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WORKERS' HEALTH IN THE REGION OF THE AMERICAS

Among its requests, Resolution CSP23.R14 of the 23rd Pan American Sanitary Conference (1990) urges the Member States to increase the development of different institutional workers' health care arrangements in order promote the attainment of universal coverage, soliciting the support of PAHO in this endeavor.

The situation analysis determined that there are major economic and social inequities in the labor sector that have an impact on workers' health, as well as a significant institutional vacuum, particularly in health care for workers in the informal sector, who constitute more than half of the work force.

In light of this problem, PAHO has structured its actions around a comprehensive approach that is preventive, multisectoral, and participatory in nature, within the context of socioeconomic sectoral development. It has prepared the Regional Plan on Workers' Health, which sets out specific programming lines for country action and international cooperation, optimizing the use of resources to improve workers' health in the countries.

The document outlines the situation and trends, the basic features of the Plan (including the expected results), the role of PAHO and the Member States, and the suggested initiatives, as well as the fields in which the principal external actors operate.

The Subcommittee is requested to analyze the approach of PAHO cooperation from the standpoint of the technical, economic, and political feasibility of the Plan and consider the role of PAHO and the countries in its implementation, offering its observations on possible changes and improvements that can be made.

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EXECUTIVE SUMMARY

There is currently a global consensus on the importance of workers' health as a key element for the equitable development and social and economic well-being of human beings. Recognition of the importance of the sustainable development model has renewed concern in international and regional forums, as well as the countries, about the situation of workers' health and the need to improve it.

The 23rd Pan American Sanitary Conference (1990) adopted Resolution CSP23.R14 on workers' health, urging the Member States to increase the development of different institutional workers' health care arrangements in order to promote the attainment of universal coverage and requesting the Director of PASB to support the initiative. Thus, workers' health has been included in the Strategic and Programmatic Orientations for PASB, 1999-2002.

The situation analysis of workers' health in the countries of the Region reveals major economic and social inequities in the labor sector, as well as a significant institutional vacuum at both the international and national level when it comes to addressing the problem of workers' health, particularly in the informal sector.

Responding to this situation, PAHO took the initiative and structured its technical cooperation activities in workers' health around an integrated, multisectoral, and participatory preventive approach. The result was the preparation of the Regional Plan on Workers' Health, which includes cooperation activities at the regional, subregional, and country level. The Plan has been conceived as a frame of reference and orientation that will enable the actors in the field of workers' health to operate with a common perspective, permitting synchronized country and international cooperation activities and optimum use of the available resources on behalf of the countries.

This document is presented to the Subcommittee to report on the workers' health situation in the Region, pointing out current inequities, and to present the comprehensive approach adopted by PAHO, whose concrete expression is the Regional Plan on Workers' Health. Table 1 summarizes the proposed activities and expected results.

1. Introduction

Workers' health has been a matter of growing concern in many countries and international organizations, including PAHO/WHO. In the 1990s, this concern has intensified, particularly after the recognition of the sustainable development model as a means for meeting basic needs, improving living conditions for all, offering better protection for ecosystems, and ensuring a safer, more prosperous future. Within this context, workers' health has been addressed directly or indirectly in international, regional, and national forums, and several institutions have taken action.

The Governing Bodies of PAHO have adopted specific mandates on workers' health. In 1990 Resolution CSP23.R14 of the 23rd Pan American Sanitary Conference, urged the Member States to increase the development of different institutional workers' health care arrangements in order to promote the attainment of universal coverage. The United Nations Conference on Environment and Development (UNCED, 1992) noted the need for protecting health and safety in the workplace. The International Labor Organization (ILO) has incorporated the concept of sustainable development in its policies. The United Nations Development Program (UNDP) has affirmed the concept of human development, noting that the real objective of development should be to create an environment that enables human beings to enjoy long, healthy, and creative lives.

The Hemispheric activity that began with the Summit of the Americas (Miami, 1994) recognizes the importance of workers' health. The Declaration of Principles of the Summit states that free trade and greater economic integration are key factors for improving working conditions and protecting the environment. More recently, WHO adopted Resolution WHA49.12 (1996), endorsing the World Strategy on Occupational Health for All. The Strategic and Programmatic Orientations for PASB, 1999-2002 include the priorities in workers' health for regional action. The XIII Meeting of the Health Commission of the Latin American Parliament, which met in São Paulo in November 1998, dealt specifically with the topic of workers' health. In a recent declaration, the Secretary General of the United Nations emphasized that ensuring safe and healthy work environments was a key consideration in all decisions on investment and production. He also emphasized the role of the United Nations system in developing standards, conducting research, providing technical assistance, and increasing the level of public awareness.[1] At the same time, the countries are making efforts to draft and execute national workers' health plans that address current needs.

In light of the above considerations, PAHO has analyzed the workers' health situation in the countries of the Region and has found major inequities. For example, the working-age population (WAP) (the population aged 15 to 64) in Latin America and the Caribbean has been estimated at 351 million for 1996, and the economically active population (EAP) at 201 million.[2] Some 55% of this latter population are employed in the

informal sector and 10% are farmers.[3] Only 30% of the working population in the formal sector of nine countries of the Region[4] receives health care, mainly through Social Security. Concerning wages, some 20% to 40% of the employed population has an income that does not cover the basic market basket.[5] Moreover, women receive lower wages than men for equal work.[6] Working children run addition risks in the workplace, due to their biology and social situation.[7]

Bearing in mind the mandates of the Governing Bodies and the current situation, which involves countless actors with limited and sometimes isolated objectives; the deficiencies in workers' health care, which reflect a significant institutional vacuum at the national and international; and the trends toward change, PAHO has designed an approach to workers' health care that is comprehensive, preventive, proactive, participatory, and coordinated—an approach that will contribute efficiently to an improvement in the current situation and is expressed in the Regional Plan on Workers' Health.

The current situation and the impact of trends on the health and well-being of the working population are analyzed in greater detail below. Table 1 includes the expected results in the four program areas of the Plan and the activities for achieving them.

2. Current Situation and Impact of the Trends

2.1 *Composition of the Work Force and Work Profiles*

Estimates for 1996 put the population of the Region of the Americas at 781 million. Of this, the estimated EAP* was 351 million—that is, 44.9% of the total population, with 201 million (57.3%) corresponding to Latin America and the Caribbean and 150 million (42.7%) to the United States of America and Canada.[8] The EAP will continue to grow in Latin America and the Caribbean, reaching an estimated 270 million by the year 2025 (a 34% increase). [9]

Since mid-century, at different rates and to differing degrees, the countries of the Region have shifted from primary agricultural and mining economies to relatively industrialized economies with trade and service activities, a shift that has modified work profiles. The developing countries are consequently dealing with the dual work pattern of transitional economies, marked by an increasingly differentiated work force among and within them. This work force ranges from the employees of the multinational corporations to workers in the informal sector who barely eke out a living, a situation that accentuates the social and health inequities.

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* The EAP does not include workers under 15 nor persons 65 or older.

In Latin America policies to promote labor flexibility in commercial enterprises, facilitated by reforms in the labor laws and in hiring regulations, have affected job stability, the work day, shifts, vacation time, and wages.

Unemployment in Latin American declined in 1997 for the first time since 1989, when it was around 5.4%. It gradually rose to 8.8% in 1996, falling to 8.3% in 1997 as a result of the economic recovery. [10]

ECLAC estimates that the percentage of the population employed in the informal sector out of total nonagricultural employment in Latin America increased from 51.6% in 1990 to more than 56.7% in 1996, [11] with the figure ranging from 38% to 64% among the countries. The new employment generated is largely inadequate. Eighty-five out of every 100 new jobs are in the informal sector. [12] Moreover, contracting out of services and the informalization of the employment structure are seriously undermining the quality of jobs and equity in terms of access to services and the social distribution of wealth.

Employment in the informal sector is growing chiefly among traditional economic activities, consisting of small businesses (sometimes linked with medium-sized and large companies) and independent occupations that generally entail higher risks and more unstable working conditions. Added to the biopsychosocial risk factors for workers in the informal sector are the conditions of personal insecurity to which they are exposed on the street and in the home. Work in the informal sector, moreover, exposes family members who directly or indirectly employed in the sector to occupational risks.

With regard to wages, it is estimated that some 20% to 40% of the employed population in Latin America receives a income lower than the minimum necessary to cover the basic market basket of goods and services.[13] The drop in real household income as a result of the decline in the purchasing power of wages, added to inflation, open unemployment, and other factors, obliges many women and children to accept low-paying jobs that are often unstable and unsafe.[14] The indigenous population of the Andean Area typically earns less than other workers in the same economies.[15]

It was estimated that 56 million women would join the work force by 1995.[16] Women's participation in the work force rose from a rate 37% to 45% between the 1980s and mid-1990s, while men's participation held steady at 78% to 79%.[17] Women generally work in more precarious conditions than men and receive only 71% of the wages that men receive.[18] Like the rest of the working population, women are exposed both to chemical substances (pesticides) and adverse physical conditions (heat and cold, heavy loads), as well as the problems deriving from temporary work. Women usually have a double workload (paid work, plus household work), which exposes them to greater health risks.[19, 20]

Some 15 million children work in Latin America. One out of every five people under the age of 18 is employed, half of them between the ages of 6 and 14.[21] In the United States the number of child workers is estimated at 4 million.[22] In addition to the usual problems connected with poverty, malnutrition, anemia, and fatigue, children who work run the risks associated with unsafe and unsanitary conditions in the workplace. [23, 24] Among the most intolerable forms of child labor are jobs in mining, agriculture, the informal tanning industry, street vending, and domestic service. [25]

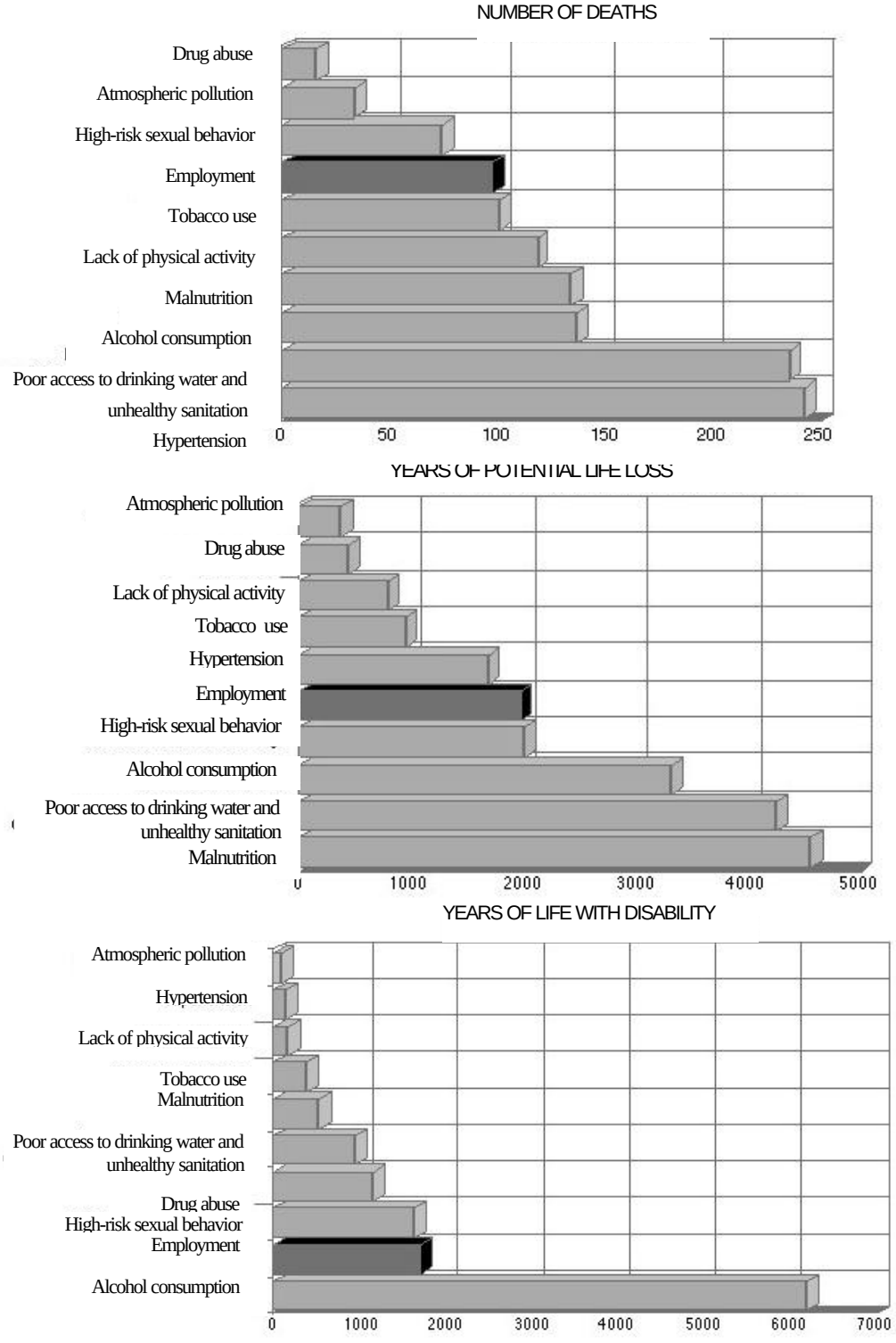
2.2 *Risk Profiles*

Technology development has produced major transformations in the traditional forms of production, resulting in new and varied forms of hazards in the workplace. A study by Leigh et al. [26] demonstrates the importance of occupation as a risk factor in mortality and potential disability-adjusted life years. The study concludes that in 1990, some of the principal risk factors for mortality in Latin America and the Caribbean—occupational risks—rank seventh in terms of years of life with disability and fourth in terms of years of potential life lost. It is also interesting to note that in 1990, occupational mortality was equal to mortality from tobacco use (Figure 1).

In its recent publication, *Health, Environment, and Sustainable Development: Five Years After the Earth Summit,*[27] WHO calls attention to exposure to risk factors in the workplace, highlighting among the principal risk factors physical overload and ergonomic risks, which affect 30% of the work force in the developed countries and from 50% to 70% in the developing countries; biohazards (more than 200 agents); physical hazards (which affect 80% of the work force in the developing and newly industrialized countries); and chemical hazards (more than 100,000 different substances used in the majority of economic activities; these include teratogenic or mutagenic chemical substances, which are particularly harmful to maternal health and workers' reproductive health).[28]

Social conditions and psychological stress are increasingly identified as occupational risk factors, affecting virtually the entire economically active population. The differential risks to which workers are exposed imply major inequities that disproportionately endanger the health of the poorest and most vulnerable population groups, since these are the people who hold down the riskiest, lowest-paying jobs with the least monitoring. [29]

Figure 1*



Ref. Leigh J. et al. Occupational Hazards. In: Murray CJL, Lopez AD, eds. Quantifying global health risks: The burden of disease attributable to select risk factors. Cambridge, Massachusetts; Harvard University Press; 1996

2.3 Profiles of Morbidity and Mortality

The social conditions of work, risks, growing social inequities, and other similar factors make the working population more susceptible to disease, more vulnerable to accidents, and more subject to burnout and physical exhaustion.[30]

The impact of these multiple factors on workers' health gives rise to an epidemiological profile characterized by the problems typical of the traditional occupational pathologies (occupational hearing loss, acute pesticide and heavy metals poisoning, skin and respiratory diseases), side by side with others recently associated with the workplace (cancer, occupational asthma, occupational stress, cardiovascular and osteomuscular diseases, immunological conditions, and diseases of the nervous system). Also important are reemerging diseases (dengue, leptospirosis, malaria, and tuberculosis). Improvements in the diagnosis, registration, and reporting of occupational morbidity and mortality will make it possible to describe the magnitude and nature of the problem.

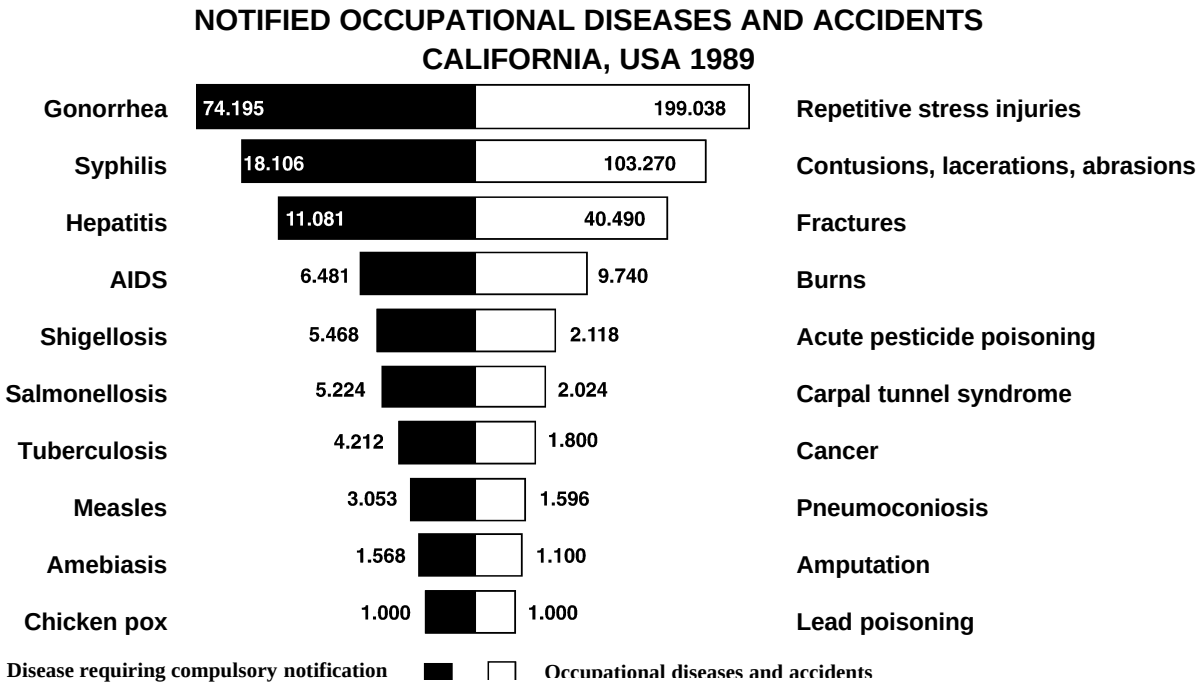
In California, in the United States, information on the 10 reportable disease has been consolidated and correlated with the 10 occupational diseases and accidents (Figure 2). Especially noteworthy is the magnitude of the most frequent occupational diseases compared to the diseases requiring compulsory notification.

The ILO[31] has estimated that 36 occupational accidents occur every minute in Latin America and the Caribbean, and that approximately 300 workers die each day as a result of these accidents. It also notes that nearly 5 million accidents occur annually, and that of these, 90,000 are fatal.

With regard to occupational diseases, WHO estimates that barely 1% to 5% of cases are reported in Latin America and the Caribbean,[32] since only cases resulting in disability subject to indemnification are recorded. The traditional occupational diseases most reported in Latin American and the Caribbean are occupational hearing loss, acute pesticide and heavy metals poisoning, skin diseases, and respiratory diseases.

Studies on occupational mortality and morbidity in the United States conducted by Leigh,[33] estimate that roughly 2% to 8% of all cancers are of occupational origin and that 10% to 30% of all types of lung cancer in men can be attributed to occupational exposure. In addition, some 5% to 10% of morbidity from cancer, cardiovascular, cerebrovascular, and chronic obstructive pulmonary diseases in workers aged 25 to 64 are work-related.[34] In Latin America and the Caribbean, chronic work-related diseases (such as cancer, cardiovascular and osteomuscular diseases, and neurobehavioral disorders) are not registered as such.

Figure 2



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2. Centers for Disease Control, Summary of Notifiable Diseases, United States, 1989. Morbidity Mortality Weekly Report 1989,38(54)

2.4 *Cost of Accidents and Occupational Diseases*

The available information on the cost of occupational accidents and occupational diseases usually comes from Social Security and includes the cost of health care and pensions for disabilities or death. The cost of occupational injuries and diseases in the sectors not covered by Social Security is not known; this burden falls on workers and their families and increases demand in the health services.

In Costa Rica, where the National Insurance Institute alone is responsible for managing occupational risks and covers 56% of the country's work force and 84.3% of the salaried population, the direct cost (care and indemnification for occupational injuries and diseases) and the administrative cost for 1995 was US$ 50 million. This amounts to nearly 0.6% of the gross domestic product (GDP), not counting the indirect costs or the costs for the workers not covered.[35]

Estimates in Bolivia[36] and Panama[37] for 1995 yield figures of 9.8% and 11% of GDP, respectively, for occupational injuries and diseases. The ILO estimates the cost of occupational accidents at as much as 10% of the GDP of the developing countries[38] and has calculated that if the countries reduced this figure by half, they could pay their foreign debt.[39] In the United States it was estimated that in 1992 the direct cost (US$ 65,000 million) plus the indirect cost amounted to US$ 171,000 million, with the cost of occupational accidents US$ 145,000 million and the cost of occupational diseases US$ 26,000 million. These latter two figures are considered to be underestimated.[40]

3. Implementation of the Regional Plan on Workers' Health

The basic principles of PAHO technical cooperation in workers' health are Pan Americanism and equity. Technical cooperation responds to the mandates of the Governing Bodies of PAHO and, in particular, to the strategic and programmatic orientations (SPO) of PASB on workers' health. It is consistent with the recommendations of UNCED, the objectives of the ILO, and the commitments of the Summits of the Americas and other international organizations.

Concerning the situation of workers' health, PAHO has taken the initiative to fill the enormous gap that currently exists and promote the adoption of a comprehensive approach grounded in the basic principles that guide the action of the Organization, through the Regional Plan on Workers' Health.

The Plan emphasizes the need for national leadership and the important role that the international, regional, and subregional organizations, as well as other institutions, play in the application of a common approach to carry out synchronized interventions and optimize the available resources on behalf of the countries. Also required are the cooperation and participation of employers and workers alike, who with their actions must help to ensure health, safety, and well-being. Groups of experts, individuals from various sectors and disciplines, and the majority of the countries of the Region were involved in the preparation of the Plan. It has also benefited from the conclusions and recommendations of national and international forums, as well as the national plans for workers' health.

The Plan is conceived as a frame of reference for the countries for the preparation of plans, policies, and programs geared to improving working conditions and worker's health. It is also designed to promote and orient international cooperation, as well as horizontal cooperation among countries, agencies, and institutions, both national and international, with a view to optimizing the available resources. Furthermore, given the changing situation in the countries and the Region, the Plan is a dynamic and flexible instrument that can be adapted to new situations and trends.

The Plan presents objectives, strategies, and lines of action in order to consolidate the preventive approach:

– *Program area No. 1: Quality of Work Environments.* Strengthening of the countries' capacity to anticipate, identify, evaluate, and control risks in the environments in which workers labor and live. This area is characterized by its primary prevention approach, aimed at identifying and eliminating occupational risks.

– *Program area No. 2: Policies and Legislation on the Regulatory Policy Framework.* Strengthening of the countries' capacity to establish policies and draft legislation on workers' health through ongoing situation analysis, within the context of sectoral reform, integration, and globalization; strengthening of the capacity to develop legal instruments to support technical surveillance standards; and integration of this work area with the national health, social security, and labor plans.

– *Program area No. 3: Promotion of Workers' Health.* Support for the countries in their implementation of the health promotion strategy, using a healthy workplaces approach to the work environment; emphasis on positive aspects of work and the personal growth and development of workers to promote individual and community action by improving the physical, psychosocial, economic, and organizational work environment.

– *Program area No. 4: Comprehensive Workers' Health Services.* Strengthening of the countries' capacity to expand the coverage and access of workers to comprehensive health services that include health promotion, disease prevention, care, and physical and social rehabilitation. Comprehensive health services should be integrated or coordinated with the national and local health systems, implemented by multidisciplinary teams.

The expected results for each program area and the activities for achieving them are detailed in Table 1.

3.1 *Role and Activities of PAHO*

As resources permit, PAHO will continue to provide cooperation to the countries to strengthen national capacity in the field of worker's health, particularly to implement aspects of the Plan for national application. In particular:

- it will promote the mobilization of human, financial, and material resources;

- it will promote and collaborate in the strengthening of institutional networks in scientific and technical, as well as policy, areas;

- it will promote and collaborate in the planning and programming of activities at the national level;

- it will promote the participation and collaboration of international organizations and other external actors in Plan activities;

- it will emphasize interprogrammatic and interdivisional cooperation within PAHO, as well as horizontal cooperation among countries, employing a regional and subregional approach;

- it will promote information systems on workers' health in the countries at the regional and subregional level;

- every four years it will report to the Governing Bodies of the Organization on PAHO cooperation activities, within the context of the implementation of the Plan;

- it will report on workers' health conditions in the Region for inclusion in the publication *Health in the Americas*.

3.2 *Initiatives and Leadership of the National Governments*

The success of the Plan at the country level depends on the leadership and initiatives of the national governments in the following areas:

- sectoral, intersectoral, and interinstitutional action to ensure that the countries act together with a common purpose to improve workers' health;

- determining the areas of international cooperation in which this type of support can be most effective for the country.

Some of the specific activities suggested for the national governments are:

- to establish intersectoral coordination with the ministries, the private sector, the labor sector, nongovernmental organizations, local governments, international agencies, and other actors;

- to develop and implement effective policies and national laws and to adopt national standards for the programs in health promotion, disease prevention, care, and rehabilitation directed toward workers;

- to develop the capacity of workers as a community to understand the link between working conditions and health, developing the capacity of local authorities, promoting community participation, and supporting local initiatives.

3.3 *Areas of Action of the International Organizations and Other Actors*

At the global level several actors are directly or indirectly involved in workers' health. The number varies according to the geographical region, the degree of industrialization, the nature of the problem, and other factors. Under the Regional Plan a list of regional actors is gradually being drawn up, particularly those that are being incorporated into the Plan.

Table 1

**REGIONAL PLAN ON WORKERS' HEALTH:
PROGRAM AREAS**

EXPECTED RESULTS	ACTIVITIES
1. Quality of Work Environments	
1. 1 Strengthened development and utilization of the basic disciplines for risk prevention and control.	To strengthen teaching of the basic disciplines at all levels for the identification and control of risks • To strengthen training for entrepreneurs and workers' organizations • To strengthen technical and institutional capacity in occupational safety and health • To promote the use of inspection and intervention methods that are practical, simple, and effective • To develop intervention models that attach special importance to comprehensive control of risks • To promote the establishment of mixed occupational safety and health committees for surveillance in the workplace.
1.2 Information systems in place for the reporting, registry, surveillance, and control of workers' health risks	• To prepare diagnoses of the national situation with regard to surveillance systems in occupational health and safety • To develop practical, simple proposals for notification, registry, and surveillance systems on workers' health (in national, local, sectoral and company surveillance systems) • To design protocols for investigating risk/harm; to identify and prioritize sentinel indicator and warning systems

EXPECTED RESULTS	ACTIVITIES
1.3 Systems installed to permit systematization and dissemination of the existing information	• To install and maintain an Internet discussion list on workers' health in the Region • To promote systematization, information dissemination, and feedback on experiences at all levels • To maintain an up-to-date Web page in CEPIS on workers' health • To train specialized human resources in the management of information systems on the workers' health in the different levels • To develop documentary information networks. • To maintain a directory of institutions, specialists, and actors involved in workers' health in the countries of the Region
1.4 Appropriate and clean technology developed and in place to ensure risk prevention and control in the workplace	• To identify, validate, and disseminate appropriate and clean technology for risk prevention and control in enterprises and workplaces • To form and strengthen a national and regional network of databanks on appropriate and clean technologies in risk prevention and control in the workplace that can be accessed for the dissemination of these technologies • To adopt and apply standards leading to clean and safe technologies • To train specialists in clean and safe technology to advise enterprises
2. Policies and Legislation on the Regulatory Policy Framework	
2.1 Workers' health incorporated in the plans and policies for national, subregional, and regional development	• To identify policy guidelines regarding the living and working conditions of the economically active population • To promote the approval and application of international work standards as well as environmental quality standards • To advise the agencies with the responsibility for drafting national policies and legislation in a concerted manner • To prepare diagnoses of policies and legislation that outline the individual and collective rights of workers; to calculate the cost of the harm to the work force and the environment produced by work processes
2.2 Harmonization of the legal framework and legal instruments on occupational safety and health	• To formulate and implement laws, regulations, and technical standards on workers' health • To develop, promote, and disseminate instruments for standardization and implementation
2.3 Agreement on policies and legislation in workers' health among workers, employers, and the State and their application	• To promote the establishment of the Standing Commission on Workers' Health, organized by subregion • To form national technical commissions on workers' health • To develop instruments and indicators for the generation of policies and legislation • To include the topic in all forums on economic globalization and integration • To strengthen regional and subregional parliamentary entities with their specific areas of discussion and intervention • To establish consensus-building entities among the representatives of workers, employers, and the State with the capacity for decision-making

EXPECTED RESULTS	ACTIVITIES
3. Promotion of Workers' Health	
3.1 Sensitization of decisionmakers, policymakers, business executives, labor, and public opinion to the economic and social importance of workers' health	• To develop instruments for information dissemination and training that utilize specialized groups in the countries • To train the human resources of these specialized groups and develop the basic design of the corresponding instruments • To develop and implement strategies on communicating for health among workers
3.2 Inclusion of workers' health in the different levels of formal education	• To include workers' health in the different educational levels and in formal and nonformal training • To train the instructors of the direct educators and convince decisionmakers about the educational policy of the countries • To produce educational materials on workers' health for the different levels
3.3 Entrepreneurs and their business representatives sensitized and trained in prevention and control of occupational risks and its importance to productivity	• To disseminate indicators of social and economic costs in connection with workers' health to the business sector • To develop communicating for workers' health campaigns to foster the effective participation of employers • To develop technical assistance programs for adapting workplaces to international quality standards • To develop programs for strengthening managerial capacity using the healthy workplaces approach • To strengthen the technical capacity of human resources in methodologies for health promotion and negotiation with the business sector • To prepare entrepreneurs to reincorporate disabled workers in the work force
3.4 The conditions for the empowerment of workers and the community to permit social participation in risk control have been ensured	• To increase the level of awareness among workers and the community about workers' health and its association with the quality of living conditions • To promote worker and community participation in risk identification, evaluation, and control, and in control of the organization of the work • To systematize and disseminate healthy and safe practices based on the knowledge generated by worker and community participation • To mobilize education and communication technologies • To prepare guidelines and manuals
3.5 Strengthening of workers' activities to improve working conditions and the working and living environment	• To prepare an instrument for assessing working conditions and the work environment. To promote the formation of workers' health committees and other forms of intervention in workers' organizations • To prepare workers' organizations to identify, evaluate, monitor, and apply techniques for improving working conditions and the work environment • To develop socioepidemiological surveys geared to workers and the community • To promote the validation, consensus, and protagonism of workers and the community for the solution of their problems

EXPECTED RESULTS	ACTIVITIES
4. Comprehensive Workers' Health Services	
4.1 The comprehensive worker's health systems have been incorporated at the primary care (PHC) level of the existing health systems (ministry of health, SS) with universal coverage and full access for workers	• To develop the frame of reference for primary health care for workers • To promote the establishment of appropriate mechanisms to increase coverage and access in terms of their relation to work, with special emphasis on the informal sector • To encourage health institutions (public or private) to establish procedures and standards that facilitate care for workers at the different levels of care, as well as others related to health promotion and rehabilitation • To guarantee the programming and financial autonomy of the services • To establish programs for professional rehabilitation and the reincorporation of disabled workers into the work force
4.2 The specialized services of public and/or private health enterprises and the public health system have the necessary human resources and technology	• To include training in workers' health in the models or curriculum plans for the health professions (college and graduate-level), with emphasis on public health and epidemiology • To include basic programs on the relationship between productive processes, work, and health in the education and training of other disciplines. Strengthening of continuing education for health workers in areas related to workers' health • To incorporate the activities of the comprehensive workers' health services into the health care delivery network and to incorporate appropriate technologies by levels of care
4.3 Enterprises have comprehensive workers' health systems involving the participation of workers and employers	• To search for opportunities for consensus-building between employers and workers • To develop mechanisms to promote the participation of both workers and employers and establish health services in the workplace (Agreement 161, ILO) • To develop and promote the use of low-cost methods and prevention technologies • To develop mechanisms for rehabilitating disabled workers
4.4 Expansion of coverage to less protected groups of workers	• To identify and quantify the most vulnerable and unprotected working population • To develop coverage models inside and outside of the formal health and social security system that have their own financing scheme

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