally "Eurocentric" organisation could ever really be of use to them (Maul, 2012). In response the ILO launched the World Employment Programme (WEP) and put an enormous amount of energy into raising "awareness within the developing countries of the necessity of focused planning and active policies to create productive employment" (Maul, 2012: 250). Although the WEP was certainly the flagship programme of the ILO during the 1960s, technical assistance programmes, which included OSH, were not neglected, and still accounted for a significant proportion of the budget. The ILO, according to Maul (2012) was rapidly becoming a provider of services to poorer countries, and employment had secured its place within the development agenda.

[212] ILOA, Z 8/4/9, Merger of the Industrial Health and Safety Divisions, Robert to Rens, 5th August 1952.
[213] ILOA, Z 14/8/1, Relations with the World Health Organisation, 1949-1969, Ammar to Director General, 1958.

By 1969 it was in fact the WHO which had now become worried about its position in the field of international workers' health. Although the ILO had moved towards placing greater emphasis on industrial hygiene in its OSH programme, it had maintained a contingent of doctors, meaning that the "medical aspect" had not been left entirely to the WHO. By now the OSH Division was again headed by a medical doctor, an Italian named Parmeggiani. The result was a shift in focus back to health[214], which clearly threatened the WHO's position. In a letter to his Director, the head of the WHO's OH Division, Dr. Dukes-Dobos, wrote that the WHO were now falling significantly behind the ILO in terms of workers' health activities, noting as well that the ILO were "trying" to become involved in issues that strictly speaking should be seen as part of the WHO's competence such as ambient air pollution and medical education.[215]

This expansionism was happening, argued Dukes-Dobos, because within the ILO's programme of work, OSH had a much higher priority than did the OH Division within the WHO and therefore commanded significantly more resources. Indeed a review of the respective budgets of the ILO and WHO reveals that, while the ILO maintained a consistent budget for OSH of approximately 3 percent of the total budget for 'Major Programmes' during the years 1963, 1964, and 1968 [216] and additional support from the UNDP,[217] the WHO's regional offices in Africa (AFRO) and South Asia (SEARO)(from which technical activities were carried out) maintained an OH budget of 0 and 0-1.6 percent of the combined Technical and Regular budget respectively over a similar time period.[218] Indeed, it was only the European Office (EURO) which appeared to have any significant budget at all for OH activities,[219] and a memo from the Deputy Director of the WHO to the Regional Offices noted that "an increasing number of countries are directing their requests to the ILO," and that WHO representatives should "try to encourage member states to direct their requests for assistance to the WHO."[220]

In order to counteract the ILO's expansion into its territory, Dukes-Dobos argued that the WHO would have to expend more resources and give greater administrative priority to its OH programme.

---

[214] WHOA, 0 2/372/2: Cooperation with the ILO on various OH questions, Dukes-Dobos to Director HPP, 5th May 1969.
[215] *Ibid*.
[216] ILOA, Budgets and Programmes of Work, 1963, 1964, 1968.
[217] WHOA, 0 2/372/2, Cooperation with the ILO on various OH questions, *Memo,* 24th July 1967.
[218] WHOA, AFRO and SEARO Budgets, 1964 and 1971. These figures are derived from the authors own calculations. The years used here are meant to give an indication of the budgetary allocation over several years.
[219] WHOA, EURO Budget, 1964 and 1971.
[220] WHOA, 0 2/372/2, Cooperation with the ILO on various OH questions, Deputy Director General to Regional Directors, 24th August 1962.

If this were done, "it should be very easy to at least match Dr. Parmeggiani's efforts."[221] There had been suggestions to sit down with the ILO and work out clearly demarcated areas of competence between the two organisations, but Dukes-Dobos stated that he was categorically opposed to this solution because it would "sooner or later inevitably and officially place the WHO in a very junior role."[222] Instead, he suggested that the WHO continue to work with those countries which looked "more closely to the WHO for leadership."[223] Overlap could not really be avoided when the two organisations were working in the same area, and, although the official line would always be one of cooperation between UN agencies, the WHO should in fact view the ILO's activities as "healthy and stimulating competition."[224]

The overt tension between the ILO and WHO revealed by the above correspondence foreshadowed, and was probably even further catalysed, by an incident in East Africa during 1966 and 1967 which had been particularly galling to the WHO.[225] During 1966, the Ugandan Health Ministry had been in negotiations with the WHO Regional Office for Africa (AFRO) to fund a consultancy to assess the feasibility of establishing an East African Occupational Health Institute, which would most likely act as a WHO Collaborating Centre in the region. Unbeknownst to AFRO, this request had also been transmitted to the UNDP via the Ugandan Ministry of Planning, and the UNDP had passed the request on to the ILO rather than the WHO. The AFRO office was "then mystified" to receive notification from the UNDP that a consultant had been proposed and that the ILO had made budgetary provision in their 1967 budget for this position, effectively transforming it from a WHO project into an ILO one.[226] Clearly upset by the "Gilbertian situation"[227] which had arisen, the WHO internal correspondence reveals a suspicion that the ILO had conducted this takeover with "devious procedures" intended to undermine the WHO.[228] Officially, however, these suspicions were never mentioned; the need for the UN family to put forward a united and harmonious front to governments had to trump the antagonism between the two organisations.[229] The WHO did,

[221] WHOA, 0 2/372/2: Cooperation with the ILO on various OH questions, Dukes-Dobos to Director HPP, 5th May 1969.
[222] *Ibid*.
[223] *Ibid*.
[224] *Ibid*.
[225] WHOA, O 2/37/2/2, Memo: Possible Formation of East African Institute of Occupational Health, 23rd August, 1967.
[226] WHOA, O 2/37/2/2, WHO Representative, Entebbe to AFRO Regional Director, 29th May 1967.
[227] WHOA, O 2/37/2/2, AFRO/Occ. Health/796, Memo, 21st June 1967.
[228] WHOA, O 2/37/2/2, WHO Representative, Entebbe to AFRO Regional Director, 29th May 1967.
[229] WHOA, O 2/37/2/2, Notes by Dr. S. Hall on a meeting between Dr. Sven Forssman, Chief Medical Officer, Social and Occupational Health and Dr. A. Quenum, Director AFRO. Stuart Hall, of the Ross Institute, unwittingly revealed the tension between the need for UN agencies to present a united front, and the internal tensions between them, when he presented the meeting notes he had taken on a meeting between Forssman

however, make its displeasure known internally and Dr. Ezzat, the consultant initially appointed by the ILO, was later designated as a joint ILO/WHO consultant, although ultimately it remained an ILO-led project.[230]

It was this need to present a unified face to the world that led to a framing of the problems between the ILO and the WHO as a matter of poor co-ordination and communication. The memorandum written up by the WHO after the East African incident argued that the problem essentially lay with the fact that two channels of communication had been used in an uncoordinated manner by two different government departments.[231] An earlier WHO memorandum had already mentioned that the development of an improved system of coordination and communication at local, national (particularly between health and labour ministries), and international levels (between the ILO and WHO) was necessary if OH was to make advances.[232] In later years "improved cooperation" became almost a mantra as more and more meetings were held in order to align the WHO and ILO in attempt to avoid replication and overlap of activities.[233]

It would be hard to deny that there *was* a problem of coordination and communication between the two agencies. However, the framing of the problem as one rooted solely in a failure of systems represents what Tanya Murray Li (2007) has called "rendering technical," a concept which draws on James Ferguson's (1990) work on the depoliticisation of international development practice. Rendering technical happens when social problems that are embedded within a confluence of political and economic forces are redefined as technical problems which can be solved by a logical set of interventions which do not necessarily address the more complex underlying political economy of the problem (Li, 2007). In the process, argues Li (2007), subjects which are deeply political in nature are "rendered non-political." It was true that coordination and communication between the ILO and WHO was not particularly good. Yet to place the emphasis on coordination systems as the root of the problem was to see the solution as relatively straightforward and

---

and Quenum to Forssman for correction. Hall had noted that "It is already agreed between the ILO and WHO that requests for assistance from the UN Special Fund in the field of OH are made through the WHO, as the body best able to assess needs in relation to the complete health requirements of the country." Forssman, knowing what trouble such a statement could cause, had placed a large question mark next to the paragraph and written a sharp note back to Hall asking him to delete the sentence and saying that "The position is that WHO and ILO are actively collaborating with governments in the field and keep each other mutually informed of requests by governments."

[230] WHOA, O 2/37/2/2, AFRO/Occ. Health/796, Memo, 21st June 1967.

[231] *Ibid.*

[232] WHOA, O 2/37/2/2, Memo, Chief SOH, 12th December 1966.

[233] WHOA, OH Questions Arising, Coordination between ILO and WHO in OH, Meeting, 5th June 1979; WHOA, Towards a co-ordinated programme of action of the UN for the improvement of the environment, Vienna, 1979.

technical – "improving coordination and communication." What this did not solve, however, was the underlying cause of tension between the two organisations, which, aside from egotistical battles over territory, was (and still is) rooted in different conceptions of the relationship between workers and health policy.

The conceptual differences between the ILO and WHO were similar, although not identical, to the tensions discussed in the previous chapter around the NHS and the Industrial Health Service in Britain – between work-based social provision and state-based social provision. As mentioned earlier, the ILO was an organisation based on the social democratic model which saw the employment relationship as central to both economic and social policy. Its central concern with labour standards meant that its approach to social policy was determined by the labour agenda. The citizen *as worker* was the core subject of its social policy work, and the tripartite consultative model was indispensable to social progress. For the WHO, on the other hand, which was a purely inter-governmental organisation, the worker was seen not as central to health policy, but as a small "special group" amongst the wider citizenry, as "primarily a member of the community." [234] So unlike the ILO, the WHO saw the citizen first, and the worker second – their concern was the worker *as citizen*. The important relationship then was that between citizen and state, rather than that between employer and worker.

It was not that the WHO was not based on the social democratic model – the idea that health was a right for all was indisputably underpinned by social democratic values. Indeed, the ILO and WHO together represented the two axes of the social democratic model. As the last chapter showed, these axes could operate both in concert and in tension with one another. Unfortunately, within the realm of occupational health, the relationship between the two organisations reflected the tension rather than complementarity. Consequently, rather than being seen as two aspects of a whole, the axes of the social democratic model were positioned in opposition to one another. This had negative effects on both sides; the WHO took an approach to workers' health which was top-down and did little to actually include workers, and it remained a fairly marginalised department within the organisation. Within the ILO the health of workers retained its narrow, individualised approach, remaining segregated from wider issues to do with public health because these were seen as areas of competence for the WHO. However, perhaps the most serious effects of this separation are only now really being felt, as the following section will show.

[234] WHOA, 12th Session of the WHO Executive Board, Minutes of 2nd Meeting, 28th May 1953.

Health and the Worker under Neo-liberalism

The global context in which the ILO and WHO operated changed radically after the late 1970s. Economic crises and the "failure" of modernist development in many countries led to a questioning of this development paradigm. By the 1980s neo-liberalism had emerged as an alternative economic model, particularly in Britain and the USA, and increasingly it began to be seen as a solution to the economic crises in the developing world. Peck et al. (2009) have noted that the term "neo-liberalism" is a contested one – on the one hand there are those of a structuralist bent (Hardt and Negri, 2000; Harvey, 2010b) who have viewed it as a hegemonic form of economic and social organisation with a systemic logic; on the other hand there are those who adopt a more post-modern approach have refused to use such "big-N" formulations, instead focusing on a more "refined" vision of neoliberalism as represented by "local trajectories, contingent forms and hybrid assemblages" (Peck et al., 2008: 96-7). However, on a broad level there were certain characteristics of neo-liberalism which represented a break with the previous social democratic model. Its philosophical underpinnings came from two sources – liberal individualism rather than communalism, and neo-classical economics as opposed to the Keynesian variety. The policies associated with neo-liberalism were a well-known array of economic and social reforms which included a much reduced role for the state in managing economic and social development, an emphasis on individual self-reliance and on markets as the driver of economic development – defined as economic growth which would ultimately 'trickle down' to the poor without the intervention of government, but with the privatisation of state services, the removal of regulations on global flows of capital, and the integration of the global economy.

For the purposes of this chapter, perhaps the most important of these breaks from the past was that which occurred between economic and social policy. The assumptions underpinning neo-classical economics included the idea that social problems could be solved as long as the market was left to deal with them without the interference of government. In terms of employment, it was argued that "wage rigidity" created by policies and institutions (such as collective bargaining agreements) led to a labour surplus and an increase in unemployment. In order to solve this, it was necessary to promote "wage flexibility" by removing the institutions and policies which created the problem in the first place. Left to the market alone, which would determine the wage to allow for market clearing, the problem would resolve itself (Heintz, 2013). Social protections attached to employment were also seen as inducing rigidities and market distortions in the labour market. Macroeconomic policy now turned away from employment creation and instead focused on reducing public debt and inflation (Heintz and Razavi, 2012). The implications of these ideas for the terms of inclusion into social policy were dramatic. The axis of responsibility between employer and worker fell away. The

axis between the citizen and state remained, but only in a limited form. They were displaced by a market logic which was based inclusion on the ability to pay – the age of the citizen had been superseded by the age of the consumer. Health, as Pickstone (2000) has pointed out, became something that was traded on the open market – not as a right of citizenship, but as something that could and should be purchased. Within this ideology, the "rights of citizenship" were no longer universal and applied only to the poor who were unable to pay for services. Social policy was transformed into a marginal domain which focused on "indigence policies" and "safety nets" for the poor.

It should be noted that these changes applied to the developing world in a far more apparent manner than developed countries. Particularly in Europe, social democratic policies remained in place. Yet the power of social democracy to influence international health policy was waning. One of the most dramatic changes that occurred in international health policy was the entrance of the World Bank as a major force from the early 1980s onwards. Prior to 1980 the World Bank had not seen a role for itself in global health, viewing health as something that would improve with economic development. This began to change under the stewardship of Robert McNamara (1968-1981) (Garrett, 2007). By the late 1980s World Bank economists were starting to argue, in a manner reminiscent of productionism (but with a market based twist), that improvements in health were essential to economic development (Garrett, 2007). In 1993 this stance became official with the publication of the World Development Report: *Investing in Health*. By the 1990s, the World Bank had become an acknowledged, though controversial, leader in global health issues and health sector development (Koivusalo and Ollila, 1997). The Bank along with its partner organisation, the International Monetary Fund (IMF), were at the forefront of promoting neo-liberal health policy reform globally. Countries indebted to the IMF were forced to undergo a process of structural adjustment, which meant cuts in state spending on health care, the introduction of user fees in public health facilities, and the promotion of privatised health services.

The World Bank is not a monolithic entity, and has had progressive elements and dissenting voices working within it at times. Yet the general direction of its health work has been to promote private sector involvement in health, cut back on state health services, and to centre the "poor citizen" as the subject of social policy whilst actively discouraging any discussion of the place of employers in the provision of health services. Forcing employers to provide work related health benefits was considered a hindrance to economic growth because it increased the costs associated with employing workers and hindered the move towards a "flexible" labour force which could be hired

and fired with ease. Even the provision of occupational health services – which as the previous chapter has shown, allowed big businesses to justify their exit from the wider provision of health services – now began to be questioned. Labour standards were not a priority in world where the unrestricted and unregulated movement of capital across the globe were key drivers of economic policy.

However, it is important to note that the process by which the neo-liberal ethic entered the international development scene was complex and contested. If neo-liberalism is understood as creating uneven development, it should also be understood as itself developing unevenly (Peck et al., 2009). The world did not wake up one day to find that development policy had been radically altered. It was a slow process that at times co-existed with a more social democratic approach – one which was simultaneously (and even paradoxically) beginning to open up to progressive alternative models of social provision besides the male industrial breadwinner.

For the ILO and WHO the 1970s had been both a challenging and exciting period, and again represented a period of transition. Within the ILO, the World Employment Programme (WEP) was in full swing and in 1972 a "comprehensive employment mission" had been sent to Kenya. It was in the report of this mission that the term "informal sector" (coined two years earlier by the economic anthropologist Keith Hart in Ghana) was officially recognised. It referred to the large number of particularly urban workers working in atypical forms of employment in atypical workplaces – market women, street vendors, people working in their own homes – workers who, in general, were not covered by state labour regulation and had not necessarily been recognised as workers previously. An important departure in this report was the idea that the informal sector, with its energy and resourcefulness, could be seen as an engine of job growth, rather than as a transitory phase on the way towards modernist development (as it had been seen by mainstream economists until that point).

Events during the 1970s meant that the integration of this changing conception of the "worker" into the ILO's structures was delayed by some years. Firstly, the World Employment Conference in 1976 endorsed a "Basic Needs" approach to development. Basic Needs was a reaction to the failure of modernist development, aimed at addressing absolute poverty. Although the ILO maintained an employment focus within Basic Needs by arguing that jobs were fundamental to poverty reduction, the focus of the approach was largely rural which meant that the urban informal sector was not necessarily a priority (Bangasser, 2000). Secondly, in a dispute over the USSR's membership, the USA

had walked out of the ILO in 1977, taking with it a significant share of the budget (Bangasser, 2000). This meant that the scope for spending increases in new areas of work was severely circumscribed.

In 1979, the UN organised a multi-agency meeting in order to "co-ordinate a programme of action … for the improvement of the working environment."[235] The agencies invited included the ILO, the WHO, the United Nations Conference on Trade and Development (UNCTAD), the Food and Agriculture Organisation (FAO), the United Nations Industrial Development Organisation (UNIDO), the United Nations Development Programme (UNDP), the International Atomic Energy Agency (IAEA), the World Bank, the General Agreement on Tariffs and Trade (GATT), the International Mechanisms Coordinating Committee (IMCC), and each of the UN Regional Economic Councils. During the meeting the subject of the ILO and WHO's jurisdiction over occupational health again arose, with the argument made that the two agencies needed to coordinate themselves better. What is particularly noteworthy from the documented discussion is the comparative list of activities in the area from the ILO and WHO. It is quite clear that by this stage the WHO had started to make strides into looking at how OH could be made to serve what they termed "underserved workers," "vulnerable workers," and those working in "small industries in developing countries."[236] The ILO listed as its activities:

1. International labour standards adopted by the ILC, model codes, codes of practice, and guides;
2. Tripartite meetings;
3. Research and dissemination;
4. Coordination meetings of experts, regional conferences and technical cooperation activities.[237]

Nowhere was there an indication that it had done anything to integrate the "informal sector" into its activities.

In 1982 the ILO began, to a limited extent, to engage with the informal sector, making it one of the five "global themes" of the Medium Term Plan (1982-1987), and the International Programme for the Improvement of Working Conditions and Environment (PIACT, under which OSH now fell) contained several activities which included informal sector workers (Bangasser, 2000). Despite this,

[235] WHOA 6-1-1, Occupational Safety and Occupational Health: Questions arising therefrom, "Towards a co-ordinated programme of action of the UN for the improvement of the working environment." Working document prepared by the ILO in consultation with the agencies concerned and especially WHO, Vienna 1979.
[236] *Ibid*.
[237] *Ibid*.

the ILO had started late with the inclusion of informal workers. It was only in the 1988 ILO Plan of Work, for example, that a project was first proposed which would "prepare a study on the provision of OH services at the national level for small enterprises, agricultural workers and the informal sector."[238] Robert Cox (1977: 390) has argued that the ILO was the manifestation of a particular model of production relations – one which engaged unionised workers, employers, and the state in a tug of war which ultimately benefited those three groups and left the remaining unprotected workers "as a human buffer softening the blow of an economic downturn." For the ILO to begin engaging with unprotected workers was to threaten that consensus, and as Bangasser (2000) argues, there was no natural champion for the informal sector within the tripartite alliance.

The WHO, on the other hand, had no such problem and seized the opportunity to promote their vision of workers' health. In the late 1970s the WHO were embarking on their Health for All campaigns, in which primary health care featured as the core organising principle. Here the organisation was learning from China and its "revolutionary" innovations to the health system. Agricultural workers were being trained to provide sanitation services, health education, immunizations, first aid, and a certain level of primary care (WHO, 2008). These barefoot doctors "challenged the health manpower models of the developed world," and inspired the WHO towards a model of health systems development which became known as the primary health care (PHC) movement (WHO, 2008: 2). Within the PHC model there was also a place for the worker – particularly the "poor, vulnerable and underserved workers" who had until now been excluded from labour protections. While the WHO had for a long time argued that workers' health should be integrated into national health services, it now adjusted this to argue that workers' health should be integrated into primary health care, and in 1976 launched its Plan of Action on Workers' health.

> *The situation is that much more serious in developing countries with few health services of any kind, where it becomes essential to ensure the development of community-based primary care capable of dealing with occupational health hazards for the underserviced working populations,*[239] [240]

stated the WHO's Director-General at the 33rd World Health Assembly held in 1980.

In 1978 the historic Declaration of Alma Ata on Primary Health Care had seemingly placed the WHO in what seemed like a secure position from which to lead health systems development in the

[238] ILOA, ILO Budget and Programme of Work, 1988.
[239] "Underserved populations of workers" was later officially defined by the WHO as those workers not served by Factory Inspectorates.
[240] WHOA 6-1-1, Occupational Safety and Health: Questions arising therefrom, 33rd World Health Assembly, 1980: Workers' health Programme: Progress report by the Director General.

developing world. It had certainly inspired a clearer mission and greater confidence within the OH Unit, which was at this time headed by the Egyptian Mustafa El-Batawi (who had incidentally started out his international career as a regional advisor for the ILO). In 1979 the World Health Assembly had urged that "special attention be given to working people, by the development of occupational health care, as a contribution to the attainment of health for all by the year 2000."[241] Resources to back up this commitment were also forthcoming – particularly from the USA's National Institute for Occupational Safety and Health (NIOSH), which was a WHO Collaborating Centre on Occupational Health. In 1981 an agreement was signed between the WHO and NIOSH for approximately $200 000 per year over a four year period. The NIOSH money was to be used for scientific studies of exposure limits, but also for promoting the WHO model of occupational health around the world.[242]

Indeed, the WHO's OH programme now moved from something which only the European Regional Office (EURO) had really taken on, to one which was included in the programme of work of the other regional bodies. The African Regional Office (AFRO) and the South and East Asian Regional Office (SEARO) were singled out in particular for occupational health systems development, with the goal of integrating occupational health services into primary health care in at least seven countries in each of the regions.[243] The Pan-American Health Organisation (PAHO), the WHO's regional office in the Americas, also began a large drive towards the primary health care model of workers' health, with a substantial portion of the NIOSH budget moving towards supporting work in the Latin American region during the mid-1980s.[244]

Importantly, the perspective of the WHO doctors and scientists was beginning to change. It began to be recognised that the science of OH might actually need to change if it was to be relevant in the developing world. The research programme moved towards studies which concentrated on the interactions between the "general diseases" occurring in poorly served areas and "occupational diseases."[245] There was also a drive to develop "appropriate occupational health technologies" which would be relatively cheap to use, such as "simplified methods for air analysis in the work environment."[246] Finally, in a departure from its previous methods of working, the WHO also began to engage with trade unions, with El Batawi writing a series of letters to international trade union

[241] WHOA 6-1-1, Occupational Safety and Health: Questions arising therefrom, WHO Plan of Action on Workers' health.
[242] WHOA OCH-02/370/15, WHO Programme on Workers' health, El Batawi to Macedo, 30th July 1987.
[243] WHOA AFRO Proposed Programme Budget 1980-1981; SEARO Detailed Programme Budget 1980-1981.
[244] WHOA OCH-02/370/15, WHO Programme on Workers' health, El Batawi to Macedo, 30th July 1987.
[245] WHOA OCH-02/370/15, WHO Programme of Action on Workers' health, 1979-1984.
[246] *Ibid*.

federations in 1987 in an attempt to "build up a working relationship."[247] Interestingly, the trade unions themselves did not seem to have the same reservations as the ILO about working with the WHO, with positive replies coming back from major unions like the International Union of Food and Allied Workers, Public Services International, and the International Federation of Building and Woodworkers.[248]

It should be noted, however, that while informal or 'underserved' workers were starting to gain recognition within occupational health circles around 1980, these workers still appeared, on the whole, to be male. A 1977 report on the health of workers in the African region talked about the need to reach out to agricultural workers and those working in small industries, but did not really engage with the deeper implications of this for the ways in which OHS was conceived and regulated.[249] It showed no understanding of the situation women market traders in Ghana or home based workers in India faced – the women whose working lives were described in Chapter Three and who will again be a central concern in Chapter Six.

Little had improved for such women in the era after independence. In Ghana, market women continued to be subject to harsh municipal regulations and were the victims of smear campaigns led by successive governments to blame them for inflation (Robertson, 1983). In India, whilst middle class women were beginning to make headway into professions such as medicine and teaching, formal job opportunities for poorer women remained scarce. By 1985 women's formal employment in the textile industry had declined to below 4 percent over a 50 year period (down from a high of approximately 25 percent in the 1890s) (Bhatt, 2006). In the absence of a formal economy to absorb their labour, women – as Ela Bhatt, the founder of the Self-Employed Women's Association (SEWA), discovered in 1968 when two of Ahmedabad's major textile factories closed – were turning to small scale informal economic activities (Bhatt, 2006).

However, when women workers did finally become a subject of interest in 1985 when the WHO established an expert committee on the occupational health needs of women workers,[250] it was not the women working in home based factories in India or in the markets of West Africa who were a major concern. The discussion focused on "the common problems of working women," such as the

[247] WHOA O2/348/7, Relations with International Trade Unions in the Field of Occupational Health, 1987.
[248] *Ibid.*
[249] WHOA AFR/RC27/7: Health of the Working Populations in the African Region, 22nd June 1977.
[250] WHOA OCH/86.1: Expert Committee on Occupational Health for Working Women, Geneva, 26th March-1st April, 1985.

double burden of childcare and economic activity, and the effect of workplaces on reproductive health. It also mentioned the need in developing countries to reach the many women working in agriculture and in "cottage industries."[251] However, it did not in any serious way think about the challenges that informal work posed to the conceptual models on which the discipline and practice of OHS was built.

A notable omission from the discussion was the need to think carefully about the local level of governance in relation to health and sanitation. In a recent double volume, Mitlin and Satterthwaite (2013) and Satterthwaite and Mitlin (2013) argue that international organisations' neglect of this level of governance in favour of the national level has been detrimental to urban dwellers in the Global South. A similar point can be made about the neglect of local government as an institution which, in many ways, is a regulator of labour and working conditions. As Chapter Three showed, it was this level of government which had a great impact on both the health and productivity of working women in both Ghana and India who worked either in public spaces such as streets and markets, or in their own homes. The problem was, of course, that these local level institutions were not set up to recognise people operating as economic agents in public spaces as workers, instead treating them as a threat from which the public needed to be protected. The WHO's consideration of OHS and working women did not extend to these considerations.

The ILO's reaction to the WHO's increasing activity in the field of workers' health was again far from positive. In 1976, the WHO Director General had reported to the Executive Board on the Human Environment and Health that the relationship between the WHO and ILO had improved, as "evidenced by several joint country projects and joint meetings on Occupational Health problems."[252] In reality, however, the tension continued to simmer. When the ILO saw an advance copy of the WHO Director-General's Progress report on the Workers' Health Programme that was to be delivered at the 33rd World Health Assembly, they protested vociferously. They were particularly concerned that the WHO was positioning itself as the defender of workers' health for the "underserved populations," which the progress report suggested could only be resolved by the WHO. "WHO has no monopoly on the extension of protection to neglected categories of workers," argued an ILO official.[253] Moreover,

[251] *Ibid*.
[252] WHOA 6-1-1, Occupational Safety and Health: Questions arising therefrom, Report of the Director General to the WHO Executive Board on Human Environment and Health, January 1976.
[253] ILOA, WHO 6-1-1, Occupational Safety and Occupational Health: Questions Arising Therefrom, Lemoine to Hellen, 14th March 1980 [own translation from French].

> *… the time has come…to solicit from the [ILO] Board a clear position that reaffirms on the one hand, that the problems concerning safety and hygiene at work and the health of workers – as workers – are the main competence of the ILO and that while the ILO is willing to participate in any joint programming exercise in this area…it will be a condition that it has main competence in the matter and it is recognised unequivocally that the conclusions adopted at these joint programming meetings should be submitted to the Board of the ILO, specifically to the representatives of employers and workers who are the main groups concerned with this matter.*[254]

Perhaps not yet aware of the threat on the horizon, the arms of the social democratic model continued the fight for position. Yet by the late 1980s much of this was to become irrelevant. The ideals of the WHO, as put forward at Alma Ata, were defeated by the increasingly powerful philosophy of the World Bank. The PHC movement became increasingly marginal in the face of the widespread adoption of the World Bank model. As the World Bank continued to gain in power and influence, the WHO was forced to retreat into a subsidiary role as a cooperative partner (Koivusalo and Ollila, 1997). The defeat of the principles of Alma Ata was also a defeat for the WHO's vision for basic occupational health services, which it had tied to PHC. This was compounded by the Reagan Administration's cut in the NIOSH budget, which meant that it in turn had to radically reduce its financial contributions to the WHO.[255] Certain branches of the WHO continued to work towards the model of Occupational Health for All (particularly PAHO and EURO), but the vision of the widespread integration of OH into primary health care services for Africa and Asia remained only a vision.

The ILO remained a lone voice representing workers' issues in the international development sphere. Yet even then, it was watered down. The plan to integrate productivity into national economic development plans represented by the WEP was no longer in vogue as countries accepted the IMF and World Bank's structural adjustment programmes, and turned their economic plans towards a focus on economic growth and little else. Rather than trying to define the development agenda, the ILO now had to adopt a more reactive stance. It turned, for example, towards measures to assist those employees (particularly public sector workers) who were the "collateral damage" of structural adjustment.[256] Notably, even with the WHO's weakness and the rise in informal workers' numbers that accompanied structural adjustment, the ILO was still having difficulty in adjusting the focus of its workers' health programme to meet the needs of the informal sector. The 1992 OSH Programme of Work mentioned nothing about the informal sector specifically, choosing instead a

[254] ILOA, WHO 6-1-1, Occupational Safety and Occupational Health: Questions Arising Therefrom, De Givry to Jain, 17th February 1980 [own translation from French].
[255] WHOA OCH 02/370/15, WHO Programme on Workers' health: General, Sanders to El Batawi, 2nd March 1986.
[256] ILOA, ILO Programme of Work, 1988.

programme which focused on nuclear safety, chemical hazards, the electronics industry, and work related diseases for workers using "new technologies" such as "visual display units."[257]

Health and the Worker under Post-neoliberalism

During the late 1990s and early 2000s the neo-liberal consensus was rocked by a series of economic crises in the developing world: the 1997 Asian Financial Crisis, the 1998 Brazilian and Russian financial crises, and the Argentinian "Great Depression" which lasted from 1998 to 2002. In 2008 the USA and Europe were also badly affected by a global financial crisis which led to widespread questioning of the neo-liberal economic model and re-opened the debate on the merits of state involvement in society and the economy. These debates have led to new terms being used to describe the current conjuncture – terms such as "post-neoliberalism," and the "post-Washington consensus" (Ballard, 2013). Within the World Bank, social policy started to take on a more central role, as the consensus shifted back towards (a limited version of) the productionist ethos "seeing social spending not just as a cost, but also as an investment in human capital" (Lund, 2009: 8). Within this context, health policy was also re-invigorated, research proving conclusively that user fees and privatisation had increased health inequalities rather than reducing them (Global Health Watch, 2012) .

This "post-neoliberal" moment is a complex one, however. On the one hand it has seen the return to the development agenda of some progressive trends which started in the late 1970s and 80s. Participatory approaches to policy development and development interventions have come to be seen as important. (Eyben, 2009). The worker has also made a return to the development agenda, albeit now in the form of "the informal worker." The "jobless growth," increasing flexibilisation of labour, and inadequate social security that were features of neo-liberalism have led to increases in the size of the informal economy, with ILO and World Bank studies showing that most jobs created in the last 10-15 years have been informal (Meagher, 2013). The latest regional estimates on the size of the global informal economy from the ILO and Women in Informal Employment: Globalizing and Organizing (WIEGO) show informal employment making up 82 percent of employment in South Asia, 66 percent in Sub-Saharan Africa (with a large differences between West Africa and Southern Africa which tend to have higher formal employment), 65 percent in East and South-East Asia, and 51 percent in Latin America (Vanek et al., 2014). This process of informalisation and casualisation of labour has not only affected developing countries, however. "Non-standard" forms of employment

[257]ILOA, ILO Programme of Work, 1992.

have also increased in the developed world, with 2008 OECD data reflecting an increase in own-account, temporary, and part-time employment in those countries (Vanek et al., 2014).

In response to this, the World Bank begun to engage with informal workers; its 2005 World Development Report made, according to Lund (2009), a "genuine effort" to see the informal sector as both permanent and normal. In 2012, the Bank went even further to a focus on jobs and employment as the theme of the WDR, with important sections dedicated to the informal economy. There has been an important gendered aspect to this. What was originally known in development circles as "women's empowerment" has been rejuvenated and transformed into what is now known as "women's economic empowerment" (Kabeer, 2012). The greater emphasis on the economic aspect of empowerment, has formed a bridge between gender concerns and development economics. Partly this has been influenced by the recognition that informal work (which absorbs large numbers of women), is both a source of livelihoods and asset accumulation (Kabeer, 2012). In this way, policy spaces have opened up for women, informal workers, and women as workers in ways never previously seen.

Yet, despite these positive moves, many remain suspicious. Peck et al., (2009: 103), for example, argue that neo-liberalism is a "flexibly mutating regime of market rule," which adapts after each crisis in ways that allows it to both pacify its critics and continue with its policies of market led growth. Room might be made for progressive ideas, and even a limited type of redistributive politics, but they will be adapted in such a way that neo-liberalism's underlying principles are not challenged, meaning that egalitarian principles will remain limited in scope. Nancy Fraser (2009) has made this argument in relation to feminism. She argues that under neo-liberal capitalism, the two arms of the feminist movement – that which sought recognition for women, and that which sought economic redistribution for women – have become separated. Whilst the recognition element has been relatively successful, with the importance of gender equality now widely recognised, this has not been matched with a simultaneous transfer of resources. Therefore while women are now entering the labour market in greater numbers, the fact remains that the jobs which await them are generally low-paid and menial. Women and men may now have more equal opportunities in some workplaces, but more people will be working in bad jobs earning low wages.

How can one judge whether the same thing is happening within health policy and provision? One way would be to compare current configurations of power with those of the social democratic period. If the social democratic era was one in which redistributive politics took precedence (even if

it was a limited idea of equality), then a comparison between the movements and shifts of post-neoliberalism and the ideas underpinning social democracy should give some indication of whether redistribution is really at the heart of the project, or whether these moves are just a thin disguise for continued market dominance. Key to making this judgement are Lund's (2009) "axes" of the welfare state – the lines of responsibility that run between citizen and state, and between employers and workers. How those two axes interact with one another is central to understanding whether a Polanyian movement to "re-embed the economy in society" is taking place, or whether there is a different dynamic at work, and if there is, what potential that dynamic has for redistributive politics. The following section provides three short summaries of the movements taking place in global health policy involving three main global actors who are now concerned with the informal worker, and then analyses these movements using the framework described above.

The World Bank

The World Bank has remained an important player in global health, and has moved away from a direct focus on user fees and "cost recovery" as the main drivers of its health policy. The main thrust of the health policy work of the Bank now centres on the Bismarckian model of health provision – Social Health Insurance (SHI).[258] The fact that SHI schemes operated through the employment relationship has made this the natural territory of the ILO, which has been concerned with the development and promotion of SHI schemes globally for many years (for example it acted as an advisor on the ESIS in India). Yet now it is the World Bank which is one of the more powerful promoters of this model, and it is important to consider why this should be so.

The reasons are clearly laid out in the influential World Bank Institute document *Social Health Insurance for Developing Nations*, authored by Hsiao and Shaw (2007). The four reasons given in support of SHI are:

i. In developing countries, tax revenues may be limited. SHI targets public funds to subsidise premiums for the poor rather than financing and providing universal health care for all;
ii. SHI frees up public funds so that they can be targeted to public health goods and services;
iii. SHI shifts public subsidies from the supply side to the demand side to improve the efficiency and quality of health care. This separates the responsibilities for collecting and

[258] Hsiao and Shaw. Social Health Insurance for Developing Nations. World Bank Institute Development Studies. 2007.

managing SHI financing from the responsibilities for providing health care to patients, whereby services are contracted from providers that are separate entities. Providers are required to be accountable to patients for the quality of services;

iv. SHI uses the capacity of non-governmental organisations (NGOs) and private providers to improve access by the insured to health care by means of contracting.[259]

From above it is clear that a shift in World Bank thinking is perhaps less significant than one would suppose. Clearly it conceives of a role for the state in providing health services, which is an important change. At the same time, the focus on "targeting" rather than publicly funded universal health care is still very much a part of the earlier language of safety nets for the poor. Importantly, it also clearly articulates a role for the private sector in health service provision, and, it should be noted, does nothing to repudiate the need for user fees. In fact, the report argues that user fees at health facilities must be in place so that people are motivated to join the health insurance scheme,[260] which is a circular argument.

Perhaps most interesting, though, is the fact that this move towards SHI has meant that the bank has had to engage with "the worker," and more particularly "the informal worker." SHI programmes have generally worked well in European countries because of the high levels of formal employment, which ensure that deductions can be made from both workers and employers. In countries such as Ghana and India and many others where informal employment makes up about 90 percent of total employment, there is a problem not only of enforcement, but also of determining who will pay the contribution. The drive to seek a solution to this dilemma has led to a plethora of studies which attempt to resolve the question of "extending health coverage to the informal workers." It is certainly not beyond the realm of possibility to think that this has been influenced by the orientation of the World Bank.

The answer from the Bank appears to be to support national SHI programmes which enforce payroll taxes amongst formal workers, but to combine this with a voluntary scheme which allows informal workers to pay in at a rate subsidised by the state. The Ghana National Health Insurance Scheme, which has received World Bank support, operates in this manner. The Bank has, however, been roundly criticised for promoting such schemes. In a recent Joint NGO Briefing Paper,[261] led by Oxfam,

[259] *Ibid.*
[260] *Ibid*.
[261] Oxfam International, Action for Global Health, Médicins du Monde, Save the Children UK, Plan, Global Health Advocates, Act Up Paris. 2013. Health Insurance in Low Income Countries: Where is the Evidence that it

it was argued that voluntary health insurance schemes do not work for the unemployed or those working in the informal sector. SHI requires strong state capacity to work well for these groups, and this capacity is often missing in developing countries, argues the briefing paper. Interestingly, a report from inside the Bank itself agrees with this assessment, revealing that alternative currents are present within the institution. In a World Bank Policy Research Paper, for example, Acharya *et al.,* (2013) state that their systematic review of the evidence on the impact of health insurance schemes on the informal sector shows that there is "no strong evidence of an impact on [health service] utilisation, protection from financial risk, and health status."[262]

The criticisms have certainly been justified in the case of Ghana where administrative chaos and an inability to reach poor households has dogged the scheme. Yet there is another problematic aspect of such schemes in terms of the way in which they incorporate informal workers. The assumption is that all informal workers are purely independent, self-employed operators. This means that contributions must come from the workers themselves, to be topped up with a subsidy from the state. Whilst in Africa many informal workers are indeed self-employed operators, there are also informal workers who are not, particularly in Asia. Jan Breman (2003: 27) has argued that to see the "informal sector as an infinite reservoir of one man businesses run by what in essence are petit-bourgeois entrepreneurs who create their own means of production and who use the resulting revenue to lead a modest but not poor existence" creates an "extremely distorted view of reality." Breman (2003) argues that significant numbers of informal workers are in fact labourers who are employed by either formal or informal firms. Moreover, he argues, "so-called self-employment is often thinly disguised work performed for others"(Breman, 2003: 27).

In many Asian countries, 'self-employed' home based workers are often in reality sub-contracted piece rate workers working at the bottom end of large and lucrative international value chains. The problem with the World Bank model of health insurance is that this aspect of informal employment is not considered. In particular no attempt is made to engage with the responsibility of capital for the health of the workers whose employment relationship is so disguised, and no attempt is made to think of innovative ways in which capital might contribute more widely to a health scheme for informal workers, whose very informalisation has been promoted by the same economic policies

Works? Joint NGO Briefing Paper, available at: https://oxfam.qc.ca/sites/oxfam.qc.ca/files/2008-05-07_health_insurance.pdf

[262] Acharya, A, Vellakal, S, Taylor, F, Masset, E, Satija, A, Burke, M and Ebrahim, S. 2013. 'The Impact of Health Insurance Schemes for the Informal Sector in Low and Middle Income Countries: A Systematic Review. *World Bank Policy Research Working Paper No. 6324*. Washington DC: The World Bank.

which have benefitted capital around the globe. The idea that capital should be made to bear some responsibility for those workers who have been pushed out of the formal labour market does not come into consideration, despite the existence of suggestions about alternative forms of taxation such as "Tobin taxes"[263] and calls for taxation on production (Kanbur, 2010). The citizen-state axis is emphasised, while the employer-worker axis remains non-existent. Therefore, while the World Bank talks about informal workers, in reality it seems to be using a new name to talk about the same poor citizens it was 'targeting' with 'indigence exemptions' during the user fee era.

"Post-neoliberalism" and the World Health Organisation and International Labour Organisation

The World Health Organisation has struggled to regain its prior status in the world of global health. The World Bank remains strong as do other organisations such as UNAIDS, and The Global Fund to fight AIDS, TB, and Malaria which draw government resources away from the WHO (Garrett, 2007). Its most recent attempt to reassert its position as the global health policy leaders has taken the form of the campaign for Universal Health Coverage (UHC), which is the structuring theme of the organisation's 12th Plan of Work. UHC has been seen as an attempt to revitalise the PHC movement in new packaging. The focus on improvements to primary health care is strong. However, in attempt to create wider consensus around UHC, the WHO has declared that there are "different pathways to UHC." It states in the 2010 World Health Report that health funds

> *… can come from a variety of sources – income and wage based taxes, broader-based value-added taxes or excise taxes on tobacco and alcohol, and/or insurance premiums. The source matters less than the policies developed to administer prepayment systems.*[264]

A flexible approach to health systems financing may have its advantages. One disadvantage is that the UHC model seems to be increasingly interpreted as Universal Health *Insurance* Coverage by many developing countries (Lund, 2012b), meaning that UHC seems to have become not so much a challenge to the World Bank model, but more as a way for it to garner greater acceptance.[265]

[263] The Tobin Tax is named after the Nobel laureate economist James Tobin. In general it refers to a tax on financial transactions which could be used as redistributive measure from the Global North to the Global South.

[264] World Health Report. 2010. Health Systems Financing: The Path to Universal Coverage, Executive Summary, Geneva: World Health Organisation, p 13.

[265] Individual WHO employees have been critical of the Social Health Insurance model in developing countries, most notably Rob Yates, a senior health economist at the WHO, who has argued that only publicly funded universal free access to health care is likely to lead to a decrease in health inequities in developing countries: Yates, R. 2013. Only public funding can guarantee universal health coverage. The Guardian Poverty Matters Blog: http://www.theguardian.com/global-development/poverty-matters/2013/oct/09/public-funding-universal-health-coverage.

Nevertheless, within the WHO itself, the focus on UHC appears to have led to something of a rejuvenation of its model for workers' health. In 2007, the WHO launched its Global Plan of Action on Workers' health, 2007-2014 at the 60th World Health Assembly, and recommitted itself "to work towards full coverage of all workers, particularly those in the informal sector, agriculture, small enterprises, and migrants."[266] Through the Joint ILO/WHO Committee on Occupational Health it has also completed the plans started under Dr. El Batawi to develop a model for what is now called 'Basic Occupational Health Services' (BOHS),[267] which involves simplified techniques to monitor and protect workers' health more easily by integrating into primary health care services. The WHO has also released a booklet titled *Gender, Work, and Health* which seeks to address the particular health needs of female workers.[268] It seems again to be increasingly accepted that in developing countries the integration of occupational health into primary health care is the way forward. At a side meeting of the World Health Assembly in 2013, it was reported that a number of countries, including Brazil, Indonesia, the Philippines, Thailand, Colombia, South Africa, Sri Lanka, and Tanzania, have begun to move towards implementing this model.[269] The influential High Level Expert Group (HLEG) report on Universal Health Coverage for India has also recommended that occupational health be integrated into primary health services, just as the Bhore Report had done 60 years earlier.[270]

The ILO has had a more difficult time in asserting its occupational health agenda within the new world of work. On the progressive side its "Decent Work" strategy, which was adopted after the election of Juan Somavia as Director-General in 1999, has led to a greater focus on "people on the periphery of formal systems of employment (Vosko, 2002). In line with this, the ILC has passed two conventions protecting the labour rights for groups of informal workers, largely made up of women: the Home Work Convention (C177, passed in 1996), and the Domestic Workers Convention (C189, passed in 2012). In both of these Conventions, the workers' right to a safe and healthy work environment is explicitly stated. Moreover, several of the programmes run under Decent Work have made important inroads into engaging local government institutions as key sites of workplace regulation. The Decent Work Pilot Programme, which ran in eight countries including Ghana, from 2000-2005 worked primarily with local governments as opposed to national level labour institutions.[271] Just prior to this, the OSH division had run a project in Tanzania to improve working

[266] WHA Resolution 60.26, 2007.
[267] Rantanen, J. 2005. Basic Occupational Health Services. ILO/WHO/ICOH collaboration with the Finnish Institute of Occupational Health.
[268] WHO. Gender, Work and Health, Geneva: WHO, 2011.
[269] WHO. Universal Health Coverage for Workers, Report of a side event of the 66th World Health Assembly, Geneva. 2013.
[270] Planning Commission of India. High Level Expert Group Report on Universal Health care in India. 2012.
[271] ILO. 2006. Decent Work Pilot Programme 2000-2005.

conditions in the urban informal sector, which explicitly engaged both primary health care and municipal institutions.[272] In 2012 the ILO collaborated with the United Cities and Local Governments (UCLG) to run a peer learning programme on "hygiene, health, and markets" in Maputo, which aimed to exchange lessons on improving working conditions in urban markets.[273]

In seeing local government as an important aspect of labour regulation, the ILO has certainly made more progress than the WHO, which continues to see environmental health and sanitation from a national perspective exclusively. The absence of any discussion on municipal regulation is notable in the WHO's *Gender, Work and Health* booklet which discusses the exclusion of informal workers and women workers from the formal discipline and regulation of OHS. It concludes, however, with unimaginative recommendations to extend labour laws to previously excluded groups, and encourages employers to make more effort educating their employees about health and safety in the workplace. Firstly, this assumes a traditional employer-employee relationship exists in the first place. Secondly, it fails to address the contradiction which often exists between labour laws (which operate at national level) and municipal level regulations which often do much to undermine the working conditions of workers working in urban public spaces (as discussed in Chapter Three).

Despite these progressive aspects of the ILO's work, there is also a deep tension within the organisation which limits how far it can stretch its progressive programmes. In examining whether Cox's (1977) arguments still hold in relation to the ILO, Vosko (2002) argues that, despite some progress "at the margins," the ILO continues to operate largely within its hegemonic tripartite model. This gives rise to a fundamental contradiction: while the ILO continues to claim protection for the ever decreasing number of formal workers in the world, it fails to provide any real challenge to the basic model of neo-liberal capitalism, which allows less and less workers to enjoy these protections. Indeed, its very essence as an organisation built on a model of tripartite consensus building, means that it cannot break from its hegemonic mould.

This contradiction is of course also tied up with the relationship between the ILO and the World Trade Organisation (WTO), and the debate on inserting so-called "social clauses" into trade agreements, which has emerged because of the difficulty of regulating increasingly transnational flows of global capital at a national level. The debate hinges on the regulation of labour standards through the WTO's multilateral trade agreements in order to halt the global "race to the bottom,"

[272] Forastieri, V.1999. Improvement of working conditions and environment in the informal sector through safety and health measures. Working Paper OH/9907/08. ILO: Geneva.
[273] UCLG. 2012. Peer Learning in Maputo City, Mozambique on "health, hygiene and markets."

where investors move to countries with the least restrictive labour laws. It has been a fraught and complex one which has been fought across the traditional political dividing lines of the left and the right (De Wet, 1995). On the one hand governments of developing countries (led by countries like India) have argued against such clauses as representing a "thinly veiled" form of protectionism from developed countries. Developing country trade unions have been divided on the issue, whilst developed countries and the trade unions from developed countries have generally supported the inclusion of such clauses. Employers have generally been against the insertion of social clauses into multilateral trade agreements (International Organisation of Employers, 2006).

According to de Wet (1995), the ILO was unwilling to take a firm stance on the issue of social clauses as they go against the organisation's commitment to voluntary compliance and the use of political persuasion (as opposed to enforcement through trade sanctions), as well as the fact that its member states have been deeply divided on the issue and unable to reach consensus. It did, however, eventually respond in 1998 with the Declaration on Fundamental Principles and Rights at Work and its Follow Up, an attempt to compel all member states to adopt four basic labour standards: freedom of association, elimination of forced labour, elimination of child labour, and elimination of discrimination in respect of employment.

The problem is, as Vosko (2002) had pointed out, the 1998 Declaration is aimed at states, *not* industries or capital. Whilst employers are represented at the ILO, there are entire industries whose production chains span the globe and do not belong to any of the more traditional "employer associations" affiliated with the ILO. It is the regulation of these globalised entities which is perhaps most urgent, but as Vosko (2002: 30) again argues, the ILO's Declaration of 1998

> *…targets nation states for adherence to core labour standards yet fails to enable states to challenge global capital collectively. In this way it does not address the issue at the heart of the labour standards - international trade debate - the erosion of basic labour rights and the weak enforcement of labour standards, leading to a race to the bottom in wages and working conditions, propelled by the practices of global capital.*

However, even those employers who do participate at the ILO are able to influence the terms of the debate to such a small extent that little progress can be made. For example, the employer representatives walked out of the ILC debate on the Home Work Convention (Vosko, 2002), which meant that while states and workers might work towards improving working conditions for home-based workers, it would always be difficult to use the C177 to hold capital to any kind of commitment. Also, Occupational Safety and Health is not one of the core labour standards.The ILO classification of occupational diseases has also suffered from a similar problem. While the WHO is

able to endorse a list of occupational diseases which takes into account the changing world of work and includes a number of diseases of the environment (such as malaria and schistosomiasis), protozoal and viral infections, as well as mental health issues,[274] the ILO's list is far narrower and to a large extent has retained its emphasis on diseases caused by industrial poisons and processes, with only nine diseases out of a total of 106 on the list classified under "biological agents and infectious or parasitic diseases."[275] The most recent additions to the ILO lists were made during two tripartite expert meetings in 2005 and 2009. The minutes of the meetings suggest that employer representatives attempted to keep the list as narrow as possible by emphasising "science over politics" and the need to show absolute direct causality between work and disease.[276] While worker organisations sometimes disputed these attempts, their interests also did not necessarily correspond to those of the workers outside of formal employment, so that alternative voices were muted.[277]

This "hegemonic tripartism" has certainly limited the ILO's ability to think creatively about how capital could be held responsible for the health and safety of workers outside of traditional formal employment relationships. Outside of the more creative Decent Work Programme, the ILO's work on OSH in developing countries has focused largely on creating labour standards and strengthening labour inspectorates[278] – which have in reality very little hope of ever reaching the vast majority of workers in developing countries. Its flagship programmes for informal workers are Work Improvement for Safe Home (WISH), Work Improvement in Small Enterprises (WISE), and Work Improvement in Neighbourhood Development (WIND), which involve a series of steps to allow informal businesses to implement very basic safety and health measures, but is essentially aimed at encouraging informal businesses to regulate their own OSH (Lund and Marriott, 2011). In shifting the burden of responsibility onto informal operators themselves, it would seem that the ILO contradicts its own Convention on Occupational Safety and Health (C155) which states that "the financing of services for protection and promotion of workers' health needs to be organized and financed in a way that workers do not have to pay for prevention and treatment of occupational diseases and

[274] Karjalainen, A. 1999. International Statistical Classification of Diseases and Related Health Problems (ICD-10) in Occupational Health. WHO: Geneva.
[275] ILO. 2010. List of Occupational Diseases (revised 2010).
[276] Report of the Meeting of Experts on Updating the List of Occupational Diseases, ILO, Geneva, 13-20th 2005; Report of the Meeting of Experts on the Revision of the List of Occupational Diseases (Recommendation No. 194), ILO, Geneva, 27th-30th October, 2009.
[277] *Ibid*.
[278] ILOA, GB 274/GB/TC Fourth Item on the Governing Body Agenda: ILO projects and programmes concerning occupational safety and health: A thematic evaluation, 1999.

injuries."[279] What this suggests, of course, is that within the WISH, WIND, and WISE models the ILO has assumed that the informal economy consists of "one man [sic] businesses run by what in essence are petit-bourgeois entrepreneurs," essentially making the same assumptions that the World Bank has made in its SHI model.

A similar problem is evident in the ILO's approach to health provision more generally. As shown earlier in this chapter, the ILO has been at the forefront of promoting schemes of employer-based health provision, such as the ESIS in India. Its latest attempt to assert its leadership in the field of social security is the Global Social Floor (GSF), which was passed as an autonomous recommendation at the 101st Session of the ILC in 2012. The GSF is aimed at providing a minimum standard of protection to vulnerable people throughout their lifecycles through cash transfers and affordable health services. It explicitly includes informal workers along with the unemployed, children, the elderly, and the disabled, describing them as "vulnerable people". Yet, as Lund (2009) has pointed out, the emphasis within the GSF is on protection provided by the state (it explicitly endorses the WHO's UHC model), with little space for any discussion of how capital could and should be held to some account for the declining labour standards and levels of formal employment which have exacerbated the vulnerable situation of the informally employed. Whilst ultimately guided by worthy aims, Lund (2009: 10) argues that the GSF "dilutes the focus on the working poor," seeing informal workers less as economic agents operating in largely unfavourable economic conditions, and rather as "just another" type of vulnerable citizen requiring state assistance.

Philanthropic Foundations

Philanthropic foundations have for a long time been a feature of the global health scene. According to Dowie (2001), amongst American philanthropic foundations, health has traditionally been the second most funded area of interest after education. The Rockefeller Foundation, in particular, has played a prominent role since 1913 when it started its first campaign against hookworm disease (1913-1918), later moving on to other areas of global health (Hewa, 1995, Amrith, 2006, Kavadi, 2007). Currently, however, the role of these institutions has increased significantly. Between 1995 and 2005 charitable giving by US based philanthropic foundations tripled, with a third of all funds going to global health (Garrett, 2007). It is difficult to pinpoint precisely why there has been such a surge in philanthropic activity for health, although the World Bank's 1993 report on health has been cited as an influence by the person heading the foundation which has surpassed all previous giving – Bill Gates (Cohen, 2006; McCoy et al., 2009). There is also the fact that staggering amounts of wealth

[279] ILO Convention on Occupational Safety and Health (C155), Article 21.

have become concentrated in the hands of a few. Garrett (2007) reports that in the first six years of its existence the Bill and Melinda Gates Foundation (BMGF) gave away $6.6 billion in support of global health initiatives, significantly dwarfing the money spent by UN agencies.

In general, the foundations have been criticised for taking a technocentric approach to health and focusing on specific diseases at the expense of working to strengthen health care systems as a whole. Dowie (2001), for example, shows that public health has received the lowest priority within philanthropic spending on health. The Gates Foundation in particular has spent large amounts of money funding "vertical" programmes on HIV/AIDS, malaria, and tuberculosis. Yet these programmes often create imbalances in health systems which ultimately serve to undermine the provision of basic primary health care, so that patients are able to receive care for specific diseases, but are unable to access basic services like maternal care or blood pressure checks (Cohen, 2006).

For the purposes of this chapter, however, the concern is whether foundations in their current form and with their increasing and more overt global influence have worked to undermine or reinforce the social democratic model of health provision and, in particular, what stance they have taken towards the place of the worker within health provision. In terms of global health, there has been less work done on health systems as a whole by foundations like BMGF,[280] which prefers to spend its money on technical work like vaccine development, although they have promoted what Moran (2007) calls a "social entrepreneurship style" – promoting partnerships between public health systems and private enterprises focused on producing low cost products for the health system. As Moran (2007) points out, although the social entrepreneurship model has been introduced by the newer foundations like BMGF, the public private partnership approach has, since the 1990s, been supported by older foundations like Rockefeller who shifted during that period towards a focus on "market based solutions," prompted no doubt by the prevailing neo-liberal economic climate. On the whole, however, US philanthropic foundations have been supportive of increased private sector involvement in health care, and in the United States itself they have been a central force in closing down discussions around the provision of state based health care (Dowie, 2001).

Further, the above suggests that foundations, at least in the recent past, have done little to support the social democratic model of health provision, with a greater focus instead on the citizen as consumer. Yet more recently the Rockefeller Foundation has started to take an interest in informal

[280] The Henry J. Kaiser Family Foundation is one philanthropic funder which does focus on health systems development, and stands out for this from other foundations.

workers. This interest is likely to have been spurred by a number of factors. An important one, however, has been the Foundation's focus on health financing reform, which has taken it into the field of health insurance, and through this to the same question posed by the World Bank: how can health insurance coverage be provided for informal workers? As part of its work in this area, Rockefeller has funded together with the World Bank, the German Development Agency (GIZ), the WHO and the BMGF, the Joint Learning Network (JLN), a network of member states currently implementing health financing reforms. Although the JLN does include within its membership countries like Thailand and Brazil – which both have free public health systems funded through general taxation – a review of reforms currently supported by the foundation reveal that, much like the World Bank, it is in large part supporting the development of health insurance schemes.[281] Indeed one does not have to look far beyond the JLN's mission statement to see that health insurance is at the core of its work: "The Joint Learning Network's members are low and middle-income countries that are implementing health financing reforms, sometimes called national health insurance."[282]

It is important to note though that there is some confusion in terminology – the use of the term "health insurance" by US influenced institutions does not always denote what would be considered a health insurance scheme in Britain. For example, the Indonesian Jaminan Kesehatan Nasional (JKN), which the JLN refers to as a health insurance scheme, is one that is single-payer and funded through general taxation. Yet the majority of the schemes supported by the JLN, including those in Ghana, Nigeria, Kenya, India, and the Phillipines are health insurance schemes that both open up the scope for private sector involvement in health provision and, importantly, require informal workers to pay in to the scheme. In all of these schemes, what has already been said about the World Bank's approach to health provision is true: the citizen-state axis is emphasised, while the employer-worker axis remains non-existent. While the Rockefeller Foundation talks about informal workers, in reality it seems to be using a new name to talk about poor citizens.

[281] JLN member countries include Ghana (the NHIS), Nigeria's National Health Insurance System, the Kenyan National Hospital Insurance Fund, Mali (with its system of small community based health insurance schemes known as mutuelles), the Phillipines (PhilHealth, an insurance scheme), India (Rashtriya Swasthya Bima Yojana – a publicly funded insurance scheme using private health insurance providers for those below the poverty line and certain groups of informal workers for tertiary level care) and Indonesia (Jaminan Kesehatan Nasional, which is the one scheme in the JLN to be funded solely through general taxation).
[282] http://jointlearningnetwork.org/

Regaining the Citizen, Losing the Worker?

The above discussion has brought to the fore some important tensions of the current period. It is difficult to argue against the WHO's UHC model, into which an inclusive model of workers' health is inserted. Not only does this attempt to break the stranglehold of large industry on the OHS profession, but it also makes more sense in a world where the boundaries between spaces – home space, work place, public space – are becoming increasingly blurred. It is similarly difficult to argue against the ILO's GSF, which perhaps does hold some hope for informal workers who are genuinely self-employed. It is easier to find fault with the World Bank's SHI model, which increasingly looks like a thinly disguised attempt to put a new spin on an old idea. At the same time though there is an important convergence between the Bank's approach and that of the ILO and WHO: the citizen-state relationship has been re-asserted, but the second axis of the social democratic model – the employer-worker axis – remains absent (in the case of the WHO and World Bank) or has been significantly weakened (in the case of the ILO). Even with the en vogue "informal worker" the emphasis is less on the citizen as worker as it is on the worker as citizen.

James Ferguson (2007) has added his voice to the burgeoning literature on how the post-neoliberal order should be categorised and understood. In his analysis of the campaign for the Basic Income Grant (BIG) in South Africa, which would provide a basic income guarantee from the state for all citizens, Ferguson argues that the progressive left has begun to appropriate "neo-liberal technologies of rule" and adapt them to fit their own ends. Whilst there are those who argue for the BIG on the leftist premise that it allows people a degree of independence from the dictates of the labour market (decommodification), the campaign has simultaneously used neo-liberal arguments about the potential for increased self-reliance and the need to support entrepreneurship. According to Ferguson this demonstrates almost guerrilla-like tactics by the left to cloak their policies in neo-liberal rhetoric.

This is certainly a worthwhile point to make; Ferguson (2007) is trying to chart a positive path for leftist politics in troubled times. It is, however, also important to be suspicious of such moves. Is this the left appropriating the language and tools of the right, or is it the right appropriating the language and tools of the left? The BIG, as Lund (2009) points out, is another piece of social policy which, while having laudable aims, fails to take account of the historical importance of employer-based social provision in South Africa. In emphasising the citizen-state axis, it fails to engage with the employer-worker axis, it places more and more responsibility for social provision on the state, and it says nothing about how and where capital is to contribute. It is exactly this that can be observed

with respect to health policy and workers. In occupational health it is the WHO's citizenship model which has become increasingly dominant, while the ILO struggles to resolve the contradiction between its desire to address the issue of informal workers, with its tripartite model which gives it little room to challenge the dominant economic model or to think seriously about new ways to challenge capital. Where the ILO has been able to reach beyond its boundaries, it has been able to do so only with a very diluted definition of worker, focusing largely on the citizen-state relationship. Whilst the World Bank talks of informal workers, they really mean poor citizens and their model is entirely based on state provision in collaboration with the private sector.

The lessons of history are clear: in 1950, when the WHO announced that health was a right of citizenship, an unanticipated consequence was that large industries would use this to "get out from under" their commitments to general health care provision, using OHS as a justification. Now under the WHO's guidance, OHS is increasingly being accepted as a responsibility of state health systems. This is a double edged sword: on the one hand the WHO's model has the potential to be more equitable – on the other hand it frees capital from all responsibility for the health of workers, and it compromises one of the founding principles of labour regulation – that industry has the responsibility to ensure that people do not damage their health in the interests of profit (or if they do, that they are compensated for this). Moreover, in the many developing countries which have historically relied on employment-related health provision to supplement those services provided by the state, a move towards state provision alone may put undue pressure on state resources (Lund, 2009). This seems particularly unfair considering that the global capitalist economy is founded on the fact that some countries will remain poor and weak, with GDPs far smaller than the profits of many large multinational corporations. Again, the problem here, as Vosko (2003: 30) has pointed out, is that the onus is being put on states to regulate without enabling them "to challenge capital collectively."

Conclusion

There are two points which should be highlighted in this conclusion. The first relates to an argument made by James Ferguson (2012) in an essay on the future of social assistance which continues the work he has done on the BIG in South Africa. Ferguson (2012: 511) argues that "historicizing" new forms of social assistance (such as the BIG) is important because it:

> *…helps us to see this circumstance as something other than simply decay and degeneration. The idea that Africans leaving agricultural village life for the city would be incorporated into a stable, Fordist industrial working class, where unemployment and destitution would be atypical conditions, stabilised through insurance mechanisms, is increasingly implausible. But*

> *if we make ourselves aware that what is being lost is not any possibility of a decent future, but instead just one very particular formulation of what such a decent future might look like, then we can perhaps learn to free ourselves from a politics of nostalgia, and see new sorts of futures, and new sorts of politics, that only a properly historicised sense of the future might be able to detect.*

Certainly, Ferguson is making another important point here. As this thesis has often pointed out, the social democratic model that developed after World War Two was a European model based on European realities and a labour market which looked vastly different from those that existed in both African and Asian countries. Though, at the same time there is a danger in making this argument; it may feed, however unwittingly and unwillingly, into an economic model which is deeply unfair and which will never really allow for the realisation of a "decent future." The social democratic model held capital responsible for the welfare of workers. Corporations had to contribute directly to social welfare, either through Worker's Compensation or through OHS (at the very least) and/or the provision of general health services. This is something that is conspicuously absent from the new "post-neoliberal" discourse on social welfare, which appears to be placing more and more responsibility on citizens to pay, through taxes, to repair the health damage caused by the pursuit of profit. In a world where many capitalists are richer than some countries, it is unlikely that state assistance alone can create a "decent future" for the majority of the world's citizens.

The second point has to do with the institutional dynamics between the WHO and the ILO, and the way in which this has played into the neo-liberal project. There is a distinct similarity here with the arguments made by Fraser (2009) with regard to feminism. According to Fraser the two "arms" of second wave feminism have become disjointed, so that while cultural critique of feminism has gained ground, the critique of capitalism has not. While there is now a "recognition of women's rights," this has not been accompanied by economic redistribution. A similar problem has been encountered by the two arms of the social democratic model – particularly with respect to occupational health. While the WHO and the ILO continue outwardly to talk the language of collaboration and cooperation, it is quite obvious that a deep tension still exists between the ILO's OSH and the WHO's workers' health models. What this has meant in reality is that the WHO's model, which has the potential to be a more equitable model, has become disjointed from any real consideration of employer responsibility. Genuine engagement between the ILO and WHO on this matter may have resulted in some creative thinking about how the financing of the WHO workers' health model might include extra contributions from large industries as part of a wider system of redistribution aimed at informal workers. Yet such conversations seem impossible whilst the antagonism between the ILO and the WHO continues.

Chapter 6: Into the Future: Informal Workers and the Struggle for Health

This thesis has traced the shifting place of the worker in health policy over a period of 120 years in the policies of the British colonial governments in India and Ghana, the post-independence governments of those same two countries, and in the policies of the ILO and WHO to the present day. In both countries worker-based entitlements to health care were emphasised as part of the late colonial project to establish a stabilised working class. This was, however, a deeply gendered idea of the worker, based on the male breadwinner model of the British welfare state. Women's entitlements to health care stemmed more from their role as mothers than as workers – a situation which failed to acknowledge their important role as economic agents outside of the large colonial industries. Post-independence governments, following international trends, shifted the discourse around entitlements to one based on citizenship, with "workers' health" transforming into the specialised discipline of occupational health. Yet workplace health care provision continued to be linked to large industries, and in the face of government failure to truly extend universal health care, continued to be an important source of health services to formal workers and their families. The previous chapter focused on the WHO and ILO, looking at the conflicts and shifts that have occurred within occupational health policy over a period of fifty years, concentrating particularly on the moves to incorporate workers outside of formal employment, as well as women workers, into occupational health services. The chapter argued that, whilst these moves have certainly opened up spaces for informal workers to make claims on the state, the fact that the focus has been on the state alone, whilst capital has increasingly been delinked from responsibility for health provision, means that actual gains for these workers are in practice limited.

In this penultimate chapter, the analysis from the previous chapter is extended by focusing on the activities of organisations of informal workers' and their engagements with the national and international policy spaces that have opened up in recent years. Previous chapters have explored the policy process "from above." This chapter adds an important element to these previous chapters by looking at how the process plays out "from below." In focusing on organisations of informal workers, the chapter once again brings gender, as well as class, to the fore. As Chapter Three showed, the informal economy is a space where women, particularly poorer women, are situated within the labour market in far greater numbers than they are in formal employment. For example, in Ghana, 88 percent of women's non-agricultural employment is informal (Budlender, 2011). In India, this figure stands at 85 percent (ILO/WIEGO, 2012). Figures for agricultural employment are less easily

available, but it is likely that levels of formal employment in agriculture in both of these countries is low. Nevertheless, informal employment is not, of course, limited to women. There are many men who are also informally employed. Yet, it is women who are more likely to be concentrated at the lower end of the socio-economic scale, and to work in the most poorly paid (or unpaid) occupations (Chen, 2012a). In Chapters Two and Four the focus was largely on how formal workers and male-dominated trade unions have engaged (or not engaged) with health policy and services. In order to maintain a gendered perspective, and now that policy spaces have opened up for informal workers, it is important as well to look at how organisations of informal workers, particularly those made up of poorer women, are engaging with health policy.

There are some omissions in this chapter of which the author is aware. The first relates to the issue of class. The theoretical framework laid out in the Introduction stated that this is a study which looks at how gender interacts with class, but prioritising class as the analytic variable. In this chapter, however, there are class issues which are not discussed. These are the class divisions that exist within the worker organisations that are explored in this chapter, all of whom struggle with the divisions between leadership and rank and file members, and also with the fact that some of their workers members are also themselves employers. These are complex social issues which can only be explored fully through ethnographic methods, and not the more distant analysis used in this study. It is, however, important to flag the issue. The second relates to the large agricultural sectors in both India and Ghana, which are not explored in this chapter. As noted in the introduction, this study does have an urban bias, this chapter particularly so. Partly this is because of the need to limit the field of study. However, it is also a result of the fact that the author's own experiences have been with organisations that are largely urban based.

The main focus will be on the world's largest organisation of informal workers: the Self Employed Women's Association (SEWA) based in Ahmedabad in Gujarat State, which has almost two million members, all of whom are poor, women workers. SEWA was formed in 1971 and has over the years developed a large and impressive range of health interventions. To provide additional insights, the activities of two smaller organisations will be discussed. Kagad Kach Patra Kashtakari Panchayat (KKPKP) is a newer and smaller organisation of around eight thousand informal waste recyclers (known as waste pickers) based in Pune in Maharashtra State, India. Waste pickers are some of the poorest and most marginalised informal workers in India, and experience some of the most serious occupational health hazards amongst such workers. KKPKP's membership is mainly made up of women, although not exclusively so. In Ghana, the actions of an alliance of four market and street

trader associations, formerly known as the StreetNet Ghana Alliance (now known as the Informal Vendors and Hawkers Association of Ghana), will be discussed. These organisations have been chosen not only because of the countries in which they are based, but because they have actively sought to engage with health policy in different ways. All three of them have also participated actively in a health research and action project run by the global research-advocacy-policy network Women in Informal Employment: Globalizing and Organizing between 2009 and 2013.[283] This chapter is a reflection on both the achievements and the tensions that have arisen through the project.

In asking questions about the processes in which these "new" worker organisations are involved, this final chapter brings the thesis full circle – from one moment of possibility to another. Based on Fred Cooper's (1996) arguments on the spaces that opened up during the decolonisation period, Chapter Two described the openings that occurred for workers in health policy during that period, arguing, in line with Cooper's more general argument, that Asian and African worker organisations were engaged in a process of co-production – that the policies which resulted were products of both openings from above and engagements from below. This chapter looks at the possibilities that are emerging for the workers previously excluded from that earlier process of policy development – asking questions about the processes with which they are currently engaged. This moment is one that has the potential to reconsider so many orthodoxies of the past – the concept of work, the worker, and the institutional designs which govern these areas of life. Yet at the same time it exists in a very different context from that of the decolonisation period. There is no colonial oppressor to mobilise against, no external occupying force to overthrow, no contradiction of the colonial enterprise to prise open and unleash. The role of the developmental state – so crucial to the earlier "welfare pacts" – has also been pared back, something that De Swaan (1988) has argued makes a repeat of this earlier time unlikely. It is the capitalist system in its current neo-liberal (or post neo-liberal) form that informal workers are engaged with, and engaging with this orthodoxy to the benefit of poorer workers is arguably a far more politically complex task than the struggle against colonialism ever was.

Of course, informal worker organisations are not alone in their engagements with the dominant social and economic system. Formal trade unions continue to play an important role. Yet neoliberal economic policies and the attendant casualisation and informalisation of the global labour force

[283] It should be noted from the start that this author has worked on WIEGO's health project as a project manager and researcher since 2009.

means that their strength has been weakened considerably (Gallin, 2001; Tendler, 2004). These processes have perhaps hit trade unions in developing countries the hardest. With a limited base of formal workers and the power of neo-liberal economic policy, public sector retrenchments and informalisation have left these unions with a declining membership and resources, and limited ability to influence economic policy (Schillinger, 2005; Ahn, 2010; Beckman and Sachikonye, 2010). As Tendler (2004) points out, they have also tended to be demonised by development policymakers as inefficient obstacles to economic growth. Yet even in the Global North, trade union density has declined considerably in some places. In Japan and the USA trade union membership has halved over the last forty years, and in Britain trade union membership is down by 27 percent (Gallin, 2001).

The central position of trade union militancy has also been altered by the growth of what is known as "social movement" activism. Social movements have sprung up around the globe partially in response to the diminishing and inadequate power of trade union-based agitations to counter the increasingly flexible and mobile flows of transnational capital and the social fallout that has resulted. Della Porta and Diani (2006) define social movements as being concerned with social justice (often with an environmental angle) and view them as marking a definitive break with what they term "workerist" modes of resistance. According to these authors,

> *The principal innovations of the new movements … are a critical ideology in relation to modernism and progress, decentralised and participatory organisational structures, defence of interpersonal solidarity against the bureaucracies, and the reclamation of autonomous spaces, rather than material advantages (Della Porta and Diani, 2006: 9).*

This definition, argue Della Porta and Diani (2006: 9), has the advantage of placing "actors at the centre of the stage, and [capturing] the innovative characteristics of movements which no longer define themselves principally in relation to the system of production."

The organisations of informal workers which are discussed in this chapter straddle a divide between the traditional workerist model of activism and the new social movement activism. On the one hand, they adopt the pragmatic tactics and strategic positions which are in keeping with social movement activism. On the other hand, they have identified strongly with the trade union model – in India, due to a loophole in the trade union legislation, both SEWA and KKPKP have been able to register as unions of self-employed workers. More importantly, their activism focuses very directly on a critique of the system of production. This orientation, it will be argued during this chapter, offers a powerful (and unique) challenge to the dominant models of the current era. Indeed the suggestion that social movements in the present era "no longer define themselves principally in relation to the system of production," and that class struggle may be considered somewhat passé, is concerning. As the

previous chapter showed, and as Nancy Fraser has articulated so clearly in her critique of second wave feminism (Fraser, 2009), the erosion of the relationship between social justice concerns and questions of economic justice does little to reinforce, and may ultimately undermine, the gains of social justice movements. Della Porta and Diani (2006) do go on to say that "the rise" of "movements of the poor," which make the notion of class central and whose goals involve the improvement of the material conditions of life for their members, has challenged the idea that the new social movements operate solely in the sphere of "post-materialism." Yet even then, many movements of the poor make their claims on very different grounds from informal workers. For example, in terms of health-related claims specifically, most social movements base their claims to health and health services on the basis of citizenship or human rights. The informal worker organisations discussed in this chapter make these claims based on their status as *workers.* In terms of the aims of this thesis, this is particularly interesting for two reasons. Firstly, it allows these organisations the space to unite issues of social *and* economic justice (which in itself is a critique of the current neo-liberal system); and second, it plays on the tension that has been discussed throughout this thesis between status as citizen and status as worker.

Yet even so, questions do remain about the direction of resistance taken by organisations of informal workers and whether they are likely to have the transformative impact on society that trade unions have had in the past. Unions have been significant political actors in both national and international politics. They have been at the heart of the Labour Party in Britain, been strong supporters of the Democratic Party in the USA, and have had representation and voice equal to that of governments and employers at the ILO. The aim of this chapter is to interrogate what impact these new worker organisations are making in a changed world, one where this union power has diminished. It will look critically at how these organisations are engaging around health services in India and Ghana, how they are taking advantage of policy spaces that are opening up, if and how they are managing to widen those spaces and if so in what direction, and what implications their strategies and tactics have more generally for a just distribution of health services. These questions also feed into a major thread running through the literature on resistance movements more generally. In essence these debates revolve around questions of purpose and process. What should constitute a desirable end-goal for the actions of resistance? What should be counted as *progress* towards that vision?

Such questions are hotly contested among those coming from different theoretical and ideological positions. Some scholars adopt a rigid Marxism which sees the downfall of capitalism as the proper

end goal of resistance activities (Smith, 2011). Therefore, on this extreme are those who Tanya Murray Li (2007: 278) refers to as "vanguards" who argue that groups who exist on the margins of society should

> *…not strive for inclusion in markets, or seek a closer relation with ruling regimes, or their share of the material benefits of development, which structurally speaking are impossible for them obtain. They should lead the way in autonomous, authentic, post-development thinking that is anti-capitalist, anti-state and grounded in local traditions and cultural diversity.*

The vision here is for an alternative to statist capitalist development which ultimately, it is hoped, will challenge the capitalist system. In this view, any kind of negotiation or accommodation within the system is seen as collaboration with it – acquiescence to a wider social structure which will keep marginalised people marginal. It might yield some benefits in the short term, but in the long run it cannot fundamentally benefit those who are seeking to improve their situation. For example, Foweraker (2001, cited in Bebbington, 2007) argues, in relation to political engagements between the Chilean and Brazilian states and social movements in those countries, that negotiation ultimately led to a "taming of social movements," whose demands for radical social justice were met with "hand-outs and programmes to help the poor cope with crisis" that the movements in question accepted in lieu of a fundamental re-ordering of the economic system (810).

On the other end of the spectrum there are a number of positions. They range from a neoliberal approach which would see reform as proceeding in a direction that is even more favourable to business interests, to a social democratic incremental approach to reform which sees social progress occurring in planned stages. In the less directly policy-oriented academic literature there is also the "everyday resistance" approach – a term first used by James Scott (1985) in his book *Weapons of the Weak.* Scott (1985), whose empirical work was conducted amongst peasant populations in Malaysia, argues against an approach which frames "peasant resistance" in revolutionary terms. Peasant revolutions, he argues, have time and time again replaced one coercive regime with another – "much at odds with the goals for which peasants had imagined they were fighting" (Scott, 1985: 29). For Scott, framing research in this way misses the importance of different forms of resistance which are perhaps more likely to create beneficial change for marginalised people. His research in Malaysia concentrated on everyday forms of peasant resistance against "those who seek to extract labour, food, taxes, rents and interest from them" (Scott, 1985: 29). These forms of struggle, he argues, are often not collective or even conscious decisions to rebel – resistance emerges from the "foot dragging, dissimulation, false compliance, pilfering, feigned ignorance, slander, arson, sabotage…" that "relatively powerless" people use in their interactions with the state (Scott, 1985: 29). Although

this form of resistance does not result in spectacles, it is often very effective, Scott argues, and can bring state programmes shuddering to a halt as people refuse to comply with them.

In a somewhat related vein, James Holston (2008) uses the term "insurgent citizenship" to describe the ways in which poor urban dwellers in the Global South gained citizenship. Holston (2008), who conducted his field work in Brazil, argues that these citizens gain their rights not primarily through labour struggles, but rather through their engagement with the spaces and institutions of cities. By occupying and transforming the peripheral spaces of the city, and demanding basic services in those spaces (insurgent citizenship), the urban poor have been able to challenge the dominant form of "entrenched" and inegalitarian citizenship and make real gains for themselves. This approach, which again views resistance in very different terms from the vanguardist framework, has also been highlighted by scholars like Asef Bayat (2009) who has spoken of the "quiet encroachment of the ordinary" to describe the way in which the poor and marginalised are able to force their imprint onto mainstream politics. The direct goal is not to destabilise the capitalist system; instead the goal may be to secure a livelihood, or to gain access to basic services. The cumulative effects of such actions, however, are to radically transform the landscape and our conceptions of the normal. These approaches tend to be more positive about the actions and potential of social movements than more hard line Marxist approaches which tend to emphasise the structural limitations to resistance. Holston (2008) in particular also emphasises the entangled nature of state and society. By challenging the classic binary divide between state and society he is able to see what may be termed "accommodation with the system" as an unavoidable part of the political process.

Returning back to the national level, this chapter will begin with an overview of developments in social and economic policy in both India and Ghana, including a description of the current labour market picture in each country. It will then move on to an analysis of the health-related activities of the three informal worker organisations before moving on to a concluding section in which three main points will be emphasised. The first point is that it is more important to understand what social movements are actually doing on the ground – to analyse these with multiple theoretical tools – than it is to jump to concrete conclusions about their relative merits and demerits based on rigid theoretical frameworks. As Scott (1985: 40) argues, "Much of the debate on these issues has taken place as if the choice of interpretation were more a matter of the ideological preference of the analyst than of actual research." Adopting a rigid vanguardist position which would see the downfall of capitalism as the end goal of resistance and judging organisations on their compliance or non-compliance with the system, may obscure the fact that there is much more going on. Specifically,

that an organisation might be revolutionary in an entirely different sense, whether that be by giving its members a sense of self-worth and empowerment in the most genuine sense of the word, or by the small but crucially important gains that are made in living standards through accommodations that are made with the current political and economic system.

At the same time, it is important to keep in mind that improvements in the living standards of most of the world's poor workers are limited by the structural constraints of the capitalist system and thus will be continually contested. Adopting a rigid vanguardism may obscure some of the gains of organisations, but completely discarding a critique of capitalism and the way in which it works to keep living standards low is equally problematic. Without taking away from the real potential of organisations to make a significant contribution, it is also necessary to ask questions about what they are doing at a fundamental level in relation to the economic system – this cannot and should not be ignored. A hybrid approach tempers optimism with realism. It allows for an appreciation of important gains that are made, yet at the same time keeps the limits in view.

This leads to the second point, which is that organisations of informal workers do indeed hold a powerful key to unlocking primary elements of the current capitalist system. Underlying their activism is the basic argument for the recognition of a "reserve army" – the term used by Marx to refer to the oversupply of labour which could keep wage rates down – as productive workers with the full rights and responsibilities that this entails. Their contributions to the economy should be recognised, and they should receive the protections and services they require to lead a good and productive life. For this to actually happen would require a radical transformation in the dominant political and economic system. Yet, as the previous chapter showed, the forces pushing in the opposite direction are powerful, and whether informal worker organisations will be indeed be able to use that key to good effect remains to be seen. At present the material gains are still small ones. Nevertheless, as Gramsci reminds us, politics cannot be read off economics alone (Hart, 2013). Where these organisations – particularly the Indian organisations – have been most powerful is in their ideological challenge to otherwise accepted orthodoxies around work and the institutions that govern it. With time this challenge may begin to bear material fruits.

The third and final point is that the systemic tensions, contradictions, and dialectics that have been drawn out throughout this thesis are reflected as well in the internal constitution of informal worker organisations. These organisations do not operate independently of the system in which they operate, nor of the history of worker politics in which their activism is deeply embedded. Their

philosophies, strategies, and tactics are both produced by, and reproduce, the tensions that exist between universalism and particularism, and between "the terms of inclusion" – inclusion based on citizenship, and inclusion based on status as worker.

India and Ghana in the 21st century

Both India and Ghana have undergone major political and economic changes since the post-independence period. Although their economies are very different, both countries have experienced periods of economic crisis and stagnation. They have also, since the 1980s in Ghana and the 1990s in India, adopted a neo-liberal model of development. There are differences and similarities in how this has played out. India has boomed since the opening up of its economy, and it is now an undisputed global economic power. The majority of its people (69 percent), however, remain in the rural areas.[284] Ghana's economic development has been a more halting success, although the recent discovery of oil off the coast has begun to stimulate rapid economic growth. Ghana has also become a predominantly urban country, with 51 percent of the population living in cities.[285] In both countries, however, rapid economic growth has led to growing inequality, and the structure of the labour market has continued to be dominated by informal employment. In both countries the informal workforce comprises over 90 percent of total employment, which has important implications for both the regulation of labour and social policy. Global forces interacted with national politics, and these national contexts in which the informal economy continues to predominate is examined in the next part of this chapter.

During the 1970s and 80s the Indian economy stagnated, culminating in 1989/1991 with a major fiscal crisis. The crisis provided the necessary impetus for Manmohan Singh's Congress-led government to introduce wide reaching reforms, abandoning the planned development approach of Nehru and embracing the global, liberalised marketplace by removing license regimes, lowering the barriers for the entry of foreign capital and goods, and privatising state-owned sectors such as information technology, telecommunications, banking, and insurance. Economic growth has been impressive, with booms in the IT and telecoms sectors in particular (Bardhan, 1998). Growth rates averaged at around 5 percent during the 1990s, increasing to 7 percent during the first decade of the 21st century (Chen and Raveendren, 2011). Previously thought of as a land of extreme poverty and hardship, India has become an undisputed global economic power.

[284] Index Mundi (2011 figures), available at: http://www.indexmundi.com/india/urbanization.html
[285] Index Mundi (2011 figures), available at: http://www.indexmundi.com/ghana/urbanization.html

Partha Chatterjee (2008) argues that the economic reforms have profoundly altered the Indian political landscape. A newly confident and globally connected "corporate capitalist class" has risen over and above the traditionally powerful "landed elites." The middle classes, the bastion of the "bureaucratic-managerial class" who devise and lead the interventions of the state, have increasingly begun to see the state itself as irretrievably corrupt and inefficient and have transferred their allegiance to the professional and efficient corporate capitalist class. This, in conjunction with the dictates of the free market, has led to a much greater acceptance of the private sector in matters previously thought of as state responsibilities. The state and the private sector, Chatterjee (2008) argues, have thereby become increasingly entangled with one another. This promotes the prioritisation of "the country's trading and investment regimes … over its 'social investment' regime" (Corbridge and Harriss, 2000: 146). India's once powerful trade union federations have suffered under this regime, losing much of their political leverage and being forced into a constant defensive position which has done little to advance the position of Indian workers (Roychowdhury, 2003). This has extended even to those with affiliations to the major political parties, such as the Indian National Trade Union Congress (INTUC), traditionally affiliated with the Congress Party. Ahn (2010: 27) argues that trade unions have lost so much ground in the Lok Sabha (India's highest decision making body) that they have effectively "turned into a peripheral support group for political parties."

One of the areas where evidence of India's change in policy is most striking is in employment. In a detailed paper on employment trends, Chen and Raveendren (2011: 1) argue that the high levels of output growth have not been matched by a growth in employment, and that job seekers are not being "…absorbed into modern formal wage employment," but rather into informal employment. Higher employment rates were in fact achieved during the late 1980s when economic growth was lower, but government spending had a greater focus on poverty reduction and social spending at this time (Corbridge and Harriss 2000; Chen and Raveendren 2011). The lack of job creation has been most marked in the period of 2005-2010, when employment growth dropped to 0.2 percent per annum from the 2.85 percent recorded in the previous five year period, and labour participation rates for both men and women aged fifteen years and older declined. This drop has affected women the most, with a 10 percent drop in women's labour force participation (Chen and Raveendren, 2011). Regular wage labour has declined, casual wage employment is also waning, and there has been a significant increase in self-employment, particularly amongst women, in both rural and urban areas (Chen, 2012b). Recent labour force statistics on urban employment reveal a small salaried workforce (20 percent), an informal waged workforce (40 percent), and a large informal self-employed workforce (40 percent), meaning that informal employment, which is largely unprotected

and has a higher chance of lower returns, now accounts for at least 80 percent of urban employment (Chen and Raveendren, 2011: 1). When rural employment is included, levels of informality rise above 90 percent, with 77 percent of these workers receiving less than US $0.50 in wages per day (Sengupta 2007, cited in Whitehead 2013).

For India's poorest workers, the liberalisation of the economy has opened up some opportunities, but has closed many others down. On the one hand, new markets have opened up globally for small home based producers. On the other hand, small home based producers, lacking any kind of protection or encouragement from the state, are easily brushed aside by competition from large producers (Bhatt 2012). Chen (2012b) paints a detailed picture of the opportunities opening and closing for informal workers in India. The boom in infrastructure development has provided opportunities for agricultural workers – new dams and canals are allowing a growth in paddy cultivation. At the same time, increased mechanisation has meant fewer jobs in wheat harvesting. The pro-business environment has also meant that employers are more easily able to avoid labour regulations without sanction. Construction labourers, for example, are only protected by legislation if they work for the same employer for 90 days a year. Employers therefore make a concerted effort not to hire for 90 days or more, and are able to do so with impunity. Street vendors are facing increasing competition from well-stocked, air-conditioned supermarkets, and are being excluded from the public (and productive) spaces of the city through urban planning initiatives which "aspire to World Class City status" (Chen, 2012b: 279). Moreover, as long as the growth in formal wage employment remains stagnant, Chen (2012b) argues that the number of entrants into the informal economy is likely to rise, putting livelihoods under even greater stress.

Although the political reconfigurations attendant on the neo-liberal reforms may be specific to India, the entanglement of state and capital is not. David Harvey (2010b) argues that it is a central and global characteristic of the neo-liberal era; the consequence being that the benefits of growth are not evenly distributed as the state increasingly favours "the ruling class." In Ghana it can be argued that this is equally true, although with little actual economic growth occurring until very recently, political reconfigurations may be harder to discern. The overthrow of Nkrumah in 1966 ushered in a period of political and economic turbulence in Ghana, with alternating periods of military and civilian rule and civil disturbance that left the economy vulnerable to the 1979 oil shock. The economic collapse of the country in 1979 led to the overthrow of the Supreme Military Council of General Acheampong by Flight Lieutenant Jerry Rawlings. A brief period of democratic government ensued under President Hilla Limann until Rawlings again took power in 1982.

In 1983, Rawlings and his Provisional National Defence Council (PNDC) embarked on a major overhaul of the economy, known as the Economic Recovery Programme (ERP). The ERP was based heavily on neo-liberal economic principles – price controls were removed, state owned enterprises and basic services were privatised, and public sector employment was cut dramatically (Gyimah-Boadi and Jeffries, 2000). The brief spurt of economic growth which followed the reforms made Ghana a poster child for the Structural Adjustment Programmes (SAP) led by the IMF and the World Bank; although, Kraus (1991) argues that the growth pattern was misleading in that it compared Ghana's performance between 1984 and 1989 with the years between 1979 and 1983 when the economy was in complete collapse, with Ghana's cocoa exports falling from 33 percent of the world market to only 12 percent (Manuh, 1994). When economic indicators for 1984-1989 are compared to 1970 indicators, it shows the cocoa and timber output remained low, and consumption per capita, real minimum wages, and levels of basic social services remained lower than in 1970 (Kraus, 1991: 24). Moreover, employment in the manufacturing sector fell below 50 percent of its 1970 share of total employment (Manuh, 1994).

Although not comparing well to the economic indicators from 1970, since 1984 the Ghanaian economy has recovered to some degree from the collapse of 1979. Agricultural, timber, and mining output has improved, and in more recent years the economy has begun to grow rapidly (at around 7 percent in 2013). This growth has been driven not only by improved output in agriculture (particularly cocoa), but also by the pro-business orientation leading to increased foreign direct investment adopted by the successive Ghanaian governments elected since Rawlings returned the country to democratic rule in 1994, and since the discovery of oil in Ghana's territorial waters off the coast of Takoradi (Manuh, 1994, Booth et al., 2005). This economic growth, and a sustained period of relative political stability, have seen Ghana move from Low Income to Low Middle Income status according to the World Bank's ranking system.

As Kanbur (2013) points out, however, this newfound wealth has not translated into benefits for all the country's citizens equally. Although income poverty has been reduced, income inequality is on the rise. Since 2000 public and private sector formal employment has recovered from its low levels during the 1980s, with the public sector wage bill as a percentage of total government spending increasing from 20 percent to 30 percent between 2001 and 2006 (STAR-Ghana, 2011). However, as Anyemedu (2000) points out, the quality of these jobs is questionable, with the daily minimum wage in 2000 sitting at half of its real value in 1991. Moreover, there continues to be a shortage of formal

jobs and the informal economy has continued to dominate employment in Ghana. Heintz's calculations in 2005 (based on the Ghana Living Standards Survey of 2000/1) showed that formal employment stood at only 9 percent of the total employment, meaning that just over 90 percent of Ghana's workers worked informally and therefore had a higher chance of earning low returns (Heintz, 2005). An analysis of the most recent round of the Ghana Living Standards Survey (GLSS 5 2005/6) showed that 15 percent of Ghanaian workers were in formal non-agricultural employment, which suggests that formal employment may have risen (in 2000/1, formal employment in agriculture was negligible) (Budlender, 2011). Again, though, the quality of this formal employment is questionable, as Anyemedu (2000) points out.

In this context, the Ghana Trades Union Congress (GTUC) has struggled to assert itself. In 1979 the organisation made the decision to withdraw from party politics. Its prior "cosy" relationship with Acheampong's Supreme Military Council regime had led to deep splits in the organisation and had demoralised the labour movement (Akwetey and Dorkenoo, 2010). The decision to remain politically independent returned credibility to the GTUC, but it has faced significant challenges nonetheless. The public sector retrenchments that occurred early on under the ERP significantly impacted the membership of the organisation, and membership numbers are yet to recover (Anyemedu, 2000). Wage restraint in order to attract foreign direct investment has been a core tenet of the ERP and subsequent economic policies of the Ghanaian government. This has created "an alliance between government and private business in opposition to demands for wage increases from formal organised labour" (Anyemedu, 2000: 11). According to Kraus (1991), the government has regularly attempted to obstruct collective bargaining agreements by requiring the Prices and Incomes Board to approve the agreements, and allowing the Board to alter agreements at their discretion. It has in fact become so difficult for the GTUC to have an influence on core worker issues like wages that it has increasingly begun to play a role as a critical voice from civil society on more general issues of social justice – although it attempts to influence economic and social policy where possible with the presence of various tripartite and policy making bodies (Akwetey and Dorkenoo, 2010).

For informal workers, Ghana's recent history has also not been easy. Like his predecessors, Rawlings's vision for Ghana was not one which was particularly amenable to the needs of informal workers. As with Nkrumah, groups of informal workers were specifically blamed for the economic problems facing the country. Shortly after he took power in 1979, Rawlings launched an attack on the market women of Accra's Makola Market, claiming that they were "hoarders" who were driving up the price of food. He continued this targeting of market women into the 1980s. As Claire

Robertson (1983) has argued, the market women, whose real crime was to play the most visible role in drawing attention to the recurring shortages of goods and foodstuffs, bore the brunt of the public displeasure which rightly should have been targeted at the less visible sources of inflation, decline in the terms of trade, and general corruption that characterised the Ghanaian economy at that time. Since Ghana's return to democracy in 1993, there has been less obvious discrimination against informal workers, although it is questionable as to whether much genuine effort has gone into promoting their inclusion into the economy on more favourable terms. The World Bank has remained one of Ghana's largest sources of international aid (Harrigan and Younger, 2000), and this has certainly played a role in the continued neo-liberal slant of economic policy, with many negative effects on informal workers. These include increased competition for livelihoods (Overå, 2007), and the (poorly regulated) privatisation of basic urban services which negatively affect the physical condition of many informal workplaces and increase the costs of operating micro and small businesses in public spaces (Alfers and Abban, 2011). The oil finds have opened up opportunities for some workers in Takoradi, but many more are struggling to cope with rising food prices, rising house rentals, and battles over productive urban space, including plans to demolish the central Takoradi market and replace it with a high rise mall to cater to the needs of middle class oil workers (Overå, 2011).

As discussed in the previous chapter, 'post-neoliberalism' has brought about a softening of the neo-liberal stance towards social policy. In both India and Ghana this has had an impact on national social policy, and in both cases there has been an attempt to extend social protections to the large informal workforce. In terms of health policy specifically, both countries have recently implemented large "flagship' health programmes. In India, where the public health system is famously neglected, the state introduced in 2008 a large central government funded health insurance scheme known as the Rashtriya Swasthya Bima Yojana (RSBY), which aims to provide health protection to poor citizens and certain specified groups of informal workers. In Ghana, Rawlings's neo-liberal reforms brought about a disastrous user fee policy for public health care facilities which saw health utilisation drop to a record low. In 2003 the country introduced its National Health Insurance Scheme (NHIS), which is meant to provide coverage for both formal and informal workers – the first time in the country's history that informal workers have been included in a national social protection scheme.

In Ghana the reform of the health system was driven by a number of factors both national and international. The deep unpopularity of the health care user fee system introduced under the ERP led to a political party (the National Democratic Congress) promising the implementation of a

national health insurance scheme as part of its policy platform during the 2000 national elections (Alfers, 2013). The failings of the free universal health service set up under Nkrumah has meant that the platform of this type of health scheme has been seen as politically unfeasible, and the choice of health insurance more attractive.[286] It is certainly the case that the World Bank has played an important role in facilitating the design and implementation of the scheme, and Ghana has been an active member of the Joint Learning Network which is also partly supported by the Rockefeller and Gates Foundations (Apoya and Marriott, 2011; Alfers 2013).

International influences have also been present in India, where the Labour Ministry was the driving force behind the implementation of the RSBY (Jain, 2013). The country is, for example, also a part of the Joint Learning Network. The structure of the scheme has also been a result of driving national concerns – in particular the government's need to be seen to be seen to be addressing some of the obvious social inequalities wrought by economic growth. De Haan (2013) argues that India has taken a "welfarist" approach to its social policy, as opposed to the "productivist" stance taken by the Asia's other great economic power, China. Despite the fact that the background to the RSBY was the SEWA-driven, 12 year initiative to pass the Unorganised Sector Bill, India, according to de Haan (2013), has not seen social spending as inextricably linked with the economy and its productivity and therefore as a productive investment in its population, but rather as a means to ameliorate the conditions of the poor. It is not social democratic principles which underpin these policies, but rather the neo-liberal idea of safety nets for the poor.

Both the RSBY and the NHIS will be discussed in further detail in this chapter, but it is worth noting here that both are considered flagship health programmes, yet are actually health insurance schemes to mitigate against catastrophic health expenditures for the poor. They do little to address the dire need for primary health care and basic essential services such as clean water and sanitation – things seen as highly important by the British productivist welfare regimes. Even though they claim to include workers, this is done in the same manner in which the World Bank has sought to include workers within its policy frameworks and recommendations – seeing them not as economic agents, but as an especially vulnerable group of poor citizens who cannot be reached through traditional social health insurance techniques.

[286] Interview with Dr. Clement Adamba, Institute for Social, Statistical and Economic Research (ISSER), University of Ghana, 22nd March 2012.

It is this national context in which informal worker organisations are currently operating. The themes brought out in the previous chapter present themselves again. On the one hand possibilities have opened up for such organisations; there are greater economic opportunities, and national social policies have started to grapple with the complex task of extending social protection to informal workers. On the other hand, the economic context means that there is greater opportunity for the already large and powerful to grab an even greater share of the profits. Social policy remains delinked from economic policy – the protections extended to informal workers do not necessarily see them as potentially productive economic agents, but rather as just another group of poor citizens requiring welfare. The challenge for informal worker organisations has been to try and re-forge that link in an image which suits the reality of work outside of the industrialised world.

The Self-Employed Women's Association (SEWA)

It was not this period, but rather an earlier time of economic instability which gave rise to the first and largest of India's informal worker trade unions, the Self-Employed Women's Association (SEWA). SEWA began its life in 1972 as a branch of the Textile Labour Association (TLA, known in India as the Majoor Mahajan Sangh, set up in Ahmedabad, Gujarat ("the Manchester of India") by Mahatma Gandhi and Anasuyaben Sarabhai in 1920). It was started by Ela Bhatt, then a lawyer working for the organisation during the period after 1968 when the large Ahmedabad textile mills came under threat from smaller operations, and some 17 000 male workers were laid off (Shani, 2007). Bhatt noticed that while the men continued to look for formal employment, it was women who managed to keep the family going through largely invisible and unrecognised forms of labour, such as rag picking, or sewing done in the home. She began to organise these women under the auspices of the TLA, but lacked support, and finally encountered outright hostility from the organisation, which Bhatt (2006: 14) says had "very little room for new ideas and a dwindling ability to face new challenges." Realising that "women workers would always be of marginal importance to the TLA – their numbers had declined to four per cent in fifty years," Bhatt set up SEWA as an independent organisation. Its roots remained Gandhian; the organisation is committed to the Mahatma's ideals of peaceful mediation and negotiation, decentralised, local production units, and "the forging of dignity through work" (Bhatt and Jhabvala, 2012).

SEWA's orientation as a Gandhian workers' organisation places it in an interesting position in regard to debates about the present day Indian left. SEWA arose alongside a number of social movements in India between the years 1972 and 1975. These movements focused largely on environmental issues, human rights, gender and caste-based issues, and, during the 1980s, started to rise to prominence as the "new" face of the Indian left (Omvedt, 1994). The "traditional left" in India –

embodied in the two Communist parties – has condemned these movements. Guha has argued that such organisations, focused as they are on gender, caste, or ethnicity, can never have the mass appeal of "class-based movements," and Alam argues that they represent the decline of truly democratic forces (cited in Omvedt, 1994).

The Gandhian organisations in particular have come in for criticism. Gandhi's philosophy of swaraj (freedom) meant freedom not only from colonial rule, but also an individual freedom which he conceptualised as self-rule: "At the individual level swaraj is vitally connected with the capacity for dispassionate self-assessment, ceaseless self-purification and growing swadeshi or self-reliance."[287] Unlike social democrats and socialists, Gandhi did not see the state as a source of liberation, but rather as a negative force and a constraint on individual swaraj, and Gandhian organisations have adopted this suspicious view. Whitehead (2003: 293), for example, citing Bakshi (1996) and Sangvai (2003), characterises Gandhian organisations as upholding the belief "that both urban and rural communities should be largely self-reliant for their basic needs, with limited dependence on expanded markets, and that decision-making should also be decentralised to the village level." Whitehead (2003) goes on to argue that this orientation fails to engage with the reality of present day India, where the market and state play a much more important role in economies that were formerly subsistence based.

Yet SEWA does not fall so easily into these categorisations. Although its work focuses on gender and caste issues, it is first and foremost a worker's organisation and as such, work is the issue which sits as its core. It is a member of the International Trade Union Confederation (ITUC),[288] and in 2010 had a representative elected to the vice-presidency. With a current membership of approximately 1.9 million workers,[289] it was considered large enough to have been given official trade union consultative status by the Government of India in 2002 alongside eleven other trade union federations, despite the hostility of the formal trade unions (Ahn, 2010). Moreover, although SEWA has refused to merge with other large union federations, it does collaborate with them where possible. For example, the 2014 announcement by India's new Bharatiya Janata Party (BJP) government that it planned to use Rajasthan as an experiment in cutting back on labour laws was

[287] Gandhi, M.K. Young India, June 28, 1928.
[288] ITUC was formed in 2006 as a merger between the International Confederation of Free Trade Unions (ICFTU) and the World Confederation of Labour (WCL). See Chapter Five.
[289] Data courtesy of SEWA Union, September 2014. Approximately 1 million of SEWA's members are in its home state of Gujarat. The organisation also has a significant presence in Madhya Pradesh (600 000 members), Uttar Pradesh (127 000 members), Bihar (82 000 members), Delhi (40 000 members), and Rajasthan (37 000). In the Communist run states of West Bengal and Kerala, its numbers are lower; 7000 and 10 000 members respectively.

met with a joint declaration from the eleven trade union federations with consultative status (including SEWA) stating their opposition to this move (Menon, 9 July 2014). Moreover, SEWA's orientation towards the state and market is different from the one described by Whitehead. It is true that there is a distrust for the centralised state and market economy – in their booklet *The Idea of Work* Ela Bhatt and Renana Jhabvala (the current SEWA president) argue strongly for the decentralisation of production into localised production units, thereby giving workers greater control over both production and surplus while boosting industry in previously neglected areas (Bhatt and Jhabvala 2012). However, they are at pains to point out that this "by no means suggests that local communities should de-link from the larger society. On the contrary, local markets need to be better linked with larger markets while the flow of goods, services and knowledge needs to be strengthened" (Bhatt and Jhabvala, 2012). Their argument is for inclusion, not exclusion, but inclusion on terms that will benefit poor workers.

However, although SEWA is arguably different, it also has similarities to the social movements which have made Indian Marxists so uncomfortable. Omvedt (1994) argues that social movements pose a challenge to traditional Marxist theories of capitalism. SEWA, being an organisation that focuses on the reserve army rather than the working class, certainly does pose such a challenge. The fact that SEWA organises poor, self-employed informal workers means that it cannot operate in the same manner as a traditional trade union. The fight for labour rights is still of course a central aspect of SEWA's work. It has argued vociferously for a reconceptualisation of the idea of work and the worker so that labour rights and social protections may be extended to self-employed informal workers (Bhatt and Jhabvala, 2012). It has thought through what this would mean in terms of institutional innovations from the state, and, where possible, it has taken on middle-men and owners of capital in the interests of the workers at the bottom of production chains (Bhatt, 2006). At the same time, realising that for poor workers the first priority is an income, it has also become involved in 'developmental work,' setting up a cooperative bank for the poor and illiterate, as well as production cooperatives, which, Bhatt (2006) says, would never have been allowed under the auspices of the TLA.

Furthermore, the organisation remains strictly non-partisan politically – a decision made by its leaders when it was established in 1972. This makes it one of the very few major trade unions in India not to involve itself in party politics (Ahn, 2010). Independence from party politics amongst trade unions is not unique to SEWA – the GTUC for example also remains independent from party politics. This is different from the corporatist arrangements of welfare state Britain, where trade

unions traditionally affiliate themselves with the Labour Party in a bid to create a workers' state (although this changed under Blair's New Labour). Yet it is one grounded in the realities of present day politics in India and Ghana. In India the politically partisan unions have been driven apart by factionalism, something which has contributed to their weakened state (Ahn, 2010). In Ghana too, political affiliation has negatively affected the GTUC. SEWA's independence meanwhile has meant that it has been able to work with a range of actors to improve the well-being of its members. Much like the GTUC, SEWA engages with the state. It is represented on the National Planning Commission and through this has become relatively influential on various policy making bodies. It sits on the advisory board of the National Rural Health Mission, launched by Manmohan Singh in 2005, as a means to improve health indicators in poorly served rural areas. More recently it has also been heavily involved in the National Urban Health Mission, launched in 2013 to target the urban poor. Through these initiatives it has also partnered with the state to improve the delivery of health services through its own network of community health workers. Depending on one's position, this way of working may represent a threat to social democracy (the end of the ideal of the worker's state), or it might signal a move towards a pragmatic politics which truly has the potential to extend social and labour protections to those previously excluded, or it may be both.

More problematic for SEWA's potential allies on the left, however, is its reluctance to state an open political position on certain key issues. For example, according to the International Coordinator of StreetNet International, a federation of street vendor organisations from over forty countries to which SEWA belongs, SEWA has not been forgiven by the Indian left wing for failing to make an open statement about the communal violence which wracked Gujarat in 2002. The violence was widely believed to have been (at least partly) encouraged by Narendra Modi's BJP government and its Hindu nationalist stance which at the time of the violence was the state government of Gujarat.[290] As the only organisation trusted on both sides, SEWA played a central role in the resolution of the crisis and the support of those affected. Many on the left felt that they were ideally placed to make an important statement critical of Modi, but the organisation chose to remain silent and remain politically neutral, despite a smear campaign led by the BJP against it.[291] Its reluctance to overtly endorse socialism has also led to problems in developing and sustaining alliances. This was a contributing factor to SEWA's leaving the New Trade Union Initiative (NTUI), an organisation it founded as a way to bring together unions working in the informal economy.[292] In a less overt way, several of these tensions play themselves out in SEWA's health work.

[290] Interview with the International Coordinator of StreetNet International, 24th September 2014.
[291] *Ibid*.
[292] *Ibid*.

SEWA's Health Work

Health policies and services have long been a concern of SEWA. Their concerns around health care stem largely from their members' status as workers and income earners. The pernicious effects of the relationship between unprotected labour, poverty, and illness are described by Ela Bhatt (2006: 24):

> *An asset that the poor are left with are their own bodies. As long as they have physical strength, they can dig, carry, haul, and cut to earn some money. Such manual labour requires a strong and healthy body, but their bodies are often weak and overtaxed from overwork, inadequate food and poor nutrition. On days that they are able to work, they earn; in times of illness, they still work but their productivity declines, and consequently they earn a lot less money. So during illness – precisely the time when they need good nutrition the most – the family half starves.*

SEWA's activism around the provision of health care – whether general health services, reproductive health services, or occupational health services – has therefore been centred on the worker. Their underlying argument is that India's poor workers, making up such a large percentage of the population, are productive economic agents who provide essential services to the Indian economy. If their health is not cared for they cannot be productive, and the economy and society ultimately suffers. This language is a productivist one, very different from the language of the "poor citizen" who cannot work and must be cared for by the state on an altruistic basis – the language which governs neo-liberal safety nets. It is an argument that says that poor people work hard, that they contribute in many ways to the social and economic life of the nation, and for that reason are deserving of the rights of citizenship. Here SEWA is employing a discourse which draws on that of the social democratic era. Citizenship for SEWA is rooted in work, just as it was in post-World War Two Britain. The difference is that the definition of a worker is a much broader one, encompassing home based workers, street vendors, and waste pickers, whose economic contribution, in a country where these sectors employ a substantial number of people, should be recognised.

Importantly, SEWA's emphasis on access to health care as a worker's right is also very different from another discourse which frames much of the global activism in the health field – that of human rights. Human rights have a different basis than citizenship rights. Rights are held on the basis of existence as a human being, rather than being attached to a particular relationship with the nation state. Although the discourse of health as a human right has been in existence since the formation of the UN system in the late 1940s and has underpinned the work of international organisations such as the WHO, it is only in more recent times that it has begun to supersede citizenship as a basis for claims making. This is because the declining power of states in relation to global economic processes, as well as the "failure" of a number of states in the developing world, has led to greater

emphasis being placed on the provision of services as a matter of human rights, meaning that international agencies have a role to play. Since the 1990s there has in addition been an attempt to argue that workers' rights should also be seen as a subset of human rights, an argument which has come most forcefully from the anti-sweatshop movement looking for ways to make transnational capital more accountable to workers through codes of corporate conduct and international labour standards monitoring systems (see for example Seidman, 2007).

Yet, according to McIntyre (2008) human rights are a "problematic basis for worker rights." This is because "they deal with what the individual is entitled to rather than what is in the interest of community, solidarity or civic virtue" (McIntyre, 2008: 56). Indeed as the political philosopher Onora O'Neill (2005) has pointed out, the discourse of human rights is an entirely individualistic one, which fits well within an otherwise problematic neo-liberal framework. What this means, argues McIntyre (2008: 55), is that those worker rights which fit into this individualised framework (e.g. the health of the individual worker or freedom from forced labour) are emphasised at the cost of rights which do not fit into this framework (e.g. freedom of association or collective bargaining) and which may be "more potent tools in developing a humane and equitable globalization." For example, in a study of the private regulation of labour standards in the global clothing industry, Bulut and Lane (2013) found that multinationals were willing to push bans on child labour and improvements in health and safety amongst their suppliers, but unwilling to enter into the realm of unionisation and improvements in general living standards.

SEWA has not taken this individualised approach to workers' health, which essentially views workers as separate from the social and economic context in which they live. The organisation's health work is considered one complementary aspect of the wider SEWA project to uplift the general living standards of the poor through organising workers, wage and welfare negotiations, slum upgrades, and many other activities. The organisation began its health work in the late 1970s with health education campaigns. This later developed into the formation of health cooperatives, of which there are now about sixty (Jain, 2013). Each of the cooperatives runs a primary health care centre, staffed by health assistants known as *aagewans,* as well as a basic dispensary which provides low cost drugs to workers. The *aagewans* conduct mobile health camps at various intervals during the year which include health education and information, as well as basic diagnostic tests (Bhatt 2006, Jain 2013). Since 1992 SEWA has also run a well-known worker-based health insurance scheme, known as VimoSEWA, which is aimed at protecting members against catastrophic health expenditures arising from hospitalisation. In the face of a very poorly resourced and managed public health care system,

SEWA has negotiated deals with a range of hospitals (mainly charitable, but also private and public) to provide quality health care for its members through the VimoSEWA scheme (Jain, 2013).

The approach that SEWA has taken to health provision does reveal the tendency towards Gandhian self-help that Whitehead (2013) criticises. As a consequence, the organisation's health scheme has come under criticism from some on the left, not least from other organisations of informal workers in India, who argue that this orientation does little to push forward the social democratic ideal of universally accessible state provided health care. If anything, by providing their own health care system to members, they claim that SEWA allows the Indian government to escape from the responsibility it has to its citizens.

Once again, however, it is difficult to exclusively categorise SEWA in this way. Its approach to health provision in fact reveals a dialectic between self-help and reliance on the external world. The organisation provides its own health system to its members. This is done in the name of pragmatism – workers cannot be productive without access to health care and, at present, the Indian state does not provide either the quantity or the quality of services that are required. This has not, however, precluded the organisation from engaging with an impressive range of actors in an attempt to institutionalise adequate health provision for poor workers within the state. As noted earlier, SEWA favours engagements that are based on negotiation rather than outright demands and hostility. Their engagements include representation on international, national, and local commissions, ranging from the WHO's Commission on the Social Determinants of Health, the Planning Commission of India's High Level Expert Group – which in its 2012 influential report recommended that India move towards universal state provision of primary health care and advocated for increased health spending by the state (India's current health spending stands at a very low 1.2 percent of GDP),[293] the National Health Mission, and local level representation on village sanitation committees. SEWA has also partnered with the state on several occasions to expand provision of health services. It has worked in collaboration with the Ahmedabad Municipality to provide tuberculosis health education and referrals. At one stage SEWA was also given seed money by the municipality to scale up the operations of its low cost dispensaries so that more poor people could take advantage of the service at one of the large municipal hospitals. "The politics of curative medicine" eventually caught up with the hospital scheme though, and the arrangement came to an end in 1999 because of opposition

[293] Planning Commission of India. 2012. High Level Expert Group Report on Universal Health Coverage for India. New Delhi.

from pharmacies and doctors unsupportive of generic medicine (although SEWA continues to run its own low cost pharmacies) (Bhatt, 2006: 133).

Basic preventive health measures such as sanitation have also been a concern for the organisation – many of its members work from their own homes and improvements to their homes done through SEWA's slum upgrading programme, is also a part of SEWA's health work. Again, it is interesting to note the reasoning behind SEWA's involvement in slum upgrading, which a number of other social movements (most notably Slum Dwellers International) are also involved in. SDI uses citizenship as a basis for claims making: "We are Citizens, Not Squatters" is a key advocacy slogan.[294] The difference between SDI and SEWA is that underpinning SEWA's argument for citizenship is again the notion that the poor are also economic agents. This is absent in the SDI rhetoric. For SEWA slum upgrades are necessary because workers need clean, healthy houses to live in because it makes them more productive.[295] Here again, social arguments are linked with economic arguments – social justice and economic justice are part of the same package. It is a social democratic argument, albeit with a Gandhian twist.

SEWA's engagements have not been limited to state and/or inter-governmental organisations. Since its inception, OHS work has been considered an important complementary aspect to the general health work. The current focus within its OHS programme is the development of ergonomically designed work tools for informal workers, which can both protect the health of workers and improve their productivity.[296] The link to productivity is important here, because without it informal workers, whose first priority is always income, are unlikely to change their work practices. Getting involved in this work led SEWA to create partnerships with scientific institutions and design institutes concerned with improving the workplace, engaging with their foundational practices and ideas, and encouraging them to shift their gaze from formal to informal work, and from top-down scientific practices to participatory ones which centre the worker's needs and experiences. There has been some success in this battle over ideas and principles: the National Institute for Occupational Health (NIOH), the lead OHS research body in India, was "not always interested in collaborating,"[297] but

[294] http://www.sdinet.org/videos/75/
[295] SEWA. 2009. Evaluating the impact of Sahbhagi Yojana 2 Support Programme (Slum Improvement Initiative. Ahmedabad: SEWA.
[296] Indian Institute of Public Health. 2013. SEWA Project: An Impact Analysis of Participatory Design and Use of Tools to Improve the Health and Productivity of Women Workers in the Informal Economy. Gandhinagar: IIPH.
[297] SEWA official, Meeting Notes, WIEGO OHS Learning Meeting, Durban, South Africa 4-6th May 2011.

through SEWA's consistent engagement has started shifting its research towards informal workers.[298]

In terms of work tool design, SEWA has engaged with two institutes of design in India which have been co-opted into lengthy participatory design processes, with workers testing the implements at several stages and sending feedback for improvements.[299] One of the more successful designs has been a frame for embroidery workers developed to allow for improved posture. A follow up study reported that "Embroidery workers find the new prototypes less tedious to work with since it's only a single piece and easier to set up for each piece. Back pain has reduced considerably and more time is saved per piece and their income has doubled from work."[300] Some of the tools that have been developed have been adopted by the Gujarat Workers' Welfare Board and will be sold to workers at a heavily subsidised rate.[301] This has been successful in the case of one of the tools developed – specifically, a table designed for kite makers.

"Ideas can take on a life of their own," argues Amrith (2011: 127), and are an important part of challenging any status quo. In line with their wider challenge to the hegemonic understanding of "the worker" and "the workplace," SEWA's tool designs, whilst ostensibly improving the working conditions and productivity of informal workers, are also about reforming scientific ideas and practices which fail to 'see' poor people as workers. Ela Bhatt (2006: 279) elaborates on these ideological battles in the following way:

> *When asked what the most difficult part of SEWA's journey has been, I can answer without hesitation: removing conceptual blocks. Some of our biggest battles have been over contesting set ideas and attitudes of officials, bureaucrats, experts and academics…The Registrar of Trade Unions would not consider us 'workers;' hence we could not register as a 'trade union.' The hard working chindi workers [weavers who use leftover cotton strips], embroiderers, cart pullers, rag pickers and forest produce gatherers can contribute to the nation's gross domestic product, but heaven forbid that they be acknowledged as workers.*

[298] NIOH studies in salt manufacturing, agate industry, tobacco plantation workers, fishing industry and bidi rolling, presented to the SEWA National Workshop on the Occupational Health of Women Workers in the Informal Economy, Delhi, 4th-6th April 2013.
[299] As detailed in Shah, M. 2012. India SEWA Country Presentation, WIEGO OHS Learning Meeting, Durban, South Africa, 4-6th 2011, available at: http://wiego.org/ohs/ohs-learning-meeting-may-2011. To date, tools have been designed for embroidery workers, kite makers, waste pickers, sugarcane cutters, wood cutters, and papad rollers.
[300] Indian Institute of Public Health. 2013. SEWA Project: An Impact Analysis of Participatory Design and Use of Tools to Improve the Health and Productivity of Women Workers in the Informal Economy. Gandhinagar: IIPH.
[301] Workers Welfare Boards provide a local level forum for contact between the state, employers, and workers in India, including informal sector workers. The Boards serve as registration points for employers seeking to employ poor or vulnerable workers in certain sectors (such as headload porters) and are theoretically entitled to regulate conditions of work for such workers.

Through the tool design process, SEWA has been challenging dominant ideas about what a worker is, and questioning the idea often implicit in the scientific field of OHS that the poor cannot benefit from the expertise of scientists concerned with the workplace. They are also demonstrating by example that the standard top down scientific approaches which have thoroughly characterised the discipline of OHS until very recently cannot work for the majority for the world's workers. In doing so SEWA are forcing the scientific discipline to engage with workers – something that Chapter Four showed was conspicuously absent from the earlier attempts to extend the OHS discipline into the developing world. There is also something interesting in the fact that the modernist science of OHS is being forced to grapple with the "liminal modernities" that continue to exist in places like India. The occupations in which many of SEWA's members are involved are not modern. They are traditional ones, such as producing bidis,[302] incense sticks, cloth, and embroidery, or are agricultural and non-industrial. The fact that modernist sciences are beginning to engage with non-modern occupations implies that, through the process of tool development, a hybridisation of the modern and the non-modern is taking place. In doing so, modernity's terms are being debated and redefined. Indeed for SEWA part of their conceptual challenge is to fight the idea that the modern and the non-modern should remain separate. They are of the mind that with thought and an openness with government, traditional forms of employment can (and should) play a role in the bright new India.

The struggle to change fundamental concepts and ideas is an area where SEWA had made some important gains. Yet the fight for recognition is related to but not the same as the fight for redistribution. Material economic realities are another front in SEWA's battle, and it is by examining the organisation's work in the context of these realities that questions begin to arise about the real impact that SEWA can make on the economic system. Once again, OHS legislation provides an important clue to uncovering these structural limitations in SEWA's work.

As mentioned earlier, SEWA is represented on the Planning Commission of India's High Level Expert Group (HLEG), which recommended in its report that the Indian Government increase expenditure on health care and reinvigorate the country's decrepit primary health care system. SEWA's presence on the HLEG resulted in the recommendation that Occupational Health Services be integrated into the primary health care system under the wider banner of the Social Determinants of Health.[303] Yet SEWA has not always been convinced by this move. In 2011 the National Planning Commission of

[302] Bidis are small hand-rolled cigarettes filled with tobacco and rolled in tendu leaf.
[303] Planning Commission of India. 2012. High Level Expert Group Report on Universal Health Coverage for India. New Delhi.

India released its *Report of the Working Group on Occupational Safety and Health for the 12th Five Year Plan.*[304] SEWA was represented on this working group, which recommended that existing OHS legislation and systems in India – which largely fall under the Labour Ministry – be overhauled and upgraded. This commission did not endorse the integration of OHS into primary health care, instead recommending that OHS training for informal workers be integrated into the mandate of existing OHS institutions such as the Factories Inspectorate and the Ministry of Agriculture's extension programmes. It went further to recommend that OHS services be integrated into India's (then) proposed comprehensive social security scheme for informal workers. Workers would have to have a medical check-up every second year by doctors trained in occupational health. As an incentive to comply with this, workers who presented themselves for the check-up would not have to pay their annual social security contributions. Health information on workers would then be sent to a central database so that a better record of worker's diseases and injuries could be maintained.[305]

It is not entirely surprising that this report differs from the HLEG's report in its bias towards a labour oriented approach to extending OHS to informal workers. Apart from the SEWA representative, the Working Group was composed largely of officials from the Departments of Labour, Mining, and Factories and included only one health representative – the health adviser to the Planning Commission.[306] The report also came out before there were any serious attempts to address the primary health care system in India, which as it exists at present would not have the capacity – either in terms of finances or human resources – to support additional occupational health services. The HLEG on the other hand was composed entirely of health professionals and it itself was the first step in a move to reinvigorate the findings of the Bhore Commission Report. Even so, the two reports do reflect a basic ambivalence in SEWA's position on the matter of where occupational health should sit within the state institutional structure.

SEWA has always fought under the banner of "the informal is normal," arguing that informal workers, who make up the vast majority of workers in India, should be afforded the same protections, rights, and responsibilities of formal workers. In this way of thinking, if formal workers are afforded workplace protections under the Labour Ministry, then informal workers should have the same protections, which includes forcing the owners of capital to contribute to improved

[304] Planning Commission of India. 2011. Report of the Working Group on Occupational Safety & Health for the 12th Five Year Plan. Available at: www.planningcommission.nic.in/aboutus/committee/wrkgrp12/wg_occup_safety.pdf
[305] *Ibid.*
[306] *Ibid.*

working conditions. Furthermore, SEWA foregrounds workers' rights for the working poor – citizenship for them is not delinked from status as worker. At a micro scale, SEWA has fought hard for this philosophy. Ela Bhatt (2006) has detailed the many struggles that the organisation has fought at the sectoral level in order to hold owners of capital accountable for wage increases and improved working conditions for piece rate workers. Carré (2012) details the battle SEWA's bidi rollers have fought against large company owners, who have tried to obscure their employment relationship through a chain of contractors and sub-contractors. After a long period of negotiation, the bidi rollers won a concession to create a tripartite health and welfare "provident fund" financed by a ten percent additional payment from the bidi companies.

Systematising these small victories at the scale of national legislation and policies has turned out to be difficult, however. In May 2011, SEWA officials who attended an international workshop on OHS – hosted by Women in Informal Employment: Globalizing and Organizing (WIEGO) – were clearly still somewhat ambivalent about whether OHS should be a labour function or a health function.[307] By June 2012, their position had moved towards an integration of OHS into primary health care. This shift may have occurred for a number of reasons. One of them is certainly pragmatism. In a personal communication with a SEWA official, this author was told that, whilst the Indian government was increasingly willing to engage on issues of state provided social protection, it was much less willing to enter into negotiations around worker or workplace rights.[308] Indeed, the HLEG report itself is a symbol of the new willingness of the Indian government to think further about the state provision of health care, and SEWA has unabashedly used this opening to push its agenda.

As discussed earlier, SEWA does in general tend to adopt a pragmatic stance on issues of policy – if advantages for their members can be gained from a particular channel, they will use it. This has sometimes meant steering a careful path between the left and the right sides of the political spectrum. In one of its slum upgrading programmes, for example, which entailed joint contributions from the Ahmedabad Municipality and SEWA members, SEWA faced opposition from the left who argued that the slum upgrading should be the entire responsibility of the municipality, and those on the right who argued that the state should play no role in housing provision at all. The pressure was such that it almost derailed the entire programme (Bhatt, 2012). A question remains though as to whether this pragmatic approach may sometimes draw too much attention away from challenging the underlying economic structures which continue to keep informal workers poor and marginal.

[307] Meeting Notes, WIEGO OHS Learning Meeting, Durban, South Africa, 4-6th May 2011.
[308] Personal communication with SEWA official, WIEGO Strategic Review, Bellagio, Italy, June 2012.

At the WIEGO OHS meeting, which was attended by SEWA and other WIEGO affiliates and partners, the Director of WIEGO's Social Protection Programme, expressed her concerns around the integration of OHS into primary health care:

> *What worries me about this [move to integrate OHS into primary health care] is that … we're losing the connection between the informal worker and formal organised labour. This is a completely unresolved and critically important question as part of an overall global political project. The question is, how do we strengthen the new movement of informal workers? Are we losing the edge that we have, by not insisting on OHS as a specifically worker's right?* [309]

Encapsulated within this question are a number of finer interrelated threads which are worth drawing out. "The edge" that Lund refers to here is the very particular critique that SEWA has of an economic system – a worker-based critique which inserts the economic into the social and vice versa. It is a critique which draws on social democratic, productivist principles to argue that "the poor" are economic agents whose needs can only be addressed by changes in both economic and social policy. It is a critique, which in Nancy Fraser's formulation, seeks both recognition and redistribution for the poor. Although redistributive arguments are not unique to movements of informal workers, the focus on employment provides the most direct challenge to a fundamental feature of neo-liberalism which assigns poverty to the realm of the "social," and draws attention away from the basic economic nature of the problem. Integrating OHS into primary health care may be a practical institutional innovation which benefits informal workers. It can also be a way of blunting the edge that informal workers have, downplaying the economic argument and treating informal workers as "just another" category of poor citizen.

In a wider sense this issue refers back to the question raised in the previous chapter: How are the working and living conditions of informal workers ever to improve in a sustained manner whilst they operate within a capitalist system where the odds are stacked against them? The state, although critically important, can only do so much in the face of powerful transnational capital – indeed as Chatterjee (2004) argues, the two are increasingly entwined in a way that is beneficial to capitalist interests. Good, low-cost primary health care systems, with an integrated workers' health component, can certainly provide an important service to informal workers. Yet if these do not operate within a wider economic system which allows marginalised workers greater access to the benefits of growth, which centres employment and places the onus on powerful economic interests

[309] Francie Lund, Meeting Notes, WIEGO OHS Learning Meeting, Durban, South Africa, 4-6th May 2011.

to contribute to social protection and improved living and working conditions, their impact will always be circumscribed.

Implicit in these questions is a tension that underlies SEWA's work. It is a tension which centres on the idea of different grades of citizenship (Meagher, 2013). On the one hand, SEWA argues that its members are workers who should be afforded the same rights as formal workers. The terms of inclusion should be the same. As Lund suggests, this is a powerful argument which links informal and formal workers together. If all of those on the margins – the reserve army – were to be incorporated into the economic system it would be unable to remain as it is. This ideal sits in tension with reality. The fact is that the current economic system is not reformed, and the informal economy is growing, not shrinking. Furthermore, the traditional institutional mechanisms for the regulation of labour are not always appropriate for informal workers. OHS services integrated into primary health care, combined with municipal policies which promote basic services such as sanitation and waste management in poor areas, are realistically far more likely to benefit informal workers than improved labour inspections. One is then forced to ask whether providing one set of institutional mechanisms for one group, and a different set for another group, is differentiating the forms of citizenship that these groups can access. This question is particularly relevant when considering how new institutional arrangements reconfigure the relationship between workers and those who profit from their work. In shifting their attention away from OHS as a workers right under a ministry which has the ability, at least in theory, to secure compliance from employers and/or owners of capital, is SEWA settling for a downgraded version of citizenship for informal workers?

This question can be answered in many different ways, and may depend on the theoretical position adopted by the interpreter. Those coming from a formal trade union background might well argue that SEWA's pragmatism is problematic. Others might argue that the European welfare pact was never realistically extendable to the whole world, except in enclave and white settler nations with close ties to the old colonial power. It was in fact the rest of the world's exclusion that made those pacts possible (Cox, 1977; Harvey, 2010b). From a pragmatic point of view, then, new ways have to be sought for workers to make gains in any manner possible. Moreover, it may be the case that at present the incorporation of OHS into primary health care has little emphasis on employer contributions, but once the institutional infrastructure is set up it may well be possible for SEWA to lobby towards this (although the experience of China, which had corporates in the textile industry move to Bangladesh once the government began insisting on tripartite contributions for health insurance would perhaps suggest otherwise). Another point of view might emphasise SEWA's impact

on changing ideas about work and workers. In fact ideas may mould material realities, and although the point has probably not yet arrived for this to happen, it may with time. Still others will point to the very real and very important gains that SEWA has made for its membership, not only in material terms, but in terms of bolstering their sense of identity as workers and as contributors to society, and in doing so providing them with a sense of dignity otherwise difficult to achieve (Kabeer et al., 2013).

It is of course also possible to take a heterodox approach. In the face of SEWA's success stories, which incorporate challenges to the system on multiple levels, including securing sectoral tripartite agreements which do connect sub-contracted workers to the owners of capital, which continues to help almost two million women to secure better working conditions and a sense of dignity as workers, which has profoundly challenged national and international institutions, as well as scientific disciplines to think differently about workers, it can be difficult to criticise this organisation. Indeed, very little of the literature on SEWA contains any criticism at all. However, rather than taking an entirely celebratory view, it is important to keep the limits of the organisation's work in view.

The Kagad Kach Patra Kashtakari Panchayat (Trade Union of Waste Pickers)

Kagad Kach Patra Kashtakari Panchayat (KKPKP) is a trade union of waste pickers located in Pune in Maharashtra state. Waste pickers (also known as rag pickers in India) are some of the poorest informal workers, who, in sorting through waste in bins and landfills, perform some of the dirtiest and most unhygienic work. In Pune, most are women from Dalit (untouchable) castes, a significant proportion of whom are widowed or deserted and provide at least half of their household's income with their average daily earnings of $1.25 (Narayan and Chikarmane, 2013). KKPKP is a much younger and smaller organisation than SEWA. It was first registered as a trade union in 1993, and has approximately 8000 members. Although it has in common with SEWA a focus on peaceful protest and negotiation, it is not Gandhian. It is much more closely aligned to the principles of Paolo Freire, the Brazilian educator and theorist of critical pedagogy, and in its health work in particular has focused largely on gaining benefits for its members from the state. A particularly interesting aspect of KKPKP's work is that its activism has often been aimed at the local level of government, rather than at national government labour institutions.

As with SEWA, KKPKP's battles are fought both at the ideological and material levels. The organisation first registered as a trade union as a way in which to reframe the activity of waste picking from something that was seen in the public imagination as a nuisance or desperate last resort of the very poor (scavenging), to something that is seen as an occupation and as work that

contributes to the local economy (Narayan and Chikarmane, 2013). Where they have been particularly astute is in their linkage of waste picking to the environmental movement, arguing that waste picking is essentially a form of recycling. Waste pickers sort through waste to collect scrap (mainly cardboard, paper, plastic, glass, and metal) which they can then sell on to recycling plants. This reduces the amount of overall waste that goes to landfill sites. Their activities, argue KKPKP, are both "economically productive and environmentally beneficial" (Narayan and Chikarmane, 2013: 209).

The link to environmental sustainability has served the organisation well. In 2000 India passed new municipal solid waste regulations, which required the segregation of waste, waste processing rather than dumping, and door-to-door collection. KKPKP took this opportunity to argue that waste pickers – as already existing waste sorters and processors who provide cost-effective and environmentally sustainable forms of waste management – should be integrated into the new municipal waste management systems, in particular into door-to-door collection. In order to take advantage of the new regulations, KKPKP formed the first cooperative of waste pickers in India, known as the Solid Waste Collection and Handling (SWaCH) cooperative.[310] SWaCH, which started off as a pilot project in collaboration with the SNDT Women's University in 2005/6, now provides door-to-door waste collection services for 125 000 households in Pune, and provides employment to 1500 waste pickers.[311]

SWaCH uses several different arrangements for collecting payment. In some areas the cooperative is contracted directly by the municipality, so that it receives a monthly fee which is then distributed amongst the cooperative members. In other areas SWaCH is contracted to body corporates and/or private citizens who pay a fee to the cooperative. Each waste picker is then able to supplement the earnings from the cooperative with earnings made from the sale of recyclables which they sort from the collected waste. Earnings are higher here as well because the workers have first access to the waste, rather than receiving it second or third hand when a lot of recyclable material has already been removed. This arrangement has significantly increased the income of the waste pickers involved. It has also improved their working conditions. Waste pickers traditionally operate in extremely unhealthy conditions – they pick through a mixture of rotting organic and inorganic waste in dustbins and landfills often without any protective gear. They are at risk for bacterial infections, toxic substances emanating from waste products, and the bites of rats and dogs which wander

[310] http://www.swachcoop.com/swachpune-history.html
[311] *Ibid*.

through the trash. Door-to-door collection allows SWaCH members to collect waste at regular intervals before it has a chance to putrefy, and to sort their waste in more hygienic conditions. The cooperative encourages citizens to separate their organic and inorganic waste so that the workers can more easily sort through the dry waste. In this way, SWaCH integrates healthier working conditions into its wider project to improve the livelihoods of waste pickers.

Unlike SEWA, KKPKP does not approach health provision through self-reliance. In part this is because it is a much smaller organisation and does not have the capacity to mount its own health services. A more salient reason is that KKPKP's orients its health work around deriving state provided health services for its members, and in this they have done some particularly innovative work. This has sometimes bought the organisation into conflict with SEWA, whose self-help approach has clearly rankled, despite SEWA's engagements with state health policy.[312] In 2002 the organisation fought for, and won, a municipally-funded health insurance scheme for its members. An ILO research study commissioned in 2000 showed that waste pickers in Pune, by sorting and removing recyclables from the waste stream, saved the PMC $330 000 in transportation costs, whilst each waste picker contributed $5 of unpaid labour to the municipality per month (Narayan and Chikarmane, 2013: 209). KKPKP went on to show that whilst the municipality was making these savings, workers themselves were having to bear the health costs of this unhealthy work. This information was used to advocate successfully for a municipally-funded health insurance scheme for the workers.

The Jan Arogya Programme (JAP), as the health insurance scheme is known, uses the services of a private insurance company, The New India Assurance Company. This has developed a scheme specifically for the waste pickers. The premiums are paid by the PMC and cover workers (but not their families) for health costs up to a sum of Rs 5000 (just over $80) per annum. Workers can access treatment at public or private health facilities. KKPKP plays the role of intermediary between the workers, the insurance scheme, the municipality, and health service providers.[313] In a recent analysis of their health data, KKPKP found that since the introduction of the scheme there has been a "new trend in health care amongst waste pickers. They no longer neglect their ailments or hesitate to get themselves treated for illness."[314] The popularity of the scheme has also risen – in 2003 there were 3707 members insured under the policy; in 2013 that number had risen to 6673.[315] Yet there are some obvious problems with the JAP. According to KKPKP's analysis, the average hospitalisation bills

[312] Meeting Notes, WIEGO OHS Learning Meeting, Durban, South Africa, 4-6th May 2011.
[313] KKPKP. 2013. A Decade since Jan Arogya Programme. Unpublished note.
[314] *Ibid*.
[315] *Ibid*.

for its members amounted to Rs 11 880 ($192), which means that workers are still having to make a significant financial contribution to their health care over and above the JAP's benefits.[316] Larger hospital bills are a consequence of the fact that although private health facilities are "prohibitively expensive," workers prefer them because of the awful state of many public facilities. This, argues KKPKP, "is a telling indictment of private hospitals and the commercialisation of health care as well as of government hospitals which are no longer attractive to patients."[317] Another problem with the scheme is that it does not include family members. If the children of waste pickers fall ill and they have to take time off from work, the JAP does not provide any form of financial relief.

The JAP suffers from the same problems as Lloyd George's workers' health insurance scheme in Britain which drove Percy Selwyn-Clarke into the Colonial Medical Service (see Chapters Four and Five), and it reflects a tension which exists in the present-day activism of informal worker organisations. KKPKP won the JAP on the basis of their members' status as workers. It was this powerful argument, centred on the economic contribution of waste pickers, which gained them their victory. Yet this argument has also *limited* the concessions that they have gained – it is a scheme for those who contribute alone. KKPKP are aware of this contradiction. In its analysis of 10 years of the JAP scheme, their official conclusion is "that publicly funded private health insurance schemes can at best be an interim measure and can never substitute for universal public funded primary, secondary, and tertiary care to all citizens."[318] In India at least, there is now a movement towards this through the work of the HLEG. There is also a state with enough resources to provide it. The reality in many other poorer countries of the Global South is that work-based entitlements to health care are likely to have to be an important contributor to overall health provision for the foreseeable future.

This fact brings into focus (again) the problem of obtaining work-based entitlements to health care for informal workers who have no recognisable employer, and who cannot be linked into a value chain in any direct manner. KKPKP has addressed this very creatively by establishing a line of responsibility between the municipality and the waste pickers as a "proxy employment" relationship. The municipality is, however, a public institution. The question remains as to how to draw capital into such arrangements. This is something that KKPKP has tried to address in a creative manner through one of its OHS campaigns. Extended Producer Responsibility (EPR) is a concept which has emerged out of the environmental movement and was codified into law for the first time in India through new plastic regulations introduced in 2010. EPR places the onus for recycling or responsibly

[316] *Ibid*.
[317] *Ibid*.
[318] *Ibid.*

disposing of a manufactured product at the end of its life onto the manufacturer of the product. It is an attempt to force manufacturers to take on responsibility for the environmental impact of their products. SWaCH have started to use the EPR concept as a way in which to benefit workers as well. EPR is a controversial topic in the broader global waste picking community because it can be used to limit access to waste. In Uruguay for example, a municipal authority adjacent to the capital city of Montevideo has developed a scheme jointly funded by the Chamber of Commerce which channels dry waste materials from companies to a sorting shed where waste pickers are paid a wage to sort through and recycle waste.[319] Although this is clearly a beneficial relationship for the waste pickers involved, the scheme benefits only about 20 workers, with many more now excluded from the waste stream and their means of making a living.

SWaCH has tried to reinterpret EPR as a beneficial concept for waste pickers in terms of improving their occupational health conditions. One of the biggest (and most unpleasant) health hazards faced by waste pickers are the large numbers of used sanitary pads and baby diapers with which they come into direct contact while sorting through waste.[320] Often these are uncovered and workers have no gloves. SWaCH, on the basis of EPR regulations, argues that the manufacturers of sanitary pads and diapers should take some responsibility for how their products are disposed of. In one campaign, the organisation's members dumped bags of used nappies at the gates of one of the manufacturers. In a less confrontational manner, SWaCH has now also started trying to negotiate with manufacturers to insert sanitary disposal bags into packets of sanitary pads and diapers. They themselves have developed environmentally friendly "ST-Dispo Bag," made by retired waste pickers, which they hope the manufacturers will adopt. So far there has been some success with the campaign – a positive meeting between SWaCH, Maharashtra State officials, and representatives from a large manufacturer took place in 2013. The campaign has however stalled because of a lack of engagement by the provincial government and the manufacturers.[321]

In wider terms, SWaCH's campaign is not only interesting because of its creativity and the obvious ways in which it will benefit waste pickers, but also because it is an attempt to think about capital's responsibility for workers' health. It does this not through the state itself (although through the passing of the Plastic Rules the state has created an enabling environment for the campaign), but by making a more direct approach to capital. The campaign manages draws a direct line of responsibility between self-employed informal workers and large formal capital, something which

[319] Personal observations, WIEGO staff field trip, Uruguay, 24th October 2013.
[320] WIEGO OHS Newsletter, October 2012. Available at: http://wiego.org/ohs/ohs-newsletter-october-2012.
[321] Personal communication with Poornima Chikarmane, KKPKP, 23rd November 2013.

the much more established fair and ethical trade movement has struggled to do. Whether the campaign succeeds or not is still in question. Yet its very existence as a concept is an important challenge to a status quo where the line of responsibility between capital and workers is becoming increasingly blurred.

The Ghana Trades Union Congress, the StreetNet Ghana Alliance, and the Ghana National Health Insurance Scheme

In Ghana the organisation of informal workers has operated differently from that in India. As discussed in Chapter Three, urban market trader associations dominated by women were developed during the colonial period largely based around commodity groupings (Clark, 2010). This structure was encouraged by the colonial authorities because it made the management of markets easier to deal with, and the structure has remained in place to the present day. Within a given market there are several commodity associations operating. Each commodity association is governed by an executive as well as a commodity "queen." The commodity queens also sit on a market executive, out of which is nominated an *Ohemaa* (Queen Mother, who is queen of the market). The queens are not elected democratically – they assume their position because of their existing connections and resources, so the market queen is likely to be one of the most well connected and wealthy traders within the market. This has obvious advantages and disadvantages. The queen's political connections can ensure that resources flow towards the market (Prag, 2010). It also means that power is highly concentrated in a few individuals, who are not always necessarily concerned with the greater good,[322] and that the fortunes of particular associations and markets depend on the government of the day. These commodity associations are also not worker associations in the same way that SEWA and KKPKP are worker associations. Their focus is largely on controlling trade within each market – determining who is and who is not allowed to trade – and on welfare activities. Queens often become queens because they have the resources to contribute to funeral and wedding costs of the association members. Some of the associations also have an entrepreneurial focus, although these are often business associations more likely to be run by men.

[322] A very clear example of this is the story of a blocked drain in Makola Market in Central Accra. The drain is horribly clogged and filled with stagnant water and debris which causes a terrible smell in the textile section of the market, as well as flooding during the rainy season. The drain is clogged because a powerful, well-connected queen has given permission for a market stall to be built over the drain. The Accra Metro's Environmental Heath Officers, although acknowledging the health hazard, were unwilling to challenge the queen because of her powerful political connections (Alfers and Abban, 2010: Focus Group Research Reports for WIEGO Occupational Health and Safety Project, Accra).

Aside from the commodity associations, there are many other types of associations operating in almost every sector of the economy. These associations vary in their strength and purpose, and are often locally based. There are associations for Kayayei (a word derived from the Hausa word "Kaya" – to carry – and the Ga word "Yei" meaning women or girls) who are the women and girls who travel down from the poor northern regions of Ghana to work as headload porters for market women and their customers. The poverty of the members, and their need for protection in an environment where they have few connections, means that these associations are often oriented towards welfare concerns.[323] There are also associations of street vendors and hawkers. These workers operate on the fringes of markets, or in informal market areas, or on the side of roads, selling their wares as they weave between traffic. They tend to be poorer than market traders who are better established and can afford to rent market stalls, but are more likely to be better off than the Kayayei. It is these traders who often bear the brunt of urban legislation which does not recognise their right to operate as workers in public spaces. As a result they have a greater awareness of themselves as an organisation engaged in a struggle with the state; they have a welfare function certainly, but are also constantly battling evictions and confiscation of their goods which gives them more of a ''workerist'' orientation (Alfers, 2009). It is was street trader organisations which StreetNet International first approached in 2003 in an attempt to develop a national association of street trader organisations.

Launched in 2002, StreetNet International now has over 40 affiliated organisations of street vendors, market traders, and hawkers drawn mainly from Latin America, Asia, and Africa.[324] SEWA and the National Alliance of Street Vendors in India (NASVI) are members of the organisation. The international conventions and meetings held by StreetNet International have allowed organisations from countries like Ghana to interact with SEWA members on a regular basis. In conversations with leaders of the Ghanaian affiliate – the StreetNet Ghana Alliance (SGA)[325] – a very clear admiration for SEWA's work was displayed.[326]

It is, however, questionable as to whether SEWA's model can ever work outside of India, where the Gandhian "glue" that holds SEWA together is absent (Devenish and Skinner, 2004). Self-employed informal workers are difficult to organise for a number of reasons. Competition for space and market

[323] Initial Research Report on status of Kayayei in Accra by Dorcas Ansah, WIEGO Accra City Coordinator, August 2011.
[324] www.streetnet.org.za
[325] SGA changed its name to the International Vendors and Hawkers Association of Ghana (IVHAG) in 2013. When this research was conducted the organisation still operated under the name of SGA, and it is this name that will be used.
[326] Interview with Juliana Brown Afari, International Coordinator, StreetNet Ghana Alliance, 10th March 2009.

share leads to divisions, as does the relative isolation of homebased workers (Sanyal, 1991). In Ghana specifically the system of queens and commodity associations keep traders divided between insiders and outsiders – often the most visible division is between those in the markets and those operating outside of the markets. As mentioned earlier there are also collusive relationships between queens and local authorities, which may provide some benefits, but do not necessarily lay the foundation for an independent, democratic organisation of traders. Kate Meagher's (2010) work on men in informal manufacturing clusters in Nigeria showed that these tensions and divisions can be exacerbated under conditions of economic stress. The influx of new operators places strain on existing organisational structures, poorer operators are less likely to be able to afford membership levies and fees, and leaders are more likely to enter into "cliental and collusive ties with officials and more powerful organisations" (Meagher, 2010: 57).

These tensions exist within the SGA, which is at present an alliance of five trader organisations including both market traders and street vendors. The organisation was originally set up to provide a challenge to the system of market queens, and in doing so to create a more unified alliance of informal workers who could launch effective protest and negotiation actions. It has not been wholly successful in achieving these aims; the organisation has remained under the control of a single group of relatively powerful (and politically partisan) market traders whose political strategies have not always been in the interests of the organisation as a whole. Yet woven into the organisation's fabric are important threads. The idea of an alliance which crosses commodity associations and locations is an important one, which cannot be dismissed if an effective movement of informal workers is to emerge in Ghana. The SGA's street vendor affiliates in particular are themselves well-functioning democratic organisations, who have long been engaged in local actions to protect members from local government initiated eviction actions, and who have begun pushing the organisation as a whole to reform towards a more democratic model. Through its international networks, the SGA has also managed to access support from organisations such as WIEGO, and, together with worker associations from other sectors of the informal economy, has pursued some interesting strategies, particularly in their health activism. These strategies have not necessarily created large-scale change in the way SEWA's work has done, but they give some indication of potential pathways for worker activism in the future, and also highlight pitfalls which such groups may encounter.

One way that StreetNet International as a whole has approached informal worker activism has been by linking formal trade unions with informal worker organisations. This has been a conscious strategy to strengthen the worker focus of informal worker organisations, and to strengthen the

workers' movement as a whole by attempting to unite the working class with the reserve army against global capital. Dan Gallin, former Secretary General of the International Union of Food, Agricultural, Hotel, Restaurant, Catering, Tobacco, and Allied Workers (IUF), has been one of the major supporters of this linkage from the side of formal labour. In a 2001 paper he argued that organising workers in the informal economy needed to become a priority for the formal labour movement for several reasons: that the informal economy, contrary to Arthur Lewis's dual sector economic model which assumed that surplus labour would ultimately be absorbed by the industrial sector as development progressed, is not likely to be absorbed into the formal economy and that it is in fact growing whilst the formal economy is shrinking; that the growth in the informal economy and shrinking of the formal are linked trends; and lastly that consequently "the stabilisation of the formal sector organisations and building trade union strength internationally depend on the organisation of the informal sector" (Gallin, 2001: 531).

In Ghana a relatively long-lasting and strong relationship has developed between informal workers and the formal worker movement in the form of the rejuvenated GTUC. SEWA's experience over the years has been that informal workers are not automatically accepted by formal trade unions, which often view informal workers as a threat to their hard won labour rights, and that the ILO would rather see them placed in the employers' camp as self-employed "entrepreneurs" (Bonner and Spooner, 2011). This has not been the attitude of the GTUC, which has instead seen the opportunity that informal workers represent. It became the first union federation in the world to formally accept membership from informal worker associations. The SGA is an affiliate of the GTUC, as are several other informal worker organisations ranging from taxi drivers and musicians to hairdressers and *chop bar* operators (owners of informal restaurants serving local food). The author's numerous conversations with informal worker organisations in Ghana revealed a very strong appreciation for this affiliation; GTUC membership bestows a formality and a dignity to informal worker organisations – they are workers who belong to a fully recognised formal worker's organisation. In theory, membership also means that they are represented on all the national commissions on which the GTUC sits.

In many ways this moves makes sense from the GTUC's perspective. Numbers have been in decline since the slashing of public sector jobs under the Rawlings regime, and there is negligible (if any) growth in formal private sector jobs. Organising the informal sector is one way to keep numbers up. However, this is only one aspect of the GTUC's willingness to work with informal workers. Kofi

Asamoah, the current Secretary-General, stated that "*all* workers are workers,"[327] a statement that encapsulates the political idea that worker solidarity across the formal/informal divide is necessary to challenge the current status quo, as Gallin (2001) points out. If *all* workers were indeed extended meaningful rights, a capitalist system which requires an expendable and "flexible" labour force would be unable to continue to operate as it currently does. Yet, as mentioned earlier in the discussion of SEWA's work, there is a tension here between the ideal of universal workers' rights, and the specificity of informal workers' needs. Bridging this tension is not simple as the story of the GTUC, the SGA, and Ghana's National Health Insurance Scheme shows.

The NHIS is a "hybrid scheme" which is underpinned by the principles of social health insurance (funded through employer and employee contributions deducted from the payroll) and voluntary community-based health insurance (Alfers 2013). This model was specifically adopted so as to include informal workers whose contributions could not be obtained through payroll taxes. The scheme is intended then to be a universal one. It has been designed to introduce cross-subsidisation between formal workers and informal workers. The National Health Insurance Fund (NHIF), which re-insures and subsidises the "satellite" community based schemes, is funded in part through a 2.5 percent deduction on the contributions of formal workers and their employers to the SSNIT retirement scheme (this makes up 22.1 percent of the Fund's resources). The NHIF is also funded through a 2.5 percent VAT levy placed on all but essential goods (which makes up 72.2 percent of the Fund's resources), in order that informal workers also contribute to the fund (Alfers, 2013).

The NHIS is problematic for a number of reasons. Apoya and Marriott (2011) have argued that it is a deeply unfair scheme which essentially sees poorer people subsidise health care for those better off than themselves. All people in Ghana pay the VAT levy which contributes most significantly to the NHIF, but only those who can pay the annual premiums (which range from $10 to $32) can actually access the services. The scheme is also delinked from health provision itself, so that the bolstering of the primary health care system has not been a feature of this flagship health programme. Under-resourced public health facilities have struggled to keep up with the increased demand placed on them. There is a well-founded suspicion that the NHIS is in fact more about the public subsidisation of private health care than it is about extending truly universal health care to the citizens of Ghana (Alfers, 2013). However, for the purposes of this chapter, what is of particular interest is the way in which the NHIS has reinforced divisions between formal and informal workers rather than creating a bridge between them.

[327] Interview with Kofi Asamoah, Secretary-General, GTUC, 9th March 2009.

The scheme is governed by a National Health Insurance Committee (NHIC), which represents the interests of government, labour, and employers. However, only one position is reserved for a labour representative, and since the inception of the scheme that has been filled by the Secretary-General of the GTUC. In his capacity as labour representative the Secretary-General is meant to represent both formal and informal workers. However, the problem is that formal and informal workers have been placed in very different positions, even oppositional positions, to one another by the design of the scheme. For formal workers, there are two main issues of concern. First, they are losing a part of their pension savings to the scheme; second, they may lose their work based private insurance benefits if employers decide to transfer to the NHIS. These are not the problems informal workers themselves face. Their issues revolve around not being able to afford the costs of the scheme premiums, not having the time to deal with the scheme's cumbersome and inefficient registration procedures which have completely ignored the fact that most of Ghana's poor are also workers who lose income when waiting in long queues, and not having enough information about what the scheme is actually about (Alfers, 2013). Moreover, (in theory at least) informal workers stand to gain from the losses that formal workers incur on their pensions.

The question then arises as to how one individual is to represent effectively two very different sets of interests. Some of the issues could of course be dealt with simultaneously – arguing that scheme registrations for informal workers should be located in their places of work does not preclude one from arguing against the loss of work-related benefits for formal workers. On the issue of cross-subsidisation, however, there is a direct conflict of interest, and the unsurprising result has been that the GTUC has chosen to focus on the interests of its original constituency. In a conversation with a World Bank consultant, who sat on the planning commission and the NHIC, it was alleged that the GTUC had in fact done little to represent the interests of informal workers on the commission. In his view the GTUC had focused instead on challenging the cross-subsidisation from the SSNIT, ultimately gaining the concession that, in return for the SSNIT deductions, formal workers would be able to register with the scheme at no further cost.[328] There was no voice on the NHIC to challenge the fact that whilst poorer informal workers are contributing to the NHIF through VAT, they still have to pay an additional premium.

This has disappointed the informal workers who are affiliated with the GTUC and who see themselves as GTUC members. Focus group discussions on the NHIS with the leadership of the SGA

[328] Interview with World Bank consultant, January 2012, Bangkok.

revealed that the leaders felt that their interests had not been represented on the NHIC.[329] There were also other areas where support from the GTUC might have been helpful, but was lacking. The GTUC's OHS programme, for example, focuses almost entirely on formal workplaces and has done little to engage with local government and the institutions which govern the workplaces of many informal workers.[330] Partly this is a result of organisational structures; the GTUC's OHS desk falls under the organising division, alongside the women's desk and the informal economy desk. This sectioning off of women's interests and informal worker interests has organisational implications. It could be argued that these specific desks are necessary in order for these groups to get adequate representation and attention. However, it also means that these interests are not mainstreamed throughout the organisation – organising informal workers becomes a side-line business, whilst the "real work" remains focused on the small formal sector.

The informal worker organisations affiliated to the GTUC are aware of their marginal position within the organisation, and have started to fight for better representation. For example, in 2012 they insisted on their own representation at a GTUC national panel on the rising costs of basic services. Through a WIEGO Law Project, the GTUC has also become more interested in engaging with local government institutions in order to challenge unfair city bylaws which discriminate against informal workers. Yet the basic contradictions of trying to organise across the formal/informal divide remain. Andrae and Beckman (2010) argue that these contradictions, which stem from the fact that formal and informal workers (particularly those who are self-employed) occupy very different positions within the economy and are surrounded by very different institutional structures, mean that the primary business of trade unions should in fact remain with formal workers and the fight against labour flexibilisation, informalisation, and the downgrading of social policy. They argue that this does not necessarily mean that formal and informal workers should not collaborate on issues that affect them both, but ultimately informal workers need to develop their own forms of organisation and advocacy which better suit their position and needs.

From a purely pragmatic point of view, Andrae and Beckman (2010) have a good point. The NHIC is a good example of where formal workers could not adequately represent the interests of informal workers. The council should have another labour position to be filled by an informal worker representative. On the other hand, though, this has implications for a stronger workers' movement overall. It goes against the idea of a universalised workers' movement, which compromises "the

[329] Alfers, L. 2009. Field notes for a WIEGO study of the Ghana NHIS and barriers to access for informal workers.
[330] GTUC Handbook on Occupational Health and Safety.

edge" that the movement of informal workers has. This is recognised by informal workers themselves. Despite feeling let down by the GTUC, the SGA has remained firmly committed to its membership of the organisation.

Two different worker movements – one made up of traditional formal worker unions and one made up of informal worker organisations – opens up the idea of difference. This is not in and of itself necessarily a bad thing. The problem comes in when, in an attempt to cope with the very different institutional realities of informal work and with the different position informal workers occupy in the economy, governments start to downgrade workers' citizenship overall. The Ghana NHIS is an attempt to extend a form of social health insurance to informal workers. Formal workers have a scheme which is funded by joint contributions with employers. Informal workers, who are generally poorer, have a scheme to which they contribute via VAT, but which many are unable to gain access to because of the additional contributions required. At the same time processes of informalisation and dispossession continue, so that more and more workers are forced to rely on such downgraded schemes – schemes which additionally do little to bring any further contributions from capital, and which rely on already weak state structures. This again is the same problem SEWA faces with its push to integrate OHS into primary health care in India. Different institutional structures are necessary, but institutional reconfigurations also reconfigure the relationship between workers and capital. The challenge for informal worker organisations in particular is in ensuring that this reconfiguration is not to the detriment of workers in the long run. This does require an alliance with the formal trade union movement, who sit at the forefront of this type of activism. As the example of the NHIS shows, however, this can be very difficult terrain to negotiate.

Conclusion: Informal workers: What is being Gained? What is being Lost?

This chapter has shown that gains have certainly been made by organisations of informal workers, led particularly by the work of SEWA. These organisations are working actively (and sometimes successfully) at international, national, and local levels to bring ideas about work, workers, and the meaning of workers' health to a more inclusive understanding. Importantly, these gains have been both enabled and constrained by specific national and local level economic, health, and labour policies. This means that whilst it is certainly worthwhile to look at the more generalised international context in which these organisations operate, it is also necessary to understand the specific national and local context. From this perspective it becomes clear that the gains that are made, however impressive, are also often contextual, contingent, and precarious.

KKPKP's JAP health insurance scheme was negotiated for a specific group of workers. The scheme remains strong and there is no present danger from the PMC. At the same time it is not a scheme covered by legislation or supported by policy. It is the product of negotiation. It is not inconceivable that the PMC might one day change its mind and decide that it no longer wishes to support the waste pickers. For example, in the neighbouring municipality of Primpri Chinchiwad, where SWaCH had begun to operate, a change in policy by the municipal corporation to allow in privatised waste management companies has led to a collapse in the negotiated settlement between the PCMC and SWaCH. Similar stories of SEWA's victories and losses are recounted by Ela Bhatt (2006). Long processes of negotiation are easily derailed by corporate pressure on politicians and by changes in state policy – such as happened with the agreement to provide low cost drug dispensaries at municipal hospitals in Ahmedabad.

At the same time, it is possible to argue that some of the work done particularly by SEWA is managing to transcend the limits of these negotiated agreements. The fact that SEWA sits on the HLEG, which is currently at the forefront of efforts to transform the Indian health system into one which allows universal access to quality health care, is one such example. Here SEWA is contributing towards the development of policy that is universal in scope. The health system envisaged by the HLEG report goes far beyond the targeted approach of the RSBY, which covers the Below Poverty Line (BPL) population and certain specified groups of informal workers. Through its HLEG work it is possible to argue that SEWA is involved in the building of a new, more inclusive welfare compact than that which has existed at any time in India. Through its work at international level, for example on the WHO's Global Commission on the Social Determinants of Health, and the work it is doing to challenge scientific workplace disciplines, it is even possible to argue that it is contributing to a new inclusive *international* welfare compact.

Even then, though, important questions remain. If informal worker organisations are really to be at the forefront of forging a new welfare pact, they do require the political power to be able to determine the terms of engagement. This is difficult terrain to negotiate, particularly because, despite the fact that the formal economy is so small, political power is becoming increasingly entangled with the power of large multinational corporations who more and more set the stage for capitalism globally and nationally. It has been said that even SEWA, with all of its influence in India, is consulted by the Indian government not because of its political weight, but because of its technical ability to extend social programmes to the poor on the ground.[331] There is a worry that this may in

[331] Interview with the International Coordinator of StreetNet International, 24th September 2014.

turn affect SEWA's mission – that it encourages it to become a technical organisation rather than one with an important economic and political vision.[332] Whilst a certain amount of political power can be leveraged through formal trade unions, as the example from Ghana shows, this is again difficult terrain to negotiate, and formal trade unions themselves are less politically powerful than they once were. There are also questions about SEWA's replicability in the rest of the world – whether a global movement of SEWA-type organisations is actually possible, creating strength in numbers on an unprecedented scale, or whether the particular context of India allows for organisations which cannot exist in other countries.

Moreover, as Breman (2003) has pointed out, it is difficult to think about a new welfare compact under current economic conditions, where the state has been cut back so dramatically and is intertwined with capital in such a way that workers' rights are not a priority. Relatively small organisations cannot take the place of the state. Without a strong state to regulate legal controls and monitor enforcement, it is difficult to think of how a truly universal health system could work. SEWA is managing to make inroads into the provision of state *benefits* at scale, but as it itself admits, it is less able to make large-scale gains against the economic processes which continue to promote informalisation and threaten the incomes of workers who make their living at the margins. Its recommendation to integrate OHS into primary care is partly about pragmatism, but it is also partly a result of the fact that SEWA does not have a strong purchase on the Labour Ministry. This begs the question posed by Lund: what "edge" does a worker's organisation have if it cannot fight specifically for workers' rights as workers, as economic agents, as people connected with the economic processes which surround them?[333] Further complexity is added to this question when considering the underlying tension that exists in informal worker organisations themselves between the particular and the universal – between addressing their members' particular needs as they exist at present, which may require a compromise of sorts, and the longer term project of economic redistribution.

Nevertheless, there are of course many innovative ways in which organisations like SEWA, KKPKP, and the SGA continue to fight successfully for wider social and economic justice, even though their victories may be small and contingent. KKPKP's use of EPR is one example, as are SEWA's myriad of sector-specific agreements which compel sub-contractors to increase piece rates and contribute to health and welfare funds for workers. Then there are the very real gains that so many women

[332] *Ibid.*
[333] Meeting Notes, WIEGO OHS Learning Meeting, Durban, South Africa, 4-6th May 2011.

workers make as individuals through their membership of these organisations; the self-esteem, as well as the sense of worth and purpose that both SEWA and KKPKP foster amongst those who have led the most difficult lives is inspiring. These cannot be simply written off because of the constraints of structural conditions. Moreover, if history tells us anything, it is that society does not move in a straight line. A time may again arrive when structural conditions are more favourable to the interests of workers. The movement of informal workers is still young; SEWA has only been in existence for 43 years. It took many more years than this for the formal trade union movement to make the gains that it did under the welfare compacts of the post-World War Two era.

Chapter Seven: Conclusion

Introduction

At its core, this study has been an attempt to explore what is revealed – what tensions emerge, what new questions arise – when the worker is seen in relation to the citizen in discussions of health provision. In this way it is primarily a study in policy discourse rather than a history of policy as it plays out on the ground. It raises important questions about contemporary policy and about the political and economic paradigms on which health policy has been built. It also challenges the practice of analysing health policy from the perspective of the citizen-state relationship, arguing, following Lund (2009), that the employer-worker relationship is an important additional analytical component. This relational focus on the worker and the citizen is the original contribution to knowledge of this study, and a contribution to the call by Mackintosh and Tibandebage (2004) to add "methodological thickness" to the study of health policy and practice in the developing world. Particularly in the developing countries, ideas about social justice and human rights abound – yet as O'Neill (2005) argues, little attention is paid to the source of these rights and to questions about the responsibility for provision. It leads to arguments such as those by James Ferguson (2012), whose attempt to "historicize social assistance" in relation to informal workers is deeply flawed by his focus on social assistance as entirely an issue of citizenship, thereby missing the importance of work-related social provision, particularly in countries of the Global South where universal state provision was always an incomplete project.

In line with the above point, this study has been framed around four key questions: i) In relation to the terms of inclusion into health policies at present, how have we arrived at the place we have and why? What light does an understanding of historical processes shed on the current moment? ii) More specifically, how has the place of the worker changed in relation to the citizen within health policy in countries of the Global South over time, and what political and economic processes have underlain this shift? What implications do these shifts have for understanding present day policy changes? iii) What role have trade unions and other worker-based organisations played in the development of health policies and institutions? In particular, how and why have their activities affected (or not been able to affect) the shifting place of the worker in relation to the citizen within health policy? iv) How has the gendered definition of the worker and the citizen changed over time, and what implications does this have for our understanding of current institutional reconfigurations?

In order to answer these questions, the study has adopted an historical approach informed broadly by Marxist theory, and has explored a number of themes related to its main thesis, drawing largely on the specific country experiences of two ex-British colonies: India and Ghana, and the policies of key health related international organisations. Chapters Two and Three laid the foundations for the thesis as a whole by looking at the place of the worker, from a gendered perspective, in colonial health policies in the British Empire, with a specific focus on India and the Gold Coast. Chapter Four moved to the decolonisation and early independence period in both of these countries, and explored the central question of why occupational health signally failed to thrive in an environment that was potentially conducive to it, arguing that a lack of engagement of both workers to the discipline, and of the discipline to the realities of the world outside Europe and North America, was a central aspect of this. The chapter also focused on the political economy of the relationship between occupational and public/clinical health provision by large employers in developing countries. Chapter Five moved the study from the post-independence period to the present, focusing specifically on how the axes of the social democratic model (the state-citizen axis and the employer-worker axis) had been interpreted by three key international organisations – specifically the ILO, the WHO, and the World Bank – in relation to health policy. Chapter Six looked at how organisations of informal workers, largely dominated by women workers, are attempting to engage with the politics of health, and asked questions about the implications of their actions for wider health justice.

In this concluding chapter, an attempt is made to draw these threads together, to assess what has been learned, and to reflect on the debates that have arisen. Using health policy as a lens, and by keeping a gendered, and contextualised worker in view, the thesis has developed a critique of the concept of social citizenship and, in particular, the way in which social citizenship has come to be interpreted at present. This not a critique of social citizenship like that which has accompanied neo-liberalism – it is not concerned with the ways in which state "interference" causes market distortions. Neither is it a critique from the radical left, such as that from Carl Offe (1984) who argued that social citizenship was merely a means to pacify the masses. Neither is it a purely feminist critique which focuses on women's exclusion from economic rights (Orloff, 1993). Rather, it is a critique that is grounded in the realities of the Global South, specifically those countries which were colonised by Britain.

It is important to emphasise here that the point of this critique is not to conclude with a demonisation of the concept of universal social rights. The idea that the state should be a guarantor of a basic standard of living for its citizens is a foundation stone of social justice, and has been of

benefit to many, even when only partially realised. Rather, it is a critique that is ultimately supportive of the values underlying social citizenship, but argues that, in order for those values to be realised in a more inclusive manner, there is a need for greater cognisance of context, gender, and historical realities in the making of policy. Looking at citizenship rights in relation to workers' rights over time has allowed the author to look critically at the meaning and value of the concept of universal citizenship in a context different from that in which it developed, and to grapple with the tension between reality and ideas about "how reality should be." This has moved the thesis away from either an optimistic but reductionist story about the progressive march forward of universal citizenship, or its corollary, a pessimistic analysis of the failure of citizenship in the developing world – exactly the "methodological thinness" against which Mackintosh and Tibandebage (2004) argue. Importantly, too, if there is to be a coherent challenge posed to neo-liberalism, then this re-thinking of social citizenship needs to be accompanied by an approach which is able to combine flexibility and pragmatism, while at the same time not ignoring key social democratic principles.

The Critique of Social Citizenship

It is the central contention of this thesis that keeping the relationship between the worker and the citizen in view over a period of time allows for important insights to emerge into past and contemporary health policy which are otherwise lost or made obscure. In practical terms this has meant looking at the economic – both economic policy and the person as economic agent, i.e. the worker – and the social in terms of both policy and relationships, as well as looking at occupational health in relation to public health throughout the thesis. This method, however, has an additional nuance laid over it, through a gendered and contextualised analysis of the worker. Gender analysis here was used as a tool with which to unlock a deeper understanding of the context of workers in India and Ghana. In both of these countries there is, and always has been, large scale informal employment. Yet, as Claire Robertson (1988) has pointed out, labour history has tended to neglect this fact, focusing on the more widely documented stories of employment in large colonial enterprises.

A gendered analysis does not focus on women alone. Rather it seeks to expose the relationship between men and women, a relationship that is infused with power and that is both productive of and produced through social institutions such as the labour market and social and labour policy. In this thesis, this was used as a theoretical grounding which allowed the study to move beyond "exclusion," and to look as well at inclusion. Cooper (1996), for example, admits that the industrial worker, in the eyes of African colonial administrators, was a male worker. Women were largely excluded from the frameworks describing this world, positioning them in the ideal world of post-war

welfarism as home makers and mothers. Yet, he does not go further than this to look at what happened to women as a result of this exclusion. The ideal was always just that – an ideal. Reality was very different – women worked, but they worked in very different ways, ways which challenged the categories drawn up by British administrators. This thesis has attempted to go further than Cooper, looking not only at the male dominated world of formal employment, but also at the world of informal work, which has always made up a disproportionately large percentage of women's employment in both India and Ghana. By moving back and forth between the two worlds of work – the "male" and "female," the thesis has aimed to get a deeper analysis of context. It has also used this approach to unlock and draw out the tension between "reality" and "ideas about how things should be" – a tension which is threaded through the critique of social citizenship below.

The critique of social citizenship in this study emerges out of two key insights, which together form the basis of the critique. First, Chapter Four emphasised a tension within post-colonial health policy in India and Ghana, between the rhetoric of universal health provision and the reality that access to quality health services often remained tied to employment. The fact that this tension did not play out in exactly the same way in both countries, despite the common colonial heritage, is a testament to the very different economic, political, and social histories of these two countries. India's longer history as a British colony, its specific political configurations, and the timing of its independence meant that health provision was more firmly tied to employment through its Employee State Insurance Scheme (ESIS) than is the case in Ghana, where the relative exclusion of labour from political decision making, and the recommendations of the Maude Commission, meant that the country implemented a free universal health scheme funded through general taxation after independence. Nevertheless, workers in Ghana did have privileges that other citizens did not, especially in underserved rural areas where large concentrations of labour existed, such as in the mining areas where large corporations like Ashanti Gold provided medical services for workers and their families. Workers were also able to access social security and Workmen's Compensation which non-working citizens could not.

The visible contribution to welfare, made through work related provisions in newly independent countries like India and Ghana interacted in a complex way with the predominant thinking on welfare provision at the time. On the one hand, the welfare states of post-war Europe had been built on what Lund (2009) describes as a double axis, with a line of responsibility running between the state and the citizen, and another running between the employer and the worker. Whilst the state often took on the responsibility of administering health services, this would not have been possible

without the contribution of capital to a broader welfare pact. In the Bismarckian models of health provision, the state, employers, and workers contributed directly to a social health insurance fund. In the British model of health provision, the NHS was a state service, free to all, and funded through general taxation. Although employment was a less visible part of the NHS model, it was nevertheless important – the NHS could never have been funded without the assumption of full employment, and the level of tax income that this would generate. In this way, the "social" (health) and the "economic" (employment) were intertwined.

However, when it came to health policy in the developing world, this interdependence of health policy and employment concerns tended to be downplayed. In the post-colonial period, health as a universal right of citizenship came to be something that existed in and of itself, without real consideration of how that right was to realistically materialise. National policymakers on the ground perhaps had a more realistic understanding of the question of how to fund free universal health care with a small tax base and a limited budget, but international policymakers and experts, no doubt buoyed by the optimism and idealism of the time, seemed to pay these concrete questions less attention. The WHO, in particular, was an important force in pushing health as a universal right of citizenship into the domain of development. The fact that it was engaged in a turf war with the ILO as well, meant that it remained largely divorced from questions of employment, and the importance of work related health provision in contexts where the state's ability to provide was limited.

The failure of the WHO to engage fully with these difficult questions has led to some undoubtedly unintended consequences. The drive towards universal health care, whilst certainly having laudable aims, also provided an opportunity for large corporations operating in developing countries to "get out from under" their commitments to providing curative health services for workers and their families. The reports of the Conference on Industry and Tropical Health showed how firms like Standard Oil, the United Fruit Company, Firestone Rubber and Tyre Company, and others viewed their responsibilities in light of the WHO's assertion that health was a right of citizenship.[334] Here the relational analysis of public and occupational health was particularly important, as it was clear how occupational health had been turned into a potential bargaining chip by corporate executives, used as a justification for their shift away from providing curative health services. Participants at the Conference argued that the rightful duty of industry was to prevent ill-health amongst individual workers in the workplace, and not to provide expensive treatment centres for workers and their families. The latter was the duty of the state, as the WHO had made clear. The same logic was used

[334] WTA, Proceedings of the Conference on Industry and Tropical Health.

by General Sir Edward Spears, the Chairman of Ashanti Goldfields, when pressed by Nkrumah's government to provide housing for the mining group's workers. His reply that the Ghanaian government should provide housing for its citizens, "like any other government," was a direct reference to social citizenship and state responsibility.

These insights formed one aspect of the basis of the critique of social citizenship contained in this thesis. The second aspect emerged from the gendered, contextualised analysis of health and employment. The welfare state of Britain (and the social democratic model in general) was not only something which was developed in the specific context of post-war Europe, but at its foundation also contained definite assumptions about the social and economic roles of men and women. The transportation of social democratic principles and welfarist measures to India and Ghana during the decolonisation and post-independence period transported a set of assumptions about citizenship, as well as set of assumptions about gender which informed the shape of health policy and provision. These two sets of assumptions did not operate in isolation from one another. As Chapters Two and Three showed, the ideal worker was largely seen to be male (except in times of labour shortage), and, particularly as the colonial administrations began to implement liberal, welfarist reforms, women were largely positioned as mothers and carers, whilst their needs as workers were relatively ignored. Health programmes and policies played an important role in this by specifically excluding women from occupations considered unsafe or unhealthy, such as occurred in India's coal mining sector when women were banned from underground work. Concerns about reproductive health were often intertwined with these arguments, drawing on a productionist logic which privileged workers and future workers. Citizenship was for workers, and work was defined by gender. Gender therefore has to be an important consideration when questions of inclusion and extending health provisions to those previously excluded are evaluated.

Again the tension between ideas and reality is present here. Post-war welfarist health policies may have positioned women as mothers and carers relegated to the private sphere more often than they recognised them as workers, but the reality of women's lives, particularly poor women, was always very different from that ideal. Ivy Pinchbeck's (1930) work showed that this was as much the case for Britain's working class women as it was for women in the colonies. As Chapter Three pointed out, many women took part in economic activities during and directly after the colonial period – both because it was necessary for the survival of the family to do so in changing times, and sometimes, particularly in the case of Ghana, because it gave them a social status they otherwise would not have had. These women included the petty traders of Accra and Kumasi, so vividly described by Claire

Robertson (1988) and Gracia Clarke (1994), the miners, factory workers, plantation workers described variously by Bannerjee (1990), Lahiri-Dutt (2001) and Sen (1996; 1999; 2008). Further, as time went on and Indian women were increasingly excluded from these workplaces, the employees in small home based production units in India were described variously by Bhatt (2013) and Roy (2000).

The fact that so many women continued to work, despite their formal exclusion from the labour market, led to a closer examination of their situation. The analysis in Chapter Three moved in this way from an analysis which looked only at how health policies were implicated in the exclusion of women from formal workplaces (such as that described above for the case of India), to one which also looked at where women continued to work and how health policies related to them in that space. The Gold Coast here was used as an example. Unlike in India, women in the Gold Coast have never worked in any significant numbers in large colonial industries. They did, however, dominate urban petty trade. Working as these women did in urban public spaces, it was not labour health regulations which interacted with them in their roles as workers, but rather municipal health and sanitation regulations. Indeed, some of the only documentary evidence on the occupational health problems of market traders comes from Percy Selwyn-Clarke's municipal health and sanitation report on plague in Kumasi, where market women died in disproportionate numbers because of the food they stored in their homes which attracted plague-ridden rats.[335] Looking at points of inclusion then, the chapter points to a very different part of the state health apparatus than a perspective which focuses on exclusion alone.

The key point to be drawn from the above is one about categories. Social categories can emerge out of material reality, but they are also the product of ideals about what a society should look like. As Cooper (1996) argues, European colonial administrators, and their successors in the newly independent countries, drew on a particular template of how the world was to be organised when they designed social and labour policies in the post-war period. The world that was imagined by colonial administrators was much like the world from which they came. In this world, men worked in places like factories, offices, and shops, and women remained at home to care for the family. The social and labour institutions they put in place matched that imagined reality – not the complexity of work and social life on the ground. Working women in India and the Gold Coast crossed these categories doubly. Firstly, they were not only mothers and carers, but also economic agents.

[335] NAG ADM 14/1/44, Gold Coast Sessional Papers 1925-1926: Report on the Outbreak of Plague in Kumasi, Ashanti, Gold Coast Colony by P.S. Selwyn-Clarke.

Secondly, the places in which they operated as economic agents – streets, homes, marketplaces, and the homes of colonialists – defied the spatial and institutional categories laid down by labour, municipal, and social policies. Consequently they were either ignored by national governments and international organisations, or, because they were an inconvenient reminder of an ideal that remained unattained, they were actively persecuted.

In Chapters Five and Six these insights from the past were used to help to make sense of the present, and in doing so put forward a critique of social citizenship. This was done though a critical examination of the changing ideas about work and health that are part of what some have called the "post-neoliberal" era. These changes centre around "informal workers" – the previously ignored petty traders and home based workers. A question that is being asked by the ILO, the WHO, the Rockefeller Foundation, the World Bank, and others, is how to extend health protections, including OHS, to workers who work in unconventional workplaces and do not have clear employer-employee relationships. After a period of high neo-liberalism, where in many countries the only basis for entitlements to health care came from the ability to pay, the citizen and the worker are back on the global health agenda.

The reasons for this shift in thinking are diverse. The shift in global development discourse towards neo-liberalism after the 1978/9 oil crisis put an end to the era of import substitution based industrialisation and the promotion of social democratic style social policies in developing countries. Ironically, at a time when the idea of social citizenship began to come under pressure in the development discourse, progressive ideas about gender and work were starting to flourish. In 1970 the economic anthropologist Keith Hart had coined the phrase "informal sector" whilst working in Ghana to refer to the petty traders and others who worked in unconventional forms of employment. The phrase was taken on in the ILO's World Employment Programme Mission to Kenya in 1972. By 1982 the "informal sector" was making an appearance in the ILO programme budget, and the WHO began to think about how to extend OHS to these "underserved workers." There was a growing acceptance, particularly as globalisation proceeded and the informal economy started to grow rather than shrink, that governments and international organisations should think about informal workers. Around the same time, and particularly as the decade turned to the 1990s, questions were being raised about the economic contribution of women to society, and the concept of "women's economic empowerment" became an important development policy issue (Razavi, 2011). Both of these shifts in thinking have also contributed to the current movements in health policy which seek to extend health services to informal workers.

Some of the most prominent suggestions have come from the World Bank, which has strongly promoted the idea of extending social health insurance to informal workers, with the state subsidising the costs.[336] Other areas in which the informal worker has gained prominence is with regard to OHS and, particularly, the WHO's call for the integration of OHS into primary health care services. What is noticeable here, when the historical importance of the employment relationship is kept in mind, is how responsibility has shifted onto the state and away from capital. As Chapter Five argued, this is occurring in a context where state power, compared to the social democratic period, is weakening, where the power of global capital is strengthening, and where states are being asked to take on more and more responsibility for the provision of social services whilst at the same time having less and less ability to derive contributions towards these services from capital. Here the argument was that the current models of health provision erode the concept of employer contributions towards social welfare in favour of greater state-based provision.

This shift is particularly noticeable in the case of OHS. The original principle behind industrial or occupational health was that of "the polluter pays" – that capital had a responsibility to protect those whose health may suffer in the interests of profit by paying, over and above their general taxes, for preventive and protective measures in the workplace and by offering compensation to those who lost their health. Shifting OHS into primary health care undermines that principle – it means that citizens now have to foot the protective bill for those who make the profits. It is in fact reminiscent of the ways in which capital attempted to "get out from under" its commitments to general health service provision in the post-independence period. As Chapter Five argued, in this way new health policy configurations can be thought of less as "post-neoliberal" and more as a continuation of neo-liberalism, albeit in a gentler form. Here it is possible to discern the workings of Bakker and Gill's (2003: 30) concept of the "new constitutionalism," which refers to the ways in which neo-liberalism has reconstructed "the political and legal terms through which governance and accountability operate," so that new reforms are structured in such a way that fundamental neo-liberal principles remain unchallenged.

However, the problem is that these shifts tend to go unchallenged because of the way in which they are able to fit into the vision of both the left and the right. The argument for the integration of OHS into primary health care is not coming from World Bank economists. It is coming from public health

[336] Hsiao and Shaw. Social Health Insurance for Developing Nations. World Bank Institute Development Studies. 2007.

professionals and health justice advocates (Barten et al., 1996, Loewenson, 1998). Here there is an uncomfortable cleaving of left social justice positions, which have historically failed to give adequate consideration to employment concerns within health policy and provision, particularly in relation to developing countries, with a "post-neoliberalism" that looks to emphasise state responsibility over employer responsibility, even for services traditionally regarded as employer based. By not seeing the employment relationship as a concern within health service provision, those who analyse health policy from a left social justice position also do not see the shifting of responsibility away from capital and towards the state. It is only when the worker is kept in view that this problem emerges clearly, thereby demonstrating the value of this approach to the analysis of contemporary health policy.

Yet, and here is where the contextually grounded gendered analysis made in this thesis is important, this is not the whole story. As much as these reforms might be a manifestation of the new constitutionalism, they also come out of a strong critique of the social democratic model. This critique comes not only from the gendered analysis of welfare states and social policy, but also from a contextualised understanding of the labour market situation in countries outside of the Global North where, particularly for women, informal employment is high. This critique, which has come from academics as well as also from organisations of informal workers themselves, emphasises the need to re-think fundamental social-democratic notions of work, the worker, and the workplace, as well as the institutional configurations which have developed around them. This in itself though is contested terrain. On the one hand, the idea that informal workers are workers like any other workers has the potential to challenge neo-liberal ideas about the labour market. On the other hand, it is also a position which sits in tension with the left, social-democratic perspective that emanates from certain trade unions, which have tended to take the position that the only thing wrong with the social democratic welfare model was that it did not spread extensively enough. This of course ignores the fact that, as Cox (1977) argues, the post-war national and international welfare pacts were made possible through the exclusion of large numbers of workers outside the Global North.

In reality this debate plays out in complex ways when it comes to the political economy of health. Again, a good example here is the movement of OHS into primary health care. On the one hand this is a pragmatic response to a world of work where employment relationships are blurred, and the workplace crosses over into living spaces and public spaces. In this way the reform makes a lot of sense. It bypasses the need for an employer-employee relationship and a defined workplace – the foundations on which the labour regime is built, including health regulation. On the other hand, it

creates a difference between informal workers and formal workers – one that is not necessarily in the best interests of informal workers in the long run, and which erodes the "polluter pays" principle. Like the social health insurance model promoted by the World Bank, it has the potential to delink capital from any responsibility to contribute to the social good. This ignores the fact that the very reason that there are so many workers without health protections in the first place is the mobility of unrestricted capital and the attendant informalisation of labour.

The period of social democracy that emerged after World War Two inspired social and economic policies in developing countries which brought tangible benefits to the citizens of those countries. Health, education, and welfare indicators in many African countries, for example, improved at a rate much faster than previously seen in European countries undergoing social and economic transitions (Sender, 1999). Indeed, from the perspective of social justice, it is difficult to argue against the idea of state provided health care and education for all, good working conditions, and fair pay. Nevertheless, a contextualised, gendered analysis of social democratic ideals – and in particular those that underpin the provision of health services – brings up some hard questions. Is it actually possible to organise capitalism all over the world in this way, or is what Meagher (2013) calls the "downgrading of citizenship" the only realistic way that everyone can take a fair share of the global economy? If it is possible, how would one think about a social democracy that incorporates different contexts, but avoids a descent into relativism?

Reflections on the Future of Social Citizenship

It is of course difficult to provide hard and fast answers to the questions posed above. It has been the aim of this thesis to draw out these questions rather than answer them. Nevertheless, it is possible, drawing on the arguments made throughout this thesis, to add some substantive comments to the debate.

Firstly, whilst it is agreed that the involvement of the state in the provision of health services is the only way to reach "universal health coverage," it is damaging to the idea of social citizenship to advocate for universal provision without regard for social and economic context. An insistence that health care should be universally provided freely by the state is not unproblematic. In a country like India, where the state does have the resources to invest more heavily in health care, these arguments do need to made, even if the state looks unwilling to make these investments. In Ghana, which is smaller and poorer, it is also possible to argue this, particularly since the discovery of oil. It also has to be recognised, however, that the prevailing international policy environment, as well as internal national politics, mean that there is a long road ahead in terms of actually seeing this

happen. In the many smaller, poorer developing countries, it is much more difficult to see how this could feasibly work. Here there really is a need for pragmatism, particularly the kind of pragmatism that emerges directly from the needs of poor people.

SEWA's VimoSEWA scheme and its Lok Swasthya Cooperative, with their emphasis on self-reliance and the use of private insurance, is very far from the ideal. As discussed in Chapter Six, it has been criticised by those who see it as detracting from the push for universal health care in India. In practical terms however, it has provided much needed health services to over 120 000 poor working women during a time when the Indian government has all but ignored ignored health provision. Dismissing pragmatic choices such as this by informal workers as "the downgrading of citizenship" is not particularly helpful. As this thesis has attempted to show, this type of social citizenship has never really existed outside of the Global North. Purely ideological arguments about what the role of the state should be, in a context where the state can never or will not be that, turns the idea of social citizenship into something unrealistic and impractical. It hinders the search for meaningful alternatives which perhaps compromise on some of those ideals, but which ultimately have a realistic chance of reaching those who have been previously excluded.

On the other hand, as argued in Chapter Six, it is important not to slide into relativism, and an uncritical acceptance of the pragmatic over the idealistic. Questions should be asked of pragmatic solutions and the structural factors which determine what is pragmatic and what is not. There must also be a line against which the politics of pragmatism can be judged – about what is and is not just. Keeping the changing place of the worker in relation to the citizen in view has helped to define that line in this thesis. It has demonstrated how the large and powerful have continued to undercut their contributions to social welfare, and it has looked at how this trend has interacted with the pragmatism of informal worker organisations, as well as those advocates of social justice whose (a)historicism neglects the important place of the worker in social democratic state configurations.

What this means is that there is a two-fronted battle to be waged by those interested in seeing the emergence of a more inclusive understanding of social citizenship. The first of these fronts is a challenge to the left – to the advocates of universal citizenship and social justice, so that there is greater acknowledgement of the fact that work related social protections have been, and still have to be, an important contributor to national social protection, including health protection. Here workers' rights and economic justice have to be seen as indivisible from social justice and citizens' rights. The drive towards universal health coverage does not rule out, for example, pressure on large

corporations to provide health services to workers which can help to ease the burden on the state. An example of this from South Africa is the HIV and AIDS programme run by Anglo Gold, which has provided vital additional health services to mine workers. The alternative is, as Nancy Fraser (2009) points out, that social justice and economic justice become divided from one another, so that the social is privileged above the economic, and more responsibility is placed on the state, whilst capital remains free of obligation to contribute to the social good.

The second front is a challenge to the idea that work and employment should operate in the same way around the world. Employment has always been structured differently in India and Ghana, particularly for women, and likely always will. This difference being accepted does not automatically signify a downgrading of worker or citizenship rights. There are ways, as organisations like SEWA and KKPKP have shown, that working conditions can be improved, and social and labour protections can be provided to informal workers working in unconventional places of work. This brings up the third point, which is that this acceptance comes with a necessary rethinking of institutional forms inherited in the late colonial period. The importance of the local state, for example, in the regulation of workplace health and safety and the implications that this has for the structure of labour regulations is something that needs to be thought through seriously. The other challenge is to the right and is perhaps both easier and more difficult than the challenge to the left. It is easier because the target is more obvious – the continued informalisation of labour, and the downgrading of work related protections to suit the interests of capital. This is difficult because the power of global capital is strong.

The question then is who are and who should be the central actors in these struggles, and what possibilities are there for change. Whatever else, the present moment has opened up some possibilities for informal workers and questions of health reform. The danger, as this thesis has shown, is that those possibilities are being shaped in a way that does little to ultimately further the ends of social or economic justice. The way in which the new constitutionalism is able to adapt to its challenges without altering its core, means that, unlike colonialism, it is a very difficult hegemony to crack. Nevertheless, the fact that possibilities have opened up can also be interpreted optimistically as a sign of change, brought on, as Bakker and Gill (2003: 30) argue, by the “emerging contradiction between the global accumulation of capital and the provisioning of stable conditions for social reproduction.” Moreover, the shape of these openings has also been influenced by hard won arguments about the role of the informal economy and women’s economic roles.

Perhaps then the battle for now should be thought of as one which seeks to alter the shape of policy openings, to contest them where necessary, and to widen them where possible. As much as contestations on the ground are important in this regard, there is a central role for ideas here. In this regard the international organisations have a potentially important part to play. As both Deacon et al. (1997) and Béland and Orenstein (2013) have argued, and as Cooper (1996) showed in *Decolonization and African Society,* the international organisations have acted and continue to act as platforms for developing and transmitting ideas. In this way they have the potential to act as a space where the limits of the possible can be contested and reformulated. Of course, there are questions about the actual impact of the international organisations on the ground – about what difference the WHO and the ILO have actually made to national level policy. The ILO might have a Homeworkers Convention, but few states have actually ratified it. There is also the fact that international agencies find it difficult to provide the contextualised solutions which states and/or regional bodies can provide. Nevertheless, there is also ample evidence that these internationalised ideas can have an impact. The language of UHC, for example, which has been spearheaded by the WHO, is woven into the Ghanaian NHIS, and it is present as well in India's RSBY.

An important point to consider is the relative strength of the international agencies of the UN system, the organisations that were borne out of the social democratic, internationalist post-war spirit versus the World Bank and the large, philanthropic foundations like the BMGF and the Rockefeller Foundation. The UN organisations – in this case the ILO and the WHO – have struggled to define the international agenda in the neo-liberal world order and indeed have tended to confine any defiance to neo-liberalism to rhetoric rather than practical action. Certainly, part of the reason for this is that they have been undermined by a lack of resources in comparison to philanthropic organisations, as national budgets have tightened and donor spending has decreased (Garrett, 2007). There has, however, also been a failure by these organisations to assert an agenda that provides an alternative to the World Bank model. The WHO's UHC agenda, although reminiscent of Alma Ata, is a very watered down version of the earlier Alma Ata model. Its attempt at providing a flexible model is on the one hand an important concession to differing country contexts. On the other hand, it fails to draw solid boundaries around what can be considered a UHC scheme. This means that a scheme such as India's RSBY, where the state pays private insurance providers to insure those below the poverty line for in-patient care at tertiary hospitals, can be considered part of the "move towards UHC" in the same breath as Brazil's free primary health care system, funded through general taxation. Yet these are two very different schemes, with very different implications for health equity.

The ILO as well could be working more forcefully and creatively to think about a labour agenda for the 21st century. Its Decent Work programme has certainly put forward some fresh ideas – specifically the way in which it has experimented with the integration of labour regulation and municipal governance. However, it continues to have difficulty with integrating the concept of informal work into its tripartite structure. The difficulties in which the ILO finds itself in this regard are exemplified in the 2014/2015 ILC Discussion on "formalising the informal," which a cynic might argue is a delaying tactic so that the organisation does not have to deal with the integration of informal workers, something which will fundamentally change the nature of the ILO.

It also continues to push some problematic ideas about health, which have not substantively changed for many years. It has failed, for example, to grapple with the WHO model of integrating OHS into primary health care, instead trying to ignore it and carve out its own territory in ergonomics. Here there could have been interesting joint work to look at how capital might contribute to the system in order to bolster the primary health care system into which OHS could be integrated. For example, the ILO could support the idea of a Tobin tax or taxes on production, as suggested in Chapter Five. Even with ergonomics, there has been little in the way of combined action or thinking about how one would institutionalise ergonomically sound designs for informal workers through the state or through other mechanisms. Rather, it assumes that informal workers will bear the costs of this themselves. The "new" Global Social Floor promotes the idea of access to free primary health care, but does this on the basis of citizenship, with no mention of workers and the employment relationship other than to include informal workers alongside other vulnerable populations.

This critique of the WHO and the ILO shows that there are possibilities for change – change that can happen without having to make dramatic changes to the system of global capitalism. The organisations of the UN system are facing a crisis of relevance, and if they are going to face this successfully, they need to provide a stronger critique of neo-liberal ideas, as well as providing stronger and more coherent policy alternatives to those being presented now. Here it is also important that space is made for worker organisations to contribute to the debate. The tripartite structure of the ILO was a revolutionary idea in its time. As Cox (1977) argues, this structure has been used to entrench the privilege of a few, is a twisting of the original idea behind tripartism, which was to allow those with lesser voice an equal voice alongside the powerful.

Spaces have opened up for informal workers to participate as for example with the Homeworkers Convention, the Domestic Workers Convention (C189), and SEWA's acceptance at the ITUC after years of struggle. These spaces need to be protected and expanded where possible, because the exclusion of informal worker voices is not only questionable in terms of fairness, but it also means that the really innovative ideas that have been developed through long periods of struggle, that have emerged out of the everyday experiences of workers, and which are going to be a necessary part of any contest of ideas, are also excluded. Their exclusion also limits the possibilities for translating ideas into material realities. It is organisations of workers who will be the ones to push for reforms to be implemented at national and local levels: they will be the ones to challenge scientists to engage differently with the world of work, they will be the ones with an interest in a new universal "language of labour" that may one day, in a more conducive economic climate, be used to force a contradiction that does bring about actual change to the lives of the majority of the world's workers.

References

ABEL-SMITH, B. & TITMUSS, K. 1987. *The Philosophy of Welfare: Selected Writings of Richard M. Titmuss,* London and Sydney: Allen & Unwin.

ADDAE, S. 1996. *Evolution of Modern Medicine in a Developing Country: Ghana 1880-1960,* Durham: Durham University Press.

AGARWALA, R. 2013. *Informal Labor, Formal Politics, and Dignified Discontent in India,* Cambridge: Cambridge University Press.

AHN, P.-S. 2010. The Growth and Decline of Political Unionism in India: The Need for a Paradigm Shift. *DWT for East and South-East Asia and the Pacific.* Bangkok: International Labour Organisation.

AHUJA, R. 2007. Making the Empire a Thinkable Whole: Master and Servant Law in Transterritorial Perspective. *International Review of Social History,* 52: 287-294.

AKWETEY, E. O. & DORKENOO, D. 2010. Disengagement from Party Politics: Achievements and Challenges for the Ghana Trades Union Congress. *In:* BECKMAN, B., BUHLUNGU, S. & SACHIKONYE, L. (eds.) *Trade Unions & Party Politics: Labour Movements in Africa.* Cape Town: HSRC Press.

ALBO, G. 2005. Contesting the New Capitalism. *In:* COATES, D. (ed.) *Varieties of Capitalism, Varieties of Approaches.* London: Palgrave.

ALCOCK, A. 1971. *History of the International Labour Organisation,* New Jersey: Riverside Publishing.

ALEXANDER, P. 2007. Women and Coal Mining in India and South Africa, c1900-1940. *African Studies* 66 (2-3).

ALFERS, L. 2009. Occupational Health & Safety for Market and Street Traders in Accra and Takoradi, Ghana. *WIEGO OHS Research Report.* Cambridge, MA.: WIEGO.

ALFERS, L. 2013. The Ghana National Health Insurance Scheme: Barriers to Access for Informal Workers. *WIEGO Working Paper No. 30.* Cambridge, MA.: WIEGO.

ALFERS, L. & ABBAN, R. 2011. Occupational Health & Safety for Indigenous Caterers in Accra, Ghana. *WIEGO OHS Research Report.* Cambridge, MA.: WIEGO.

ALFERS, L. & LUND, F. 2012. Participatory Policy Making: Lessons from Thailand's Universal Coverage Scheme. *WIEGO Policy Brief No. 11.* Cambridge, MA.: WIEGO.

ALLMAN, J. 1994. Making Mothers: Missionaries, Medical Officers, and Women's Work in Colonial Asante, 1924-1945. *History Workshop Journal,* 38.

ALLMAN, J., GIEGER, S. & MUSISI, N. 2002. *Women in African Colonial Histories: An Introduction,* Bloomington and Indianapolis: Indiana University Press.

AMRITH, S. 2006. *Decolonizing International Health: India and Southeast Asia, 1930-1965,* London: Palgrave MacMillan.

AMRITH, S. S. 2011. Health in India Since Independence. *In:* BAYLEY, C., RAO, V., SZRETER, S. & WOOLCOCK, M. (eds.) *History, Historians & Development Policy: A Necessary Dialogue.* Manchester: Manchester University Press.

ANDERSON, W. 2000. The Third-World Body. *In:* R.COOTER & J.PICKSTONE (eds.) *Medicine in the 20th Century.* Amsterdam: Harwood Academic Publishers.

ANDERSON, W. 2006. *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Phillipines.* Durham and London: Duke University Press.

ANDERSSON, N. & MARKS, S. 1989. The State, Class and the Allocation of Health Resources in Southern Africa. *Social Science and Medicine,* 28(5): 515-530.

ANDRAE, G. & BECKMAN, B. 2010. Alliances across the formal-informal divide: South African debates and Nigerian experiences. *In:* I.LINDELL (ed.) *Africa's Informal Workers: Collective Agency, Alliances and Transnational Organizing in Urban Africa.* London & New York: Zed Books.

ANYEMEDU, K. 2000. Trade Union Responses to Globalization: Case Study on Ghana. *ILO Labour and Society Programme Paper DP/121/2000.* Geneva: International Labour Organisation.

APOYA, P. & MARRIOTT, A. 2011. Achieving a Shared Goal: Free Universal Health Care in Ghana. Oxford: ARHR, Essential Services Platform of Ghana, ISODEC, Oxfam.
ARNOLD, D. 1980. Industrial Violence in Colonial India. *Comparative Studies in Society and History,* 22(2): 234-255.
ARNOLD, D. 1993. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India,* Berkeley and Los Angeles: University of California Press.
ASHFORD, D. E. 1986. *The Emergence of the Welfare States,* Oxford & New York: Basil Blackwell.
AUGUST, A. 1999. *Poor Women's Lives: Gender, Work, and Poverty in Late-Victorian London,* London: Associated University Press.
AUSTIN, D. 1964. *Politics in Ghana: 1946-1960,* London: Oxford University Press.
AUSTIN, G. 2005. *Labour, Land and Capital in Ghana: From Slavery to Free Labour in Asante, 1807-1956*: Boydell and Brewer.
BAKER, R. A. & BAYLISS, R. A. 1987. William John Ritchie Simpson (1855-1931): Public Health and Tropical Medicine. *Medical History,* 31: 450-465.
BAKKER, I. 2007. Social Reproduction and the Constitution of a Gendered Political Economy. *New Political Economy,* 12(4).
BAKKER, I. & GILL, S. 2003. Ontology, Method, and Hypothesis. *In:* BAKKER, I. & GILL, S. (eds.) *Power, Production and Social Reproduction.* Basingstoke: Palgrave Macmillan.
BALLARD, R. 2013. Geographies of Development II: Cash transfers and the Reinvention of Development for the Poor. *Progress in Human Geography,* 17: 1-11.
BANGASSER, P. E. 2000. The ILO and the Informal Sector: An Institutional History. *ILO Employment Paper 2000/9.* Geneva: International Labour Office.
BANNERJEE, N. 1990. Working Women in Colonial Bengal: Modernization and Marginalization. *In:* SANGARI, K. & VAID, S. (eds.) *Recasting Women: Essays in Indian Colonial History.* New Jersey: Rutgers University Press.
BARDHAN, P. 1998. *The Political Economy of Development in India,* London: Oxford University Press.
BARRIENTOS, A. & WARE BARRIENTOS, S. 2002. Extending Social Protection to Informal Workers in the Horticultural Value Chain. *Social Protection Discussion Paper No. 0216.* Washington DC: World Bank.
BARTEN, F., FUSTUKIAN, S. & DE HAAN, S. 1996. The Occupational Health Needs of Workers: The Need for a New International Approach. *Social Justice,* 23(4): 152-163.
BARTRIP, P. 1985. The Rise and Decline of Workmen's Compensation. *In:* WEINDLING, P. (ed.) *The Social History of Occupational Health.* London: Croom Helm.
BARTRIP, P. 2002. *The Home Office and the Dangerous Trades: Regulating Occupational Disease in Victorian and Edwardian Britain,* Amsterdam and New York: Rodopi.
BARTRIP, P. & FENN, P. 1990. The Measurement of Safety: Factory Accident Statistics in Victorian and Edwardian Britain. *Journal of the Institute of Historical Research,* 63(150).
BATTACHARYA, S. 2006. Introduction. *International Review of Social History,* 51 (Supplement): 7-19.
BAUM, F., BÉGIN, M., HOUWELING, T. A. J. & TAYLOR, S. 2009. Changes not for the Faint Hearted: Reorienting Health Care Systems Towards Health Equity Through Action on the Social Determinants of Health. *American Journal of Public Health,* 99(11): 1967-1974.
BAUM, F. & SANDERS, D. 1995. Can Health Promotion and Primary Health Care Achieve Health for All Without a Return to Their More Radical Agenda?. *Health Promotion International,* 10(2): 149-160.
BAYAT, A. 2009. *Life as Politics: How Ordinary People Changed the Middle East,* Stanford: Stanford University Press.
BEBBINGTON, A. 2007. Social Movements and the Politicization of Chronic Poverty. *Development and Change,* 38(5): 793-818.
BEBINGTON, A. & HUMPHREYS BEBINGTON, D. 2011. An Andean Avatar: Post-Neoliberal and Neoliberal Strategies for Securing the Unobtainable. *New Political Economy,* 16(1): 131-145.

BECKMAN, B. & SACHIKONYE, L. 2010. Introduction: Trade Unions and Party Politics in Africa. *In:* BECKMAN, B., BUHLUNGU, S. & SACHIKONYE, L. (eds.) *Trade Unions & Party Politics: Labour Movements in Africa.* Cape Town: HSRC Press.

BEHAL, R. P. 2006. Power Structure, Discipline and Labour in Assam Tea Plantations under Colonial Rule. *International Review of Social History,* 51: 143-172.

BÉLAND, D. & ORENSTEIN, A. 2013. International Organisations as Policy Actors: An Ideational Approach. *Global Social Policy,* 13(2): 125-143.

BERRY, S. 1992. Hegemony on a Shoestring: Indirect Rule and Access to Agricultural Land. *Journal of the International African Institute,* 62(3): 327-355.

BHATT, E. 2012. Foreword. *In:* BALI, N., CHEN, M. A. & KANBUR, R. (eds.) *Bridging Perspectives: The Cornell-SEWA-WIEGO Exposure Dialogue Programme on Labour, Informal Employment and Poverty.*

BHATT, E. & JHABVALA, R. 2012. *The Idea of Work,* Ahmedabad: Indian Academy for Self Employed Women.

BHATT, E. R. 2006. *We Are Poor but So Many: The Story of Self-Employed Women in India,* Oxford: Oxford University Press.

BHATTY, Z. 1987. Economic Contribution of Women to the Household Budget: A Case Study of the Beedi Industry. *In:* SINGH, A. M. & KELLES-VIITANEN, A. (eds.) *Invisible Hands: Women in Home-Based Production.* New Delhi: Sage.

BIELER, A. & MORTON, A. D. 2004. A Critical Theory Route to Hegemony, World Order and Historical Change: Neo-Gramscian Perspectives in International Relations. *Capital and Class,* 28(1): 85-113.

BONNER, C. & SPOONER, D. 2011. Organizing in the Informal Economy: A Challenge for Trade Unions. *International Politics and Society,* 2(11).

BOOTH, D., CROOK, R. C., GYIMAH-BOADI, E., KILLICK, T., LUCKHAM, R. & BOATENG, N. 2005. What are the Drivers of Change in Ghana? *CDD/ODI Policy Brief No. 1.* Accra: CDD/ODI.

BOZZOLI, B. 1983. Marxism, Feminism and Southern African Studies. *Journal of Southern African Studies,* 9.

BREMAN, J. 2003. *The Labouring Poor in India: Patterns of Exploitation, Subordination and Exclusion,* Oxford: Oxford University Press.

BUDLENDER, D. 2011. Statistics on Informal Employment in Ghana. *WIEGO Statistical Brief No. 6.* Cambridge, MA.: WIEGO.

BULUT, T. & LANE, C. 2013. The Private Regulation of Labour Standards and Rights in the Global Clothing Industry: An Evaluation of Its Effectiveness in Two Developing Countries. *New Political Economy,* 16(1): 41-71.

CAREW, A. 1996. Conflict within the ICFTU: Anti-Communism and Anti-Colonialism in the 1950s. *International Review of Social History,* 41(2): 147-181.

CARRÉ, F. 2012. Personal and Technical Reflections on the Working Lives of Six Women in Ahmedabad, India, 2004. *In:* BALI, N., CHEN, M. & KANBUR, R. (eds.) *Bridging Perspectives: The Cornell-WIEGO-SEWA Exposure Dialogue Programme.* Cambridge, MA.: WIEGO.

CHATTERJEE, P. 1990. The Nationalist Resolution of the Women's Question. *In:* SANGARI, K. & VAID, S. (eds.) *Recasting Women: Essays in Indian Colonial History.* New Jersey: Rutgers University Press.

CHATTERJEE, P. 2008. Democratic and Economic Transformation in India. *Economic and Political Weekly,* 43(16): 53-62.

CHEN, M. 2012a. The Informal Economy: Definitions, Theories, Policies. *WIEGO Working Paper No. 1.* Cambridge, MA.: WIEGO.

CHEN, M. 2012b. Personal and Technical Reflections on the Working Lives of Six Women in Ahmedabad, India 2004. *In:* N.BALI, M.CHEN & R.KANBUR (eds.) *Bridging Perspectives: The Cornell-WIEGO-SEWA Exposure Dialogue Programme.* Cambridge, MA.: WIEGO.

CHEN, M. A. & RAVEENDREN, G. 2011. Urban Employment in India: Recent Trends and Patterns. *WIEGO Working Paper No. 7.* Cambridge, MA.: WIEGO.
CLARK, G. 1994. *Onions are My Husband: Survival and Accumulation by West African Market Women,* Chicago: University of Chicago Press.
CLARK, G. 2010. Gender Fictions and Gender Tensions Involving "Traditional" Asante Market Women. *African Studies Quarterly,* 11(2&3).
COHEN, J. 2006. The New World of Global Health. *Science,* 311: 162-167.
CONNELL, R. 1987. *Gender and Power: Society, the Person and Sexual Politics,* Redwood City: Stanford University Press.
CONSTANTINE, S. 1984. *The Making of British Colonial Development Policy, 1914-1940,* London: Frank Cass.
COOPER, F. 1987. *On the African Waterfront: Urban Disorder and the Transformation of Work in Colonial Mombasa,* New Haven and London: Yale University Press.
COOPER, F. 1994. Conflict and Connection: Rethinking Colonial African History. *American Historical Review,* 99: 1516-45.
COOPER, F. 1996. *Decolonization and African Society: The Labor Question in French and British Africa,* Cambridge: Cambridge University Press.
COOPER, F. 2002. *Africa Since 1940: The Past of the Present,* Cambridge: Cambridge University Press.
CORBRIDGE, S. & HARRISS, J. 2000. *Reinventing India: Liberalization, Hindu Nationalism and Popular Democracy,* Oxford: Polity Press.
COX, R. 1977. Labor and Hegemony. *International Organisation,* 31(3): 420-470.
CRISP, J. 1979. Union Atrophy and Worker Revolt: Labour Protest at Tarkwa Goldfields, Ghana, 1968-1969. *Canadian Journal of African Studies,* 13(1/2): 265-293.
CRISP, J. 1983. Productivity and Protest: Scientific Management in the Ghanaian Gold Mines, 1947-1956. *In:* COOPER, F. (ed.) *Struggle for the City: Migrant Labour, Capital, and the State in Urban Africa.* California: SAGE.
CRISP, J. 1984. *The Story of an African Working Class: Ghanaian Miners' Struggles 1870-1980,* London: Zed Books.
CROOK, R. C. 1986. Decolonization, the Colonial State, and Chieftancy in the Gold Coast. *African Affairs,* 85(338).
CURTIN, P. D. 1992. Medical Knowledge and Urban Planning in Colonial Tropical Africa. *In:* FRIERMAN, S. & JANZEN, J. M. (eds.) *The Social Basis of Health & Healing in Africa.* Berkeley: University of California Press.
DAMACHI, U. G. 1974. *The Role of Trade Unions in the Development Process: With a Case Study of Ghana,* New York: Praeger Publishers.
DANGERFIELD, G. 1935 (1961). *The Strange Death of Liberal England,* New York: Capricorn Books.
DARWIN, J. 1980. Imperialism in Decline? Tendencies in British Imperial Policy between the Wars. *The Historical Journal,* 23(3): 657-679.
DE BEER, C. 1984. *The South African Disease: Apartheid Health and Health Services,* Johannesburg: Southern African Research Service.
DE HAAN, A. 2013. The Social Policies of Emerging Economies: Growth and Welfare in China and India. *Working Paper No 110.* Brasilia: International Policy Centre for Inclusive Growth.
DE SWAAN, A. 1988. *In Care of the State: Health Care, Education and Welfare in Europe and the USA in the Modern Era,* New York: Oxford University Press.
DE WET, E. 1995. Labour Standards in the Globalized Economy: The Inclusion of a Social Clause in the General Agreement on Tarriff and Trade/World Trade Organisation. *Human Rights Quarterly,* 17(3).
DEACON, B., HULSE, M. & STUBBS, P. 1997. *Global Social Policy: International Organisations and the Future of Welfare,* London: SAGE.
DEATON, A. 2013. *The Great Escape: Health, Wealth, and the Origins of Inequality,* Princeton and Oxford: Princeton University Press.

DEFERT, D. 1991. 'Popular life' and Insurance Technology. *In:* BURCHELL, G., GORDON, C. & MILLER, P. (eds.) *The Foucault Effect: Studies in Governmentality.* Hertfordshire: Harvester Wheatsheaf.
DELLA PORTA, D. & DIANI, M. 2006. *Social Movements: An Introduction 2nd edition,* Oxford: Blackwell Publishing.
DEVENISH, A. 2014. *Being, Belonging and Becoming: A Study of Gender in the Making of Post-Colonial Citizenship in India, 1946-1961.* PhD Thesis, Oxford University.
DEVENISH, A. & SKINNER, C. 2004. Organising Workers in the Informal Economy: The Experience of the Self-Employed Women's Union, 1994-2004.
DOYAL, L. 1979. *The Political Economy of Health,* London: Pluto Press.
DOYAL, L. & GOUGH, I. 1991. *A Theory of Human Need,* London: Macmillan.
DRAINVILLE, A. C. 1994. International Political Economy in the Age of Open Marxism. *Review of International Political Economy,* 1(1): 105-132.
DU TOIT, A. 2005. Forgotten by the Highway: Globalization, Adverse Incorporation and Chronic Poverty in a Commercial Farming District. *CSSR Working Paper No. 101.* Cape Town: University of Cape Town.
DUMETT, R. E. 1993. Disease and Mortality Among Gold Miners of Ghana: Colonial Government and Mining Company Attitudes and Policies, 1900-1938. *Social Science and Medicine,* 37(2): 213-232.
ECKERT, A. 2004. Regulating the Social: Social Security, Social Welfare and the State in Late Colonial Tanzania. *The Journal of African History,* 45(3): 467-489.
ESPING-ANDERSON, G. 1990. *The Three Worlds of Welfare Capitalism,* Oxford: Polity Press.
EYBEN 2009. Choosing Words with Care? Shifting meanings of women's empowerment in international development. *Third World Quarterly,* 30(2): 285-300.
FERGUSON, J. 1990. *The Anti-Politics Machine: 'Development,' Depoliticisation and Bureaucratic State Power in Lesotho,* Cambridge: Cambridge University Press.
FERGUSON, J. 2007. Formalities of Poverty: Thinking about Social Assistance in Neoliberal South Africa. *African Studies Review,* 50(2): 71-86.
FERGUSON, J. 2012. What Comes After the Social? Historicizing the Future of Social Assistance and Identity Registration in Africa. *Proceedings of the British Academy,* 182: 495-516.
FLAX, J. 1987. Postmodernism and Gender Relations in Feminist Theory. *Signs,* 12(4): 621-643.
FRASER, N. 1989. Talking about Needs: Interpretive Contests as Political Conflicts in Welfare-State Societies. *Ethics,* 99(2): 291-313.
FRASER, N. 2009. Feminism, Capitalism and the Cunning of History. *New Left Review,* 56.
FREUND, B. 1981. *Capital and Labour in the Nigerian Tin Mines,* Harlow: Longman.
FREUND, B. 1988. *The African Worker,* Cambridge: Cambridge University Press.
FREUND, B. 2012. The South African Developmental State and the First Attempt to Create a National Health System: Another Look at the Gluckman Commission of 1942-1944. *South African Historical Journal,* 64(2): 170-186.
GALLIN, D. 2001. Propositions on Trade Unions and Informal Employment in Times of Globalisation. *Antipode,* 33(3): 531--549.
GARCIA, M. R. 1973. *Liberal Workers of the World, Unite? The ICFTU and the Defence of Labour Liberalism in Europe and Latin America (1949-1969),* Bern: Peter Lang.
GARRETT, L. 2007. The Challenge of Global Health. *Foreign Affairs,* 86(1): 14-38.
GERMAIN, R. D. & KENNY, M. 1998. Engaging Gramsci: International relations theory and the new Gramscians. *Review of International Studies,* 24(3): 3-21.
GLOBAL HEALTH WATCH. 2012. *Global Health Watch 3: An Alternative World Health Report*: The People's Health Movement, Medact, Health Action International, Medico International, Third World Network.
GLADSTONE, D. 1999. Welfare Before the Welfare State. *In:* GLADSTONE, D. (ed.) *Before Beveridge: Welfare Before the Welfare State.* London: Civitas.

GLENNERSTER, H. & EVANS, M. 1994. Beveridge and his Assumptive Worlds: The Incompatibilities of a Flawed Design. *In:* HILLS, J., J.DITCH & GLENNERSTER, H. (eds.) *Beveridge and Social Security: An International Retrospective.* Oxford: Clarendon Press.
GRAMSCI, A. 1971. *Selections from the Prison Notebooks,* London: Lawrence and Wishart.
GRIER, B. 1992. Pawns, Porters, and Petty Traders: Women in the Transition to Cash Crop Agriculture in Colonial Ghana. *Signs,* 17(2).
GUHA, R. 1997. *Dominance without Hegemony: History and Power in Colonial India,* Cambridge, MA & London: Harvard University Press.
GYIMAH-BOADI, E. & JEFFRIES, R. 2000. The Political Economy of Reform. *In:* ARYEETEY, E., HARRIGAN, J. & NISSANKE, M. (eds.) *Economic Reforms in Ghana: The Miracle and the Mirage.* Oxford: James Curry Ltd.
HARDT, M. & NEGRI, A. 2000. *Empire,* Cambridge, Mass.: Harvard University Press.
HARRIGAN, J. & YOUNGER, S. 2000. Aid, Debt & Growth. *In:* ARYEETEY, E., HARRIGAN, J. & NISSANKE, M. (eds.) *Economic Reforms in Ghana: The Miracle and The Mirage.* Oxford: James Currey Ltd.
HARRIS, J. 1992. Political Thought and the Welfare State 1870-1940: An Intellectual Framework for British Social Policy. *Past and Present,* 135: 116-141.
HARRISON, B. 1991. Women's Health or Social Control? The Role of the Medical Profession in Relation to Factory Legislation in Late 19th Century Britain. *Sociology of Health & Illness,* 13(4).
HARRISON, B. 1995. The Politics of Occupational Ill-Health in Late 19th Century Britain: The Case of the Match Making Industry. *Sociology of Health & Illness,* 17(1).
HARRISON, M. 1994. *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914,* Cambridge: Cambridge University Press.
HARRISON, M. & WORBOYS, M. 1997. A Disease of Citizenship. *In:* L.MARKS & M.WORBOYS (eds.) *Migrants, Minorities and Health: Historical and Contemporary Studies.* London and New York: Routledge.
HART, G. 2006. Denaturalizing Dispossession: Critical Ethnography in the Age of Resurgent Imperialism. *Antipode,* 38(5): 977-1004.
HART, G. 2013. *Rethinking the South African Crisis: Nationalism, Populism, Hegemony,* Scottsville: UKZN Press.
HARTMAN, H. 1976. Capitalism, Patriarchy and Job Segregation by Sex. *In:* M.BLAXALL & B.REAGAN (eds.) *Women and the Workplace.* Chicago.
HARVEY, D. 2010a. *A Companion to Marx's Capital,* London: Verso.
HARVEY, D. 2010b. *The Enigma of Capital and the Crises of Capitalism,* Oxford: Oxford University Press.
HAY, D. & CRAVEN, P. 2004. Introduction. *In:* HAY, D. & CRAVEN, P. (eds.) *Masters, Servants and Magistrates in Britain and the Empire: 1562-1955.* Chapel Hill and London: University of North Carolina Press.
HEINTZ, J. 2005. Employment, Poverty and Gender in Ghana. *PERI Working Paper Series No. 92.* Amherst: Political Economy Research Unit, University of Massachussetts.
HEINTZ, J. 2013. Informal Labour Markets, Employment and Economic Policy. *Guest Lecture.* Harvard Kennnedy School of Government.
HEINTZ, J. & RAZAVI, S. 2012. Social Policy and Employment: Rebuilding the Connections. *WIEGO Policy Brief No. 12.* Cambridge, MA.: WIEGO.
HENRIQUES, U. R. Q. 1979. *Before the Welfare State: Social Administration in Early Industrial Britain,* London and New York: Longmann.
HEWA, S. 1995. *Colonialism, Tropical Disease and Imperial Medicine,* Lanham: University Press of America, Inc.
HOBSBAWM, E. 1975. *The Age of Capital 1848-1875,* London: Phoenix Press.
HOBSBAWM, E. 1987. *The Age of Empire 1875-1914,* London: Weidenfeld & Nicolson.

HODGE, J. M. 2007. *Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism,* Athens: Ohio University Press.
HOLSTON, J. 2008. *Insurgent Citizenship: Disjunctions of Democracy and Modernity in Brazil,* Princeton: Princeton University Press.
HUMPHRIES, J. 1977. Class Struggle and the Persistence of the Working Class Family. *Cambridge Journal of Economics,* 1.
ILO/WIEGO. 2012. Statistical Update on Employment in the Informal Economy. Geneva: ILO.
INTERNATIONAL ORGANISATION OF EMPLOYERS. 2006. The Evolving Debate on Trade and Labour Standards. *IOE Information Paper.* Geneva: International Organisation of Employers.
JAIN, K. 2013. Health Financing and Delivery in India: An Overview of Selected Schemes. *WIEGO Working Paper No. 29.* Cambridge, Mass.: WIEGO.
JAMES, L. 1997. *Raj: The Making and Unmaking of British India,* New York: St Martins Griffin.
JAMES, R. 1958. Politics and Trade Unions in India. *Far Eastern Survey,* 27.
JEFFRIES, R. 1978. *Class, Power and Ideology in Ghana: the Railwaymen of Sekondi,* Cambridge: Cambridge University Press.
JEFFRIES, R. D. 1975. Populist Tendencies in the Ghanaian Trade Union Movement. *In:* COHEN, R. S. A. R. (ed.) *The Development of an African Working Class: Studies in Class Formation and Action.* London: Longman.
JONES, M. 2003. Tuberculosis, Housing and the Colonial State: Hong Kong, 1900-1950. *Modern Asian Studies,* 37(3): 653-682.
JOSHI, T. 2008. Industry Influence on the IAOH. *International Journal of Occupational and Environmental Health,* 14(2).
KABEER, N. 2012. Women's Economic Empowerment and Inclusive Growth: Labour Markets and Enterprise Development. *SIG Working Paper 2012/1.* London and Ottawa: DFID and IDRC.
KABEER, N., MILWARD, K. & SUDARSHAN, R. 2013. Beyond the Weapons of the Weak: Organizing Women Workers in the Informal Economy. *In:* KABEER, N., SUDARSHAN, R. & MILWARD, K. (eds.) *Organizing Women Workers in the Informal Economy: Beyond the Weapons of the Weak.* London & New York: Zed Books.
KANBUR, R. 2010. Macro Crises and Targeting Transfers to the Poor. *Journal of Globalization and Development,* 1(1).
KANBUR, R. 2013. Economic Inequality and Economic Development: Lessons and Implications of Global Experiences for the Arab World. *Second Annual Conference for the Social Sciences and Humanities, Arab Centre for Research and Policy Studies.* Doha.
KARLEKAR, H. 1998. 1947: The Route Through History. *In:* KARLEKAR, H. (ed.) *Independent India: The First 50 Years.* London: Oxford University Press.
KATZ, E. 1994. *The White Death: Silicosis on the Witwatersrand Gold Mines 1886-1910,* Johannesburg: Wits University Press.
KAVADI, N. 2007. Parasites Lost and Parasites Regained: Rockefeller Foundation's Anti-Hookworm Campaign in Madras Presidency. *Economic and Political Weekly,* 42(2).
KELMAN, J. H. 1923. *Labour in India: A Study of the Conditions of Indian Women in Industry*.
KIDAMBI, P. 2001. Housing the Poor in a Colonial City: The Bombay Improvement Trust, 1898-1918. *Studies in History,* 17(57).
KOIVUSALO, M. & OLLILA, E. 1997. *Making a Healthy World: Agencies, Actors and Policies in International Health,* London and New York: Zed Books.
KRAUS, J. 1979. Strikes and Labour Power in Ghana. *Development and Change,* 10(2): 259-286.
KRAUS, J. 1991. The Struggle over Structural Adjustment in Ghana. *Africa Today,* 38(4): 19-37.
LAHIRI-DUTT 2001. Gin Girls to Scavengers: Women in Raniganj Collieries. *Economic and Political Weekly,* 36(44): 4213-4221.
LATOUR, B. & WOOLGAR, S. 1979. *Laboratory Life: The Social Construction of Scientific Facts,* Beverly Hills & London: Sage.

LEVENSTEIN, C. & TUMINARO, D. J. 1997. The Political Economy of Occupational Disease. *In:* LEVENSTEIN, C. & WOODING, J. (eds.) *Work, Health and Environment: Old Problems, New Solutions.* New York, London: The Guildford Press.
LEWIS, J. 1992. Gender and the Development of Welfare Regimes. *Journal of European Social Policy,* 2(3): 159-173.
LI, T. M. 2007. *The Will to Improve,* Durham: Duke University Press.
LISTER, R. 1997. *Citizenship: Feminist Perspectives,* London: MacMillan.
LITSIOS, S. 1997. Malaria Control, the Cold War, and the Postwar Reorganisation of International Assistance. *Medical Anthropology,* 17: 255-278.
LOEWENSON, R. 1998. Health Impact of Occupational Risks in the Informal Sector in Zimbabwe. *International Journal of Occupational and Environmental Health,* 4: 264-274.
LONDON, L. nd. Occupational Health as a Human Right. *In:* NEWSLETTER, W. A. H. S. A. (ed.).
LONG, V. 2011. *The Rise and Fall of the Healthy Factory: The Politics of Industrial Health in Britain, 1914-1960,* London: Palgrave Macmillan.
LUMUMBA-KASONGO, T. 2001. United States' Legacy in Liberia. *In:* DIBIE, R. A. (ed.) *The Politics and Policies of Sub-Saharan Africa.* Lanham: University Press of America.
LUND, F. 2009. Social Protection, Citizenship and the Employment Relationship. *WIEGO Working Paper (Social Protection) No. 10.* Cambridge, MA.: WIEGO.
LUND, F. 2012a. Children, Citizenship and Child Support: The Child Support Grant in South Africa. *In:* SZRETER, S. & BRECKINRIDGE, K. (eds.) *Registration and Recognition: Documenting the Person in World History.* Oxford: Oxford University Press.
LUND, F. 2012b. Work-related social protection for informal workers. *International Social Security Review,* 65(4).
LUND, F. & MARRIOTT, A. 2011. Occupational Health and Safety For the Poorest. *WIEGO Working Paper No. 20.* Cambridge, MA.: WIEGO.
LUND, F. & SRINIVAS, S. 2000. *Learning from Experience: A Gendered Approach to Social Protection for Workers in the Informal Economy,* Geneva: International Labour Organisation.
MACDONAGH, O. 1958. The Nineteenth-Century Revolution in Government: A Reappraisal. *The Historical Journal,* 1(1): 52-67.
MACKINTOSH, M. & TIBANDEBAGE, P. 2004. Inequality and Redistribution in Health Care: Analytical Issues for Developmental Social Policy. *In:* MKWANDAWIRE, T. (ed.) *Social Policy in a Development Context.* Basingstoke: Palgrave Macmillan/UNRISD.
MANN, K. 1991. Women, Landed Property, and the Accumulation of Wealth in Early Colonial Lagos. *Signs,* 16(4).
MANUH, T. 1994. Ghana: Women in the Public and Informal Sectors under the Economic Recovery Programme. *In:* SPARR, P. (ed.) *Mortgaging Women's Lives: Feminist Critiques of Structural Adjustment.* London: Zed Books.
MARK-LAWSON, J. & WITZ, A. 1988. From 'Family Labour' to 'Family Wage'? The Case of Women's Labour in the Nineteenth-Century Coalmining. *Social History,* 13(2).
MARKS, S. 2000. Doctors and the State: George Gale and South Africa's Experiment in Social Medicine. *In:* DUBOW, S. (ed.) *Science and Society in Southern Africa.* Manchester: Manchester University Press.
MARKS, S. & ANDERSSON, N. 1987. Issues in the Political Economy of Health in Southern Africa. *Journal of Southern African Studies,* 13(2).
MARSHALL, T. H. 1965. *Class, Citizenship, and Social Development,* New York: Anchor.
MAUL, D. 2012. *Human Rights, Development and Decolonization: The International Labour Organisation, 1940-70,* Basingstoke: Palgrave Macmillan.
MCCOY, D., CHAND, S. & SRIDHAR, D. 2009. Global Health Funding: How Much, Where it Comes From and Where it Goes. *Health Policy and Planning,* 24(6): 407-417.
MCCULLOCH, J. 2007. Surviving Blue Asbestos: Mining and Occupational Disease in South Africa and Australia. *Transformation,* 65: 68-93.

MCDOWELL, L. 2008. Thinking Through Class and Gender in the Context of Working Class Studies. *Antipode*.
MCINTYRE, D. 2010. Private Sector Involvement in Funding and Providing Health Services in South Africa: Implications for Equity and Access to Health Care. *EQUINET Discussion Paper No. 84.* Harare: EQUINET.
MCINTYRE, R. P. 2008. *Are Worker Rights Human Rights?,* Ann Arbor: University of Michigan Press.
MEAGHER, K. 2010. The Politics of Vulnerability: Exit, Voice and Capture in Three Nigerian Informal Manufacturing Clusters. *In:* LINDELL, I. (ed.) *Africa's Informal Workers: Collective Agency, Alliances and Transnational Organizing in Urban Africa.* London & New York: Zed Books.
MEAGHER, K. 2013. Unlocking the Informal Economy: A Literature Review on Linkages Between Formal and Informal Economies in Developing Countries. *WIEGO Working Paper No. 27.* Cambridge, Mass: WIEGO.
MELLING, J. 2010. Beyond a Shadow of a Doubt? Experts, Lay Knowledge, and the Role of Radiography in the Diagnosis of Silicosis in Britain, c 1919-1945. *Bulletin of the History of Medicine,* 84: 424-466.
MELLING, J. & SELLERS, C. 2012. Objective Collectives? Transnationalism and "Invisible Colleges" in Occupational and Environmental Health from Collis to Selikoff. *In:* SELLERS, C. & MELLING, J. (eds.) *Dangerous Trade: Histories of Industrial Hazard Across a Globalizing World.* Philadelphia: Temple University Press.
MENON, S. 9 July 2014. India: Rajasthan's Labour Reforms - A Taste of Things to Come? *Equal Times*.
MESSING, K. 1998. *One-Eyed Science: Occupational Health and Women Workers,* Philadelphia: Temple University Press.
MILLS, C. 2008. The Emergence of Statutory Hygiene Precautions in the British Mining Industries, 1890-1914. *The Historical Journal,* 51(1): 145-168.
MITLIN, D. & SATTERTHWAITE, D. 2013. *Urban Poverty in the Global South: Scale and nature,* London and New York: Routledge.
MKWANDAWIRE, T. 2004. Introduction. *In:* MKWANDAWIRE, T. (ed.) *Social Policy in a Development Context.* Basingstoke: Palgrave/UNRISD.
MOHANTY, C. 1997. Women Workers and Capitalist Scripts; Ideologies of Domination, Common Interests, and the Politics of Solidarity. *In:* ALEXANDER, M. J. & MOHANTY, C. T. (eds.) *Feminist Genealogies, Colonial Legacies, Democratic Futures.* New York and London: Routledge.
MORAN, M. 2007. Philanthropic Foundations and the Governance of Global Health: The Rockefeller Foundation and Product Development Partnerships. *6th Pan European International Relations Conference.* Torino.
MORRIS, M. D. 1955. Labor Discipline, Trade-Unions, and the State In India. *Journal of Political Economy,* 63(4): 293-308.
MORTON, A. D. 2003. Social Forces in the Struggle over Hegemony: Neo-Gramscian Perspectives in International Political Economy. *Rethinking Marxism,* 15(2).
MORTON, A. D. 2013. Traveling with Gramsci: The Spatiality of Passive Revolution. *In:* M.EKERS, G.HART, S.KIPFER & A.LOFTUS (eds.) *Gramsci: Space, Nature, Politics.* West Sussex: Wiley-Blackwell.
NAKANO GLENN, E. 1992. From Servitude to Service Work: Historical Continuities in the Racial Division of Paid and Reproductive Labour. *Signs,* 18(1).
NANDA, B. R. 1998. Ghandi and Nehru: An Intertwined Legacy. *In:* KARLEKAR, H. (ed.) *Independent India: The First Fifty Years.* Oxford and Delhi: Oxford University Press and The Indian Council for Cultural Relations.
NARAYAN, L. & CHIKARMANE, P. 2013. Power at the Bottom of the Heap: Organizing Waste Pickers in Pune. *In:* KABEER, N., SUDARSHAN, R. & MILWARD, K. (eds.) *Organizing Women Workers in the Informal Economy: Beyond the Weapons of the Weak.* London & New York: Zed Books.

NELSON, B. J. 1990. The Origins of the Two-Channel Welfare State: Workmen's Compensation and Mother's Aid. *In:* GORDON, L. (ed.) *Women, the State, and Welfare.* Madison: University of Wisconsin Press.
O'CONNOR, J. S. 1993. Gender, Class and Citizenship in Comparative Analysis of Welfare State Regimes: Theoretical and Methodological Issues. *The British Journal of Sociology,* 44(3).
O'NEILL, O. 2005. The Dark Side of Human Rights. *Internatonal Affairs,* 81(2): 427-439.
OFFE, C. 1984. *Contradictions of the Welfare State,* London: Hutchinson.
OMVEDT, G. 1994. Peasants, Dalits and Women: Democracy and India's New Social Movements. *Journal of Contemporary Asia* 24(1): 35-48.
ORLOFF, A. S. 1993. Gender and the Social Rights of Citizenship: The Comparative Analysis of Gender Relations and Welfare States. *American Sociological Review,* 58(3): 303-328.
OVERÅ, R. 2007. When Men do Women's Work: Structural Adjustment, Unemployment and Changing Gender Relations in the Informal Economy of Accra, Ghana. *Journal of Modern African Studies,* 45(4): 539-563.
OVERÅ, R. 2011. Motivations, Challenges and Performances of Local Entrepreneurship in the Emergent Oil City Takoradi, Ghana. *4th European Conference of African Studies* Upssala.
PACKARD, R. 1989a. *White Plague, Black Labour: Tuberculosis and the Political Economy of Health and Disease in South Africa,* Berkeley and Los Angeles: University of California Press.
PACKARD, R. 1997. Visions of Postwar Health and Development and Their Impact on Public Health Interventions in the Developing World. *In:* COOPER, F. & PACKARD, R. (eds.) *International Development and the Social Sciences: Essays on the History and Politics of Knowledge.* Berkeley, Los Angeles, London: University of California Press.
PACKARD, R. M. 1987. Tuberculosis and the Development of Industrial Health Policy on the Witwatersrand, 1902-1939. *Journal of Southern African Studies,* 13(2).
PACKARD, R. M. 1989. The "Healthy Reserve" and the "Dressed Native": Discourses on Black Health and the Language of Legitimation in South Africa. *American Ethnologist,* 16(4): 686-703.
PACKARD, R. M. 1993. The Invention of the 'Tropical Worker': Medical Research and the Quest for Central African Labour on the South African Gold Mines, 1903-36. *The Journal of African History,* 34(2): 271-292.
PARKER, J. 2000. *Making the Town: Ga State and Society in Early Colonial Accra,* Portsmouth, Oxford, Cape Town: Heinemann, James Currey Ltd, David Phillips Publishers.
PATEMAN, C. 1988. *The Sexual Contract,* Cambridge: Polity Press.
PATTERSON, K. D. 1981. *Health in Colonial Ghana: Disease, Medicine, and Socio-Economic Change, 1900-1955,* Waltham: Crossroads Press.
PECK, J., THEODORE, N. & BRENNER, N. 2009. Postneoliberalism and its Malcontents. *Antipode,* 41(S1): 94-116.
PHILLIPS, A. 1989. *The Enigma of Colonialism: British Policy in West Africa,* London and Bloomington: James Currey, Indiana University Press.
PICKSTONE, J. 2000. Production, Community and Consumption: The Political Economy of Twentieth-Century Medicine. *In:* COOTER, R. & PICKSTONE, J. (eds.) *Medicine in the Twentieth Century.* Amsterdam: Harwood Academic Publishers.
PINCHBECK, I. 1930. *Women Workers and The Industrial Revolution,* London: George Routledge & Sons.
PORTER, D. 1997. The Decline of Social Medicine in Britain in the late 1960s. *In:* PORTER, D. (ed.) *Social Medicine and Medical Sociology in the Twentieth Century.* Amsterdam: Rodopi.
PORTER, D. 2006. Social Medicine and the New Society: Medicine and Scientific Humanism in mid-Twentieth Century Britain. *Journal of Historical Sociology,* 9(2).
PRAG, E. 2010. Women Leaders and the Sense of Power: Clientalism and Citizenship at the Dankopta Market in Cotonou, Benin. *In:* LINDELL, I. (ed.) *Africa's Informal Workers: Collective Agency, Alliances and Transnational Organizing in Urban Africa.* London and New York: Zed Books.

QUINLAN, M. 1997. The Toll From Toil Does Matter: Occupational Health and Labour History. *Labour History,* 73: 1-29.
RATHBONE, R. 2004. West Africa, 1847-1848: Employment Legislation in a Nonsettler Peasant Economy. *In:* D.HAY & P.CRAVEN (eds.) *Masters, Servants and Magistrates in Britain and the Empire, 1562-1955.* Chapel Hill and London: University of North Carolina Press.
ROBERTSON, C. 1983. The Death of Makola and Other Tragedies. *Canadian Journal of African Studies,* 17(3): 469-495.
ROBERTSON, C. 1988. Invisible Workers: African Women and the Problem of the Self-Employed in Labour History. *Journal of Asian and African Studies,* 23(1-2).
ROBERTSON, C. C. 1984. *Sharing the Same Bowl: A Socioeconomic History of Women and Class in Accra, Ghana,* Ann Arbor: The University of Michigan Press.
RODGERS, G., LEE, E., SWEPSTON, L. & VAN DAELE, J. 2009. *The International Labour Organisation and the Quest for Social Justice, 1919-2009,* Geneva: ILO.
ROSE, S. O. 1988. Gender Antagonism and Class Conflict: Exclusionary Strategies of Male Trade Unionists in Nineteenth-Century Britain. *Social History,* 13.
ROSEN, G. 1958. *A History of Public Health,* Baltimore and London: Johns Hopkins University Press.
ROSNER, D. & MARKOWITZ, G. 1991. *Deadly Dust: Silicosis and the Politics of Occupational Disease in 20th Century America,* Princeton: Princeton University Press.
ROY, T. 2000. *The Economic History of India 1857-1947,* Oxford: Oxford University Press.
ROYCHOWDHURY, S. 2003. Public Sector Restructuring and Democracy: The State, Labour and Trade Unions in India. *The Journal of Development Studies,* 39(3): 29-50.
SAID, E. W. 1979. *Orientalism,* London: Penguin.
SAINSBURY, D. 1999. *Gender and Welfare State Regimes,* Oxford: Oxford University Press.
SAMSON, M. 2010. Producing Privatisation: Re-articulating Race, Gender, Class and Space. *Antipode,* 42(2): 404-432.
SANDBROOK, R. 2011. Polanyi and Post-Neoliberalism in the Global South: Dilemmas of Reembedding the Economy. *New Political Economy,* 16: 415-443.
SANGARI, K. & VAID, S. 1990. Introduction. *Recasting women: Essays in Indian colonial history.* New Brunswick, NJ: Rutgers University Press.
SANTANA, V. S., IRIART, J., LUNAS, M., MARINHO, E., MOURA, M. J., CORREA, H. & LUND, F. 2011. Gathering Occupational Health Data from Informal Workers: The Brazilian Experience. *ICOH/GHS Conference on Occupational Healht & Safety in Small and Medium Enterprises.* Accra.
SANYAL, B. 1991. Organizing the Self-Employed: The Politics of the Urban Informal Sector. *International Labour Review,* 130(1).
SATTERTHWAITE, D. & MITLIN, D. 2013. *Reducing Urban Poverty in the Global South,* London and New York: Routledge.
SAUNIER, P.-Y. 2007. The ILO as Organizer: Shaping the Transnational Housing Scene in the 1920s. *ILO Century Project.* Geneva: ILO.
SCHILLING, R. 1998. *A Challenging Life: 60 Years in Occupational Health,* London: Canning Press.
SCHILLINGER, H. R. 2005. Trade Unions in Africa: Weak but Feared. *Occasional Papers: International Development Cooperation.* FES.
SCOTT, D. 1995. Colonial Governmentality. *Social Text,* 43: 191-220.
SCOTT, J. C. 1985. *Weapons of the Weak: Everyday Forms of Peasant Resistance,* New Haven: Yale University Press.
SEARLE, G. 1971. *The Quest for National Efficiency,* Oxford: Blackwell.
SEIDMAN, G. W. 2007. *Beyond the Boycott: Labor Rights, Human Rights and Transnational Activism,* New York: Russell Sage Foundation.
SELLERS, C. & MELLING, J. (eds.) 2012. *Dangerous Trade: Histories of Industrial Hazard across a Globalizing World,* Philadelphia: Temple University Press.

SEN, S. 1996. Unsettling the Household: Act VI (of 1901) and the Regulation of Women Migrants in Colonial Bengal. *International Review of Social History,* 41(S4): 135-156.
SEN, S. 1999. *Women and labour in late colonial india: The Bengal jute industry,* Cambridge: Cambridge University Press.
SEN, S. 2008. Gender and Class: Women in Indian Industry, 1890-1990. *Modern Asian Studies,* 42(1).
SENDER, J. 1999. Africa's Economic Performace: Limitations of the Current Consensus. *The Journal of Economic Perspectives,* 13(3): 89-114.
SENDER, J. & SMITH, S. 1986. *The Development of Capitalism in Africa,* London and New York: Methuen.
SHANBAG, S. 2008. Indian Association of Occupational Health Denies Industry Influence. *Indian Journal of Occupational and Environmental Medicine,* 12(2): 91-92.
SHANI, O. 2007. *Communalism, Caste and Hindu Nationalism: The Violence in Gujurat,* Cambridge: Cambridge University Press.
SMITH, G. A. 2011. Selective Hegemony and Beyond - Populations with "No Productive Function": A Framework for Enquiry. *Identities: Global Studies in Culture and Power,* 18(2): 2-38.
STAR-GHANA 2011. Political Economy of Ghana and Thematic Strategy Development for STAR-Ghana. DFID.
STURDY, S. 2000. The Industrial Body. *In:* COOTER, R. & PICKSTONE, J. (eds.) *Medicine in the 20th Century.* Amsterdam: Harwood Academic Publishers.
STURDY, S. 2002. Alternative Publics: The Development of Government Policy on Personal Health Care, 1905-11. *In:* STURDY, S. (ed.) *Medicine, Health and the Public Sphere in Britain, 1600-2000.* London & New York: Routledge.
SWANSON, M. 1977. The Sanitation Syndrome: Bubonic Plague and Urban Native Policy in the Cape Colony, 1900-1901. *The Journal of African History,* 18(3): 387-410.
TENDLER, J. 2004. Why Social Policy is Condemned to a Residual Category of Safety Nets and What to Do About It *In:* MKWANDAWIRE, T. (ed.) *Social Policy in a Development Context.* Basingstoke: Palgrave Macmillan/UNRISD.
THOMAS, R. 1973. Forced Labour in British West Africa: The Case of the Northern Territories of the Gold Coast 1906-1927. *The Journal of African History,* 14(1): 79-103.
TITMUSS, R. M. 1958. *Essays on 'The Welfare State',* London: George Allen & Unwin.
TITMUSS, R. M. 1970. *The Gift Relationship: From Human Blood to Social Policy,* London: LSE Books.
TITMUSS, R. M., ABEL-SMITH, B. & LYNES, T. 1968. *Social Policies and Population Growth in Mauritius: Report to the Governor of Mauritius,* London: Frank Cass and Co. Ltd.
TRACHTER, L. N. 1962. The Labour Movement of Ghana: A Study in Political Unionism. *Economic Development and Cultural Change,* 10(2, Part 1): 183-200.
VAN NIEKERK, R. 1999. *The Long and Winding Road: An Appraisal of the Health and Welfare System in South Africa and its Transformation.* PhD thesis, Oxford University.
VANEK, J., CHEN, M. A., CARRÉ, F., HEINTZ, J. & HUSSMANS, R. 2014. Statistics on the Informal Economy: Definitions, Regional Estimates & Challenges. *WIEGO Working Paper No. 2.* Cambridge, MA.: WIEGO.
VAUGHAN, M. 1991. *Curing their Ills: Colonial Power and African Illness,* Cambridge: Polity Press.
VOSKO, L. 2002. Decent Work: The Shifting of the ILO and the Struggle for Global Social Justice. *Global Social Policy,* 2(19).
WEINDLING, P. (ed.) 1985. *The Social History of Occupational Health,* London: Croom Helm.
WEINDLING, P. 1995. Social <edicine at the League of Nations Health Organisation and the International Labour Office Compared. *In:* WEINDLING, P. (ed.) *International health organisations and movements 1918-1939.* Cambridge: Cambridge University Press.
WHITEHEAD, J. 2013. Accumulation through Dispossession and Accumulation through Growth: Intimations of Massacres Foretold. *In:* M.EKERS, G.HART, S.KIPFER & A.LOFTUS (eds.) *Gramsci: Space, Nature, Politics.* West Sussex: Wiley-Blackwell.

WHITESIDE, N. 1999. Private Provision and Public Welfare: Health Insurance Between the Wars. *In:* GLADSTONE, D. (ed.) *Before Beverdge: Welfare Before the Welfare State.* London: Civitas.
WHO 2008. *The Third Ten Years of the World Health Organisation: 1968-1977,* Geneva: The World Health Organisation.
WILLIAMS, J. 2001. *Unbending Gender: Why Family and Work Conflict and What To Do About It,* London: Oxford University Press.

Appendix A: List of Interviewees

1. Asamoah, Kofi, Secretary-General of the Ghana Trades Union Congress. Interview conducted by the author on the 9th of March 2009 in Accra, Ghana.

2. Brown Afari, Juliana, International Coordinator, StreetNet Ghana Alliance. Interview conducted by the author on the 10th of March 2009 in Accra, Ghana.

3. Chatterjee, Mirai, Director, SEWA Social Security. Interview conducted by the author in June 2012, Bellagio, Italy.

4. Horn, Pat, International Coordinator, StreeNet International. Interview conducted by the author on the 24th of September 2014 in Durban, South Africa.

5. Patel, Jagdish, Executive Director, People's Training and Research Centre. Interview conducted by the author on the 5th of April 2013.

6. Seddoh, Anthony, World Bank Consultant seconded to the Ghana National Health Insurance Scheme. Interview conducted by the author in January 2012 in Bangkok, Thailand.

Appendix B: Archive Abbreviations

AIL	**Archive of Indian Labour**
BL	**British Library**
CCA	**Cambridge Churchill Archives**
ILOA	**International Labour Organisation Archives**
LSHTMA	**London School of Hygiene and Tropical Medicine Archives**
MRU	**Modern Records Unit, Warwick University**
NAG	**National Archives of Ghana**
RH	**Rhodes House, Oxford University**
TNA	**The National Archives, London**
WHOA	**World Health Organisation Archives**
WTA	**Wellcome Trust Archives**