UNHEALTHY WORK,

UNHEALTHY LIFE

Many people see occupational or industrial health as concerned only with those illnesses which a worker is likely to contract due to the nature of his/her work. For example a person working in an asbestos factory will be predisposed to mesothelioma; a shop assistant will be more suceptible to varicose veins.
This article will show that occupational health is more than just work-related dangers ; it is also concerned with broader social conditions which work gives rise to.

We begin by presenting statistics from Britain,,and go on to draw conclusions from these statistics which we relate to South Africa.

Table 1 shows standardised mortality ratios for selected occupations in Britain. By comparing mortality rates of people from different occupations it is clear that health and work are directly related. Teachers, government officials, top management and doctors have a lower than average mortality rate. However miners, machinists and labourers have a higher than average mortality rate. In other words there is a general effect on people's health associated with their occupation.

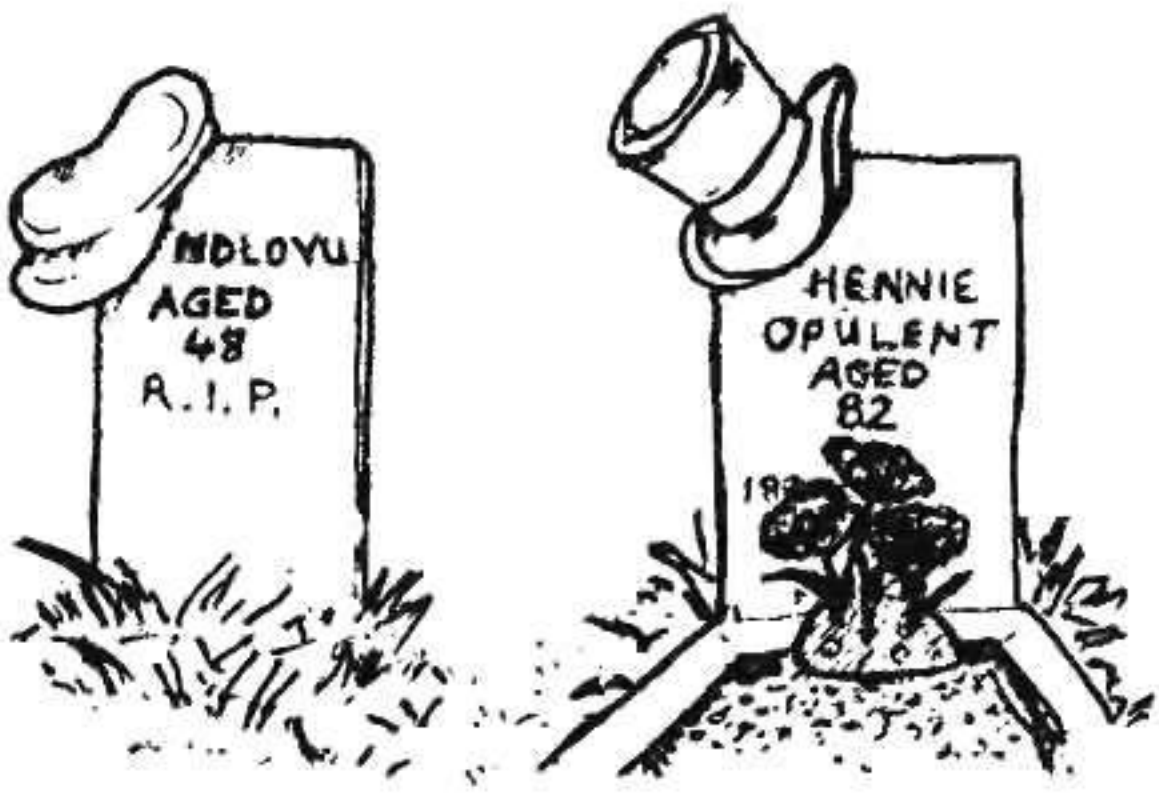


Table 1

INDIVIDUAL OCCUPATION	S M R.
UNIVERSITY TEACHERS	49
COMPANY SERETARIES	57
TOP GOVERNMENT OFFICIALS	60
TEACHERS	66
DOCTORS	81
COAL MINERS	141
MACHINE TOOL OPERATORS	156
LABOURERS- INDUSRIAL	201
BUILDING WORKERS	274

Production gives a place to each individual in society. Each person has a particular kind of job, and this job has specific effects on health. For example, if work is very noisy, there will be a risk of noise-induced hearing loss.
This is the narrow sense in which ill-health is determined by occupation. But occupation also determines one's place in society and this has a significant effect on people's health. For example, university teachers are not only healthier because their work is less dangerous, but also because they have more access to social services.

Production divides society up into definite groups of people who share common characteristics. These groups are called classes. They are defined primarily in terms of ownership of land, raw materials and machinery.' Only an approach which considers the group or class as well as the individual can provide an adequate understanding of occupational health. This contrasts with a purely disease-oriented perspective.

In Britain occupational health statistics based on social class are kept. A breakdown of the different social classes appears in Table 2. This shows that the lower social classes (skilled and unskilled workers) have a higher overall death rate. Note the gap between the mortality rates of the different groups and that

over the last 50 years this gap has been widening.

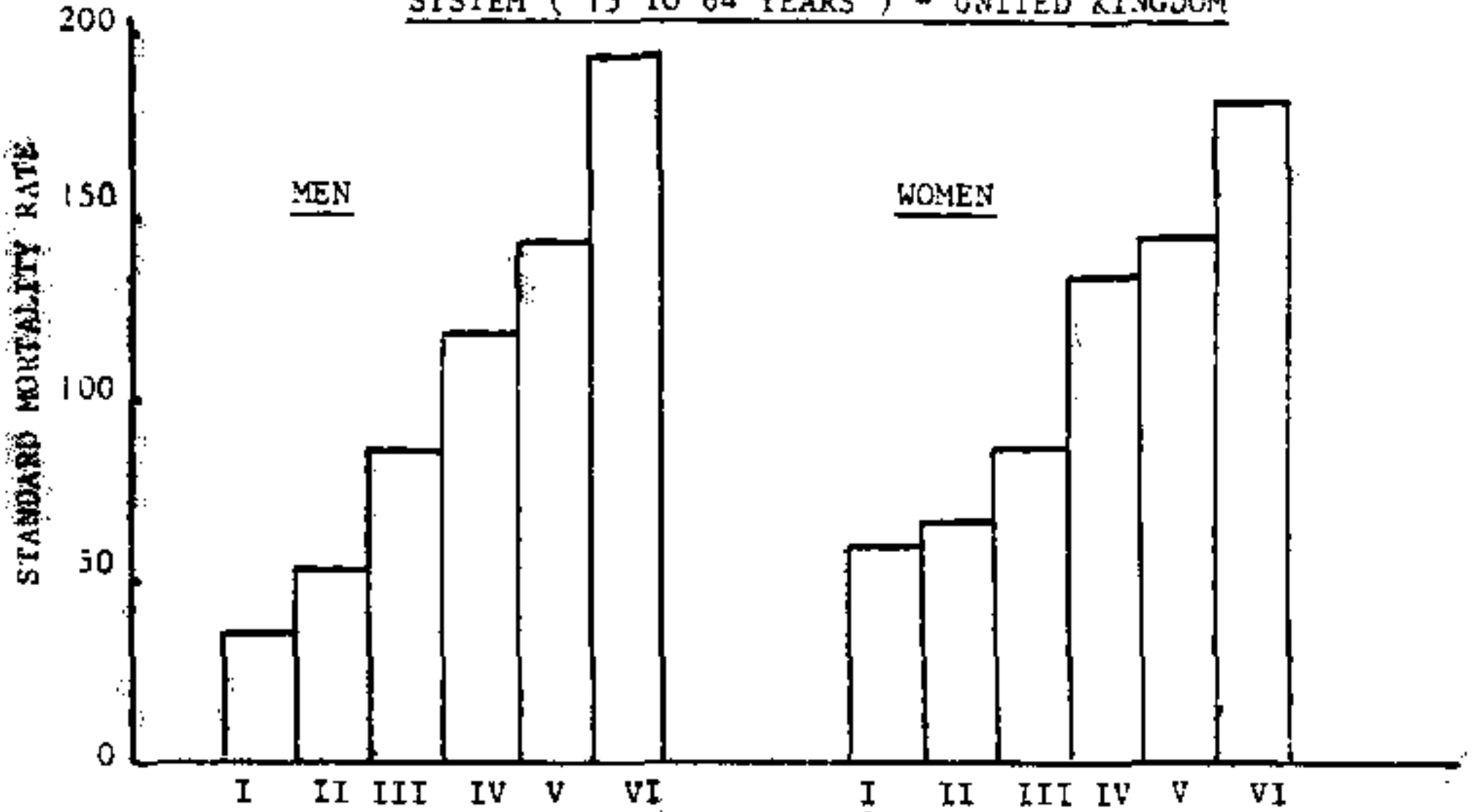
Table 2

SOCIAL CLASS	COMPOSITION	% POPULATION
I	PROFESSIONAL -doctor management	5
2	INTERMEDIATE -teacher nurse	18
3n	SKILLED NON-MANUAL -police clerk	12
3m	SKILLED MANUAL -carpenter	38
4	PARTLY SKILLED -machinist fisherman	18
5	UNSKILLED -labourer building worker	9

Table 3 shows mortality from lung disease in the British workers according to their social class. It shows that for both men and women the mortality is higher in the lower social classes. The difference between class 1 and class 5 is very marked. This pattern is repeated for other causes of death; such as infections,cancer, mental diseases, gynaecological problems and accidents. It is important to note that heart disease, long thought to be a problem of executives also has higher mortality rate in the lower social classes. This is mainly because high blood pressure, a stress related disease, is much more common in this group.

In South Africa it is difficult to understand occupational health in a social context, because statistics are not kept for different classes. Statistics are kept by race and are very incomplete. Statistics for africans do not exist for the country as a whole; there are only statistics from selected areas and information from limited studies. Statistics do exist, however, for whites and coloureds, and it is possible to derive some understanding from these.

TABLE 3 MORTALITY FROM DISEASES OF THE RESPIRATORY SYSTEM (15 TO 64 YEARS) - UNITED KINGDOM



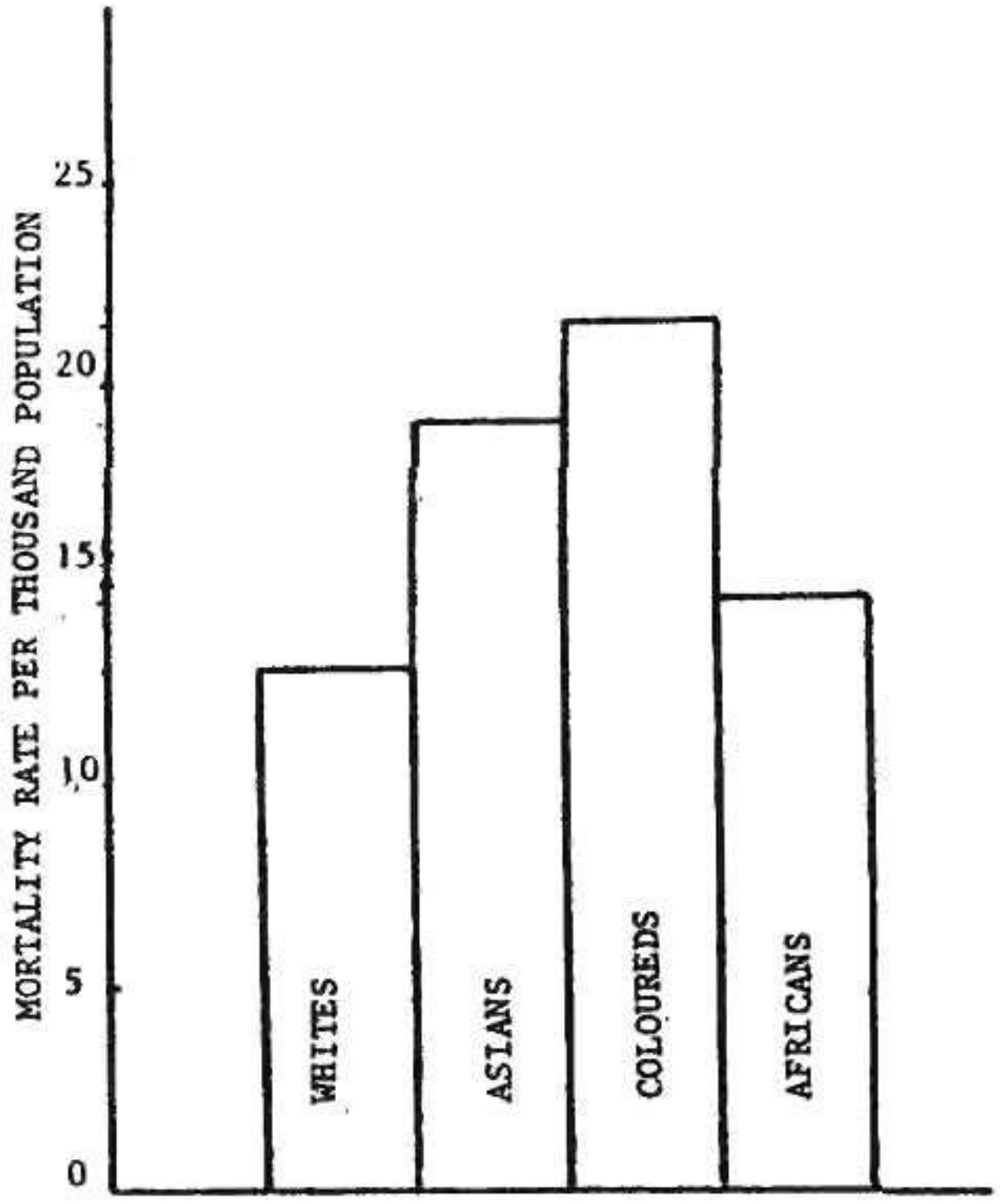
What is the relation between social class and race, Table 4 shows that black people in South Africa generally belong to the lower social classes or working classes (classes 4 and 5 according to the British classification) A total of 82% of africans and 62% of coloureds are semi-skilled or unskilled workers, but only 6% of whites. Most whites are in British classes 1 and 2. So comparisons of data by race give very similar results to comparisons by social class. For the purposes of the social analysis of occupational health, it is possible to use race statistics.

Table 4 COMPOSITION OF POPULATION BY CLASS

	S.A.	WHITES	COLOUREDS	AFRICANS
MANAGERIAL CLASS	4	11	0.6	0.5
MIDDLE CLASS	30	60	25	13
WORKING CLASS skilled	11	23	13	5
WORKING CLASS semi-skilled	17	5	29	20
WORKING CLASS un-skilled	40	1	33	62

Table 5 shows mortality rates for different races. The mortality rates for whites are shown to be substantially lower than those of the black population generally. The figures for africans are unreliable and artificially lowered by excluding figures from the homelands and being drawn from selected magisterial districts only.

TABLE 5 STANDARD MORTALITY RATES FOR WHITES COLOUREDS ASIANS AND AFRICANS



Thus the social view of occupational health is necessary to account for the fact that the burden of mortality and illness falls on the lower social classes. The disease-oriented view, which states that individuals suffer from diseases related to the nature of their work only, has numerous implications.

It can obscure the fact that the working class also bears the burden of many general diseases, by considering only diseases stemming from the work process. It often explains these specific diseases by a theory of individual susceptibility to some occupational hazard. (See article page 26)

Production is central to the workings of society, and social classes are defined through their relationships in production. It follows that individuals in these classes are subject to certain common working and social conditions. Common disease characteristics emerge from general conditions characteristic of working class life, such as low wages, poor housing, poor nutrition, poor water, washing and sewerage facilities, lack of space and recreational facilities, low social status and lack of control over their own lives.

Let us look at an example to clarify these issues. A worker in a battery factory is exposed to lead and may develop lead poisoning. This semi-skilled or unskilled worker is also a member of the working class and suffers from low wages, poor housing and poor water supply. These general social conditions lead to health problems like undernutrition, tuberculosis, alcoholism and violence. The worker is thus exposed to diseases related to his/her work, as well as to *the social conditions determined by being a member of* the working class.

Generally it is the working class that is most heavily exposed to the dirtiest and most dangerous part of the work process. In addition, the generally poor social conditions of the working class will make the individual worker even more suseptible to the hazards of his/her particular work.

Work takes place in a web of social relations. These social relations structure the working class outside of production into poor social conditions and inside production into poor working conditions. The same social relations ensure that the means of prevention, cure and health care are less accessible to those at the bottom of the class hierarchy.

NOTE:

The graphs presented in the above article were supplied by the Industrial Health Research Group.