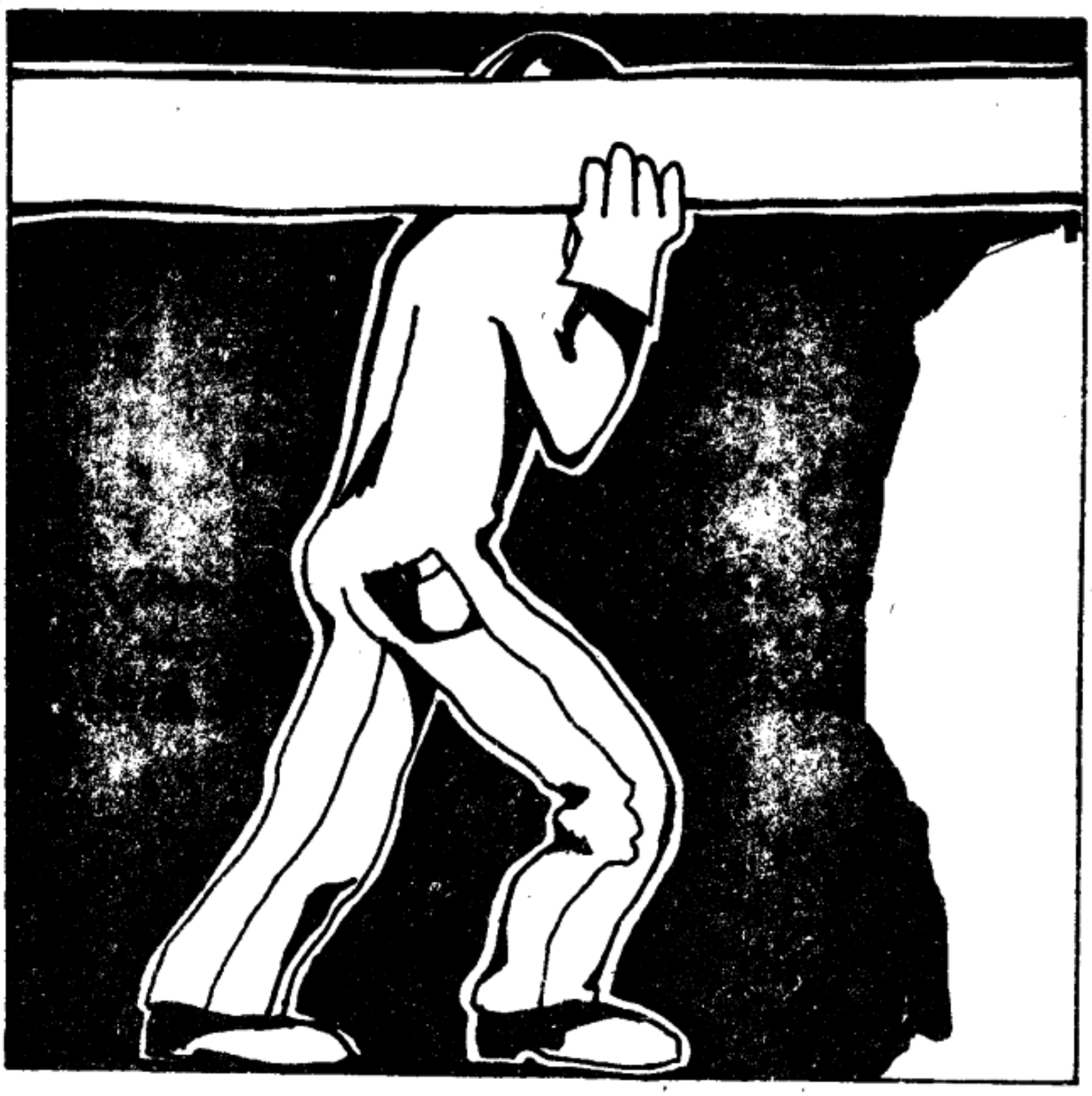
CRITICAL HEALTH

SEPT. 1982 40c No 8



WORK AND HEALTH

CRITICAL HEALTH is a publication dealing with health and politics in South Africa.

CRITICAL HEALTH aims to

- present a critique of "health" in South Africa
- provide ideas for the roles that health workers can play in promoting a healthy society
- show that "health" is a basic right
- provide a forum for the discussion of health-related issues
- provide insight into the political nature of health

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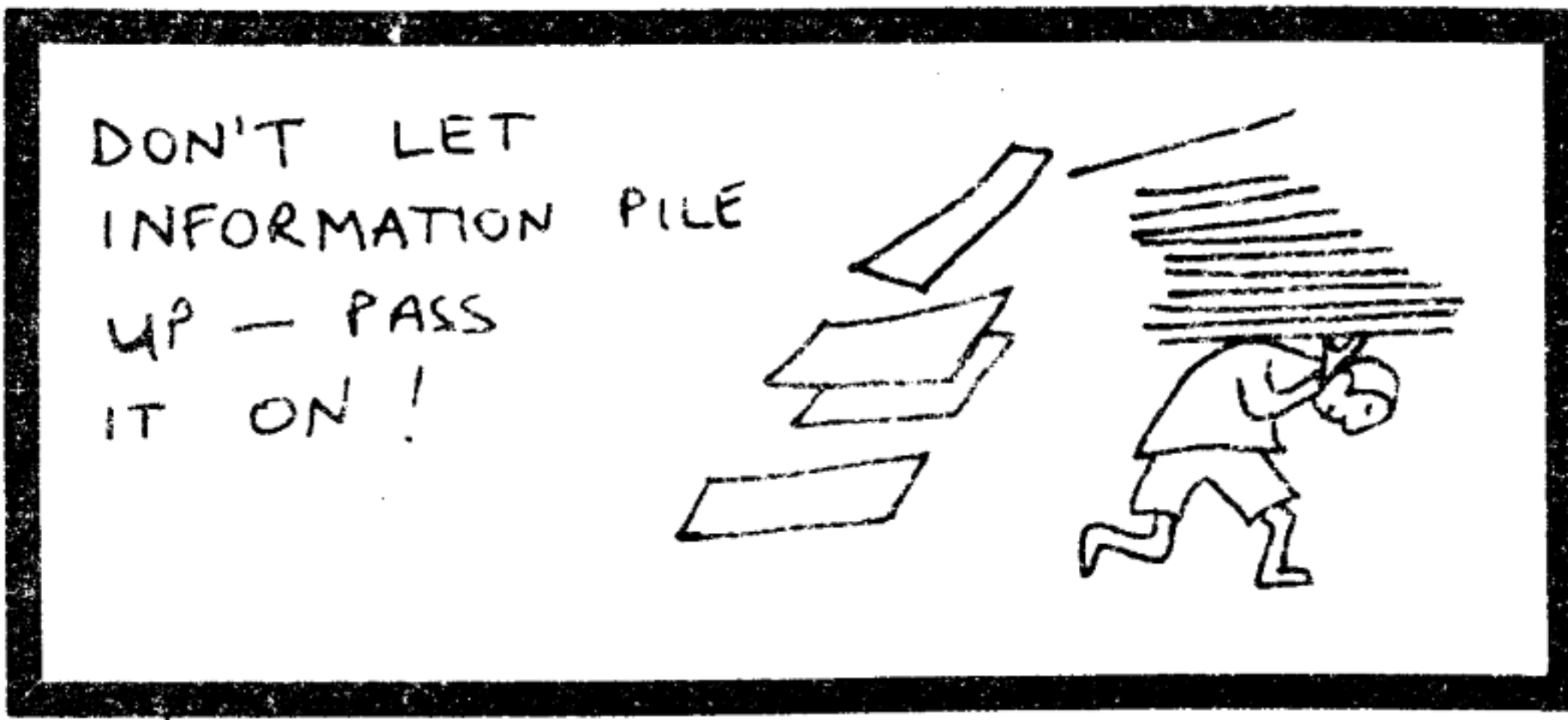

EDITORIAL

This issue of Critical Health is long overdue. Critical Health has in the past failed to devote sufficient attention to the problems related to occupational health in South Africa. We hope that this issue will mark the beginning of a commitment to give greater coverage to the issues relating to work and health in South Africa.

This issue aims to show that occupational health is more than just the study of the relationship between ill-health and specific work situations. The health of workers relates not only to the nature of their work, but also to their wages, living conditions, access to health services and other factors determined by their social class. It is this far more complex issue which we attempt to explore in some detail in the following pages.

We also aim to show that occupational health services are themselves in a contradictory position. Although they provide services for sick and injured workers, they also serve certain very definite functions for the employers.

Other articles in this issue devote attention to the limitations of workmen's compensation, struggles around occupational health, and a union-run health service. Articles not related to occupational health include brief comments on the polio epidemic and the victimisation of a recently banned health worker.

The specific problems of working women and health have been neglected in this issue. The next Critical Health, however, will deal with "Women and Health" and will contain an article on women, health and work.

As always, we would like to make a strong appeal for constructive criticism of Critical Health. It is only with the participation of our readers that Critical Health will begin to meet the needs of those that it helps to assist.

Finally, we regret to announce that we may be forced to raise the price of subsequent issues of Critical Health.

We strongly urge people to subscribe and if possible to become donor subscribers by contributing to the production costs of Critical Health.

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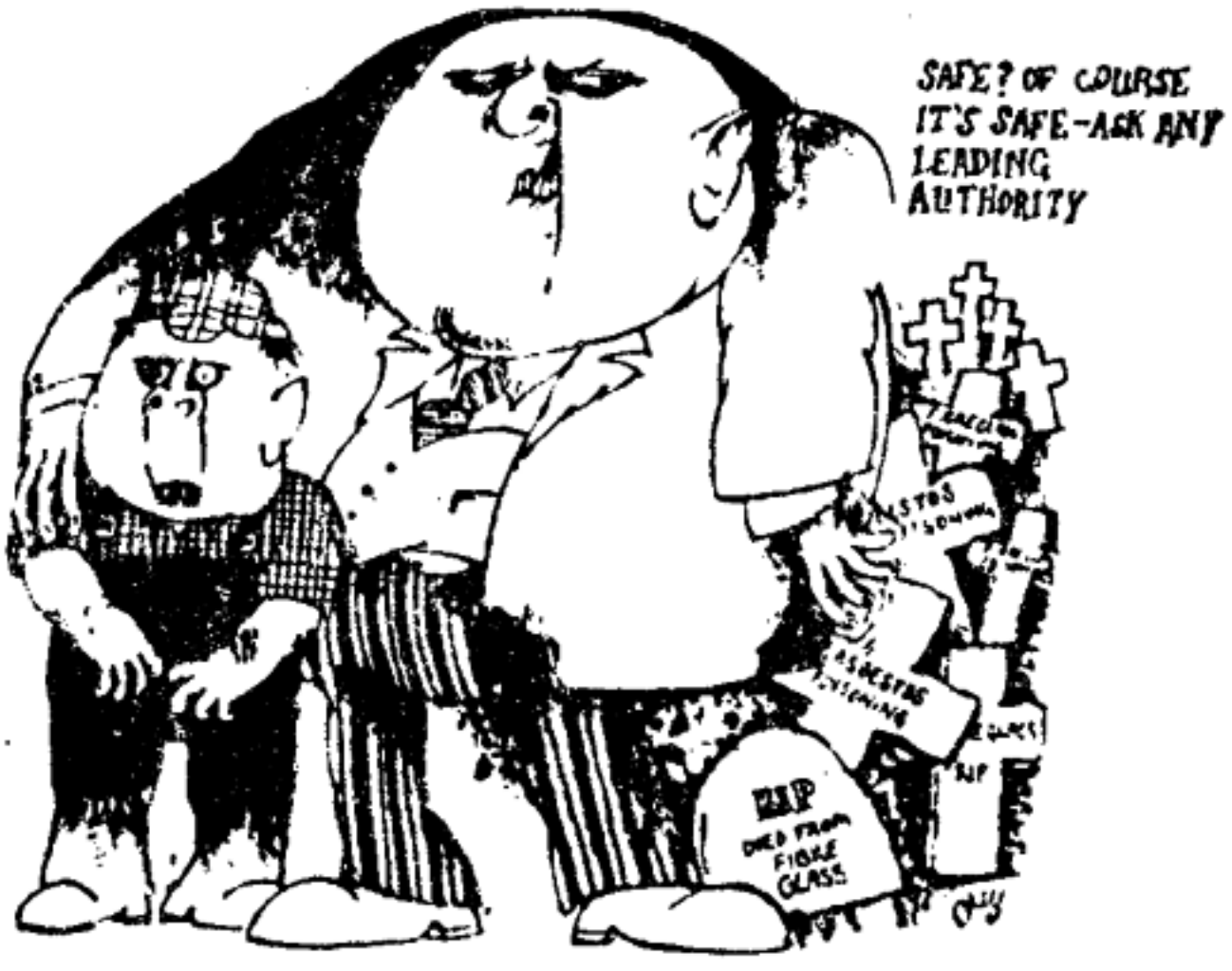


UNHEALTHY WORK,

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.

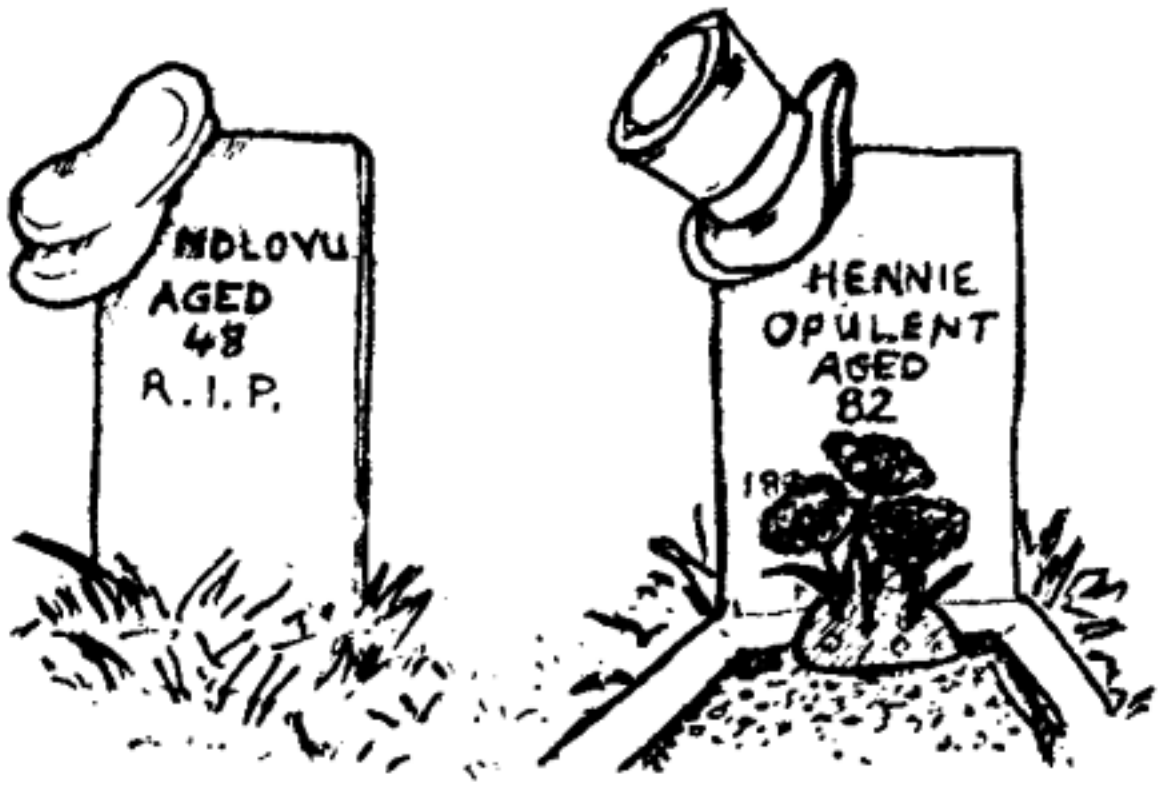


Table 1

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.

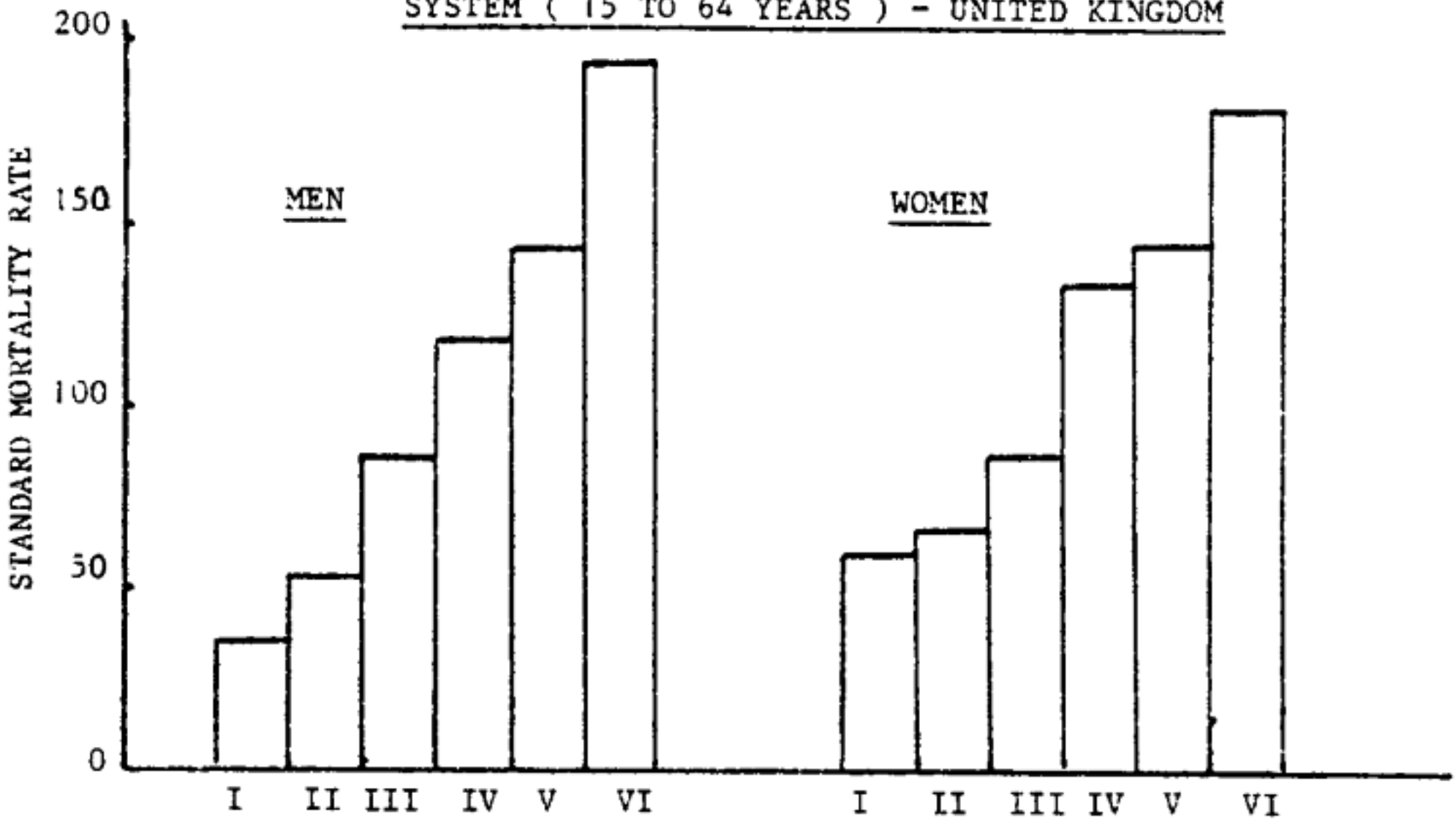
Table 2

SOCIAL CLASS	COMPOSITION	% POPULATION
1	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



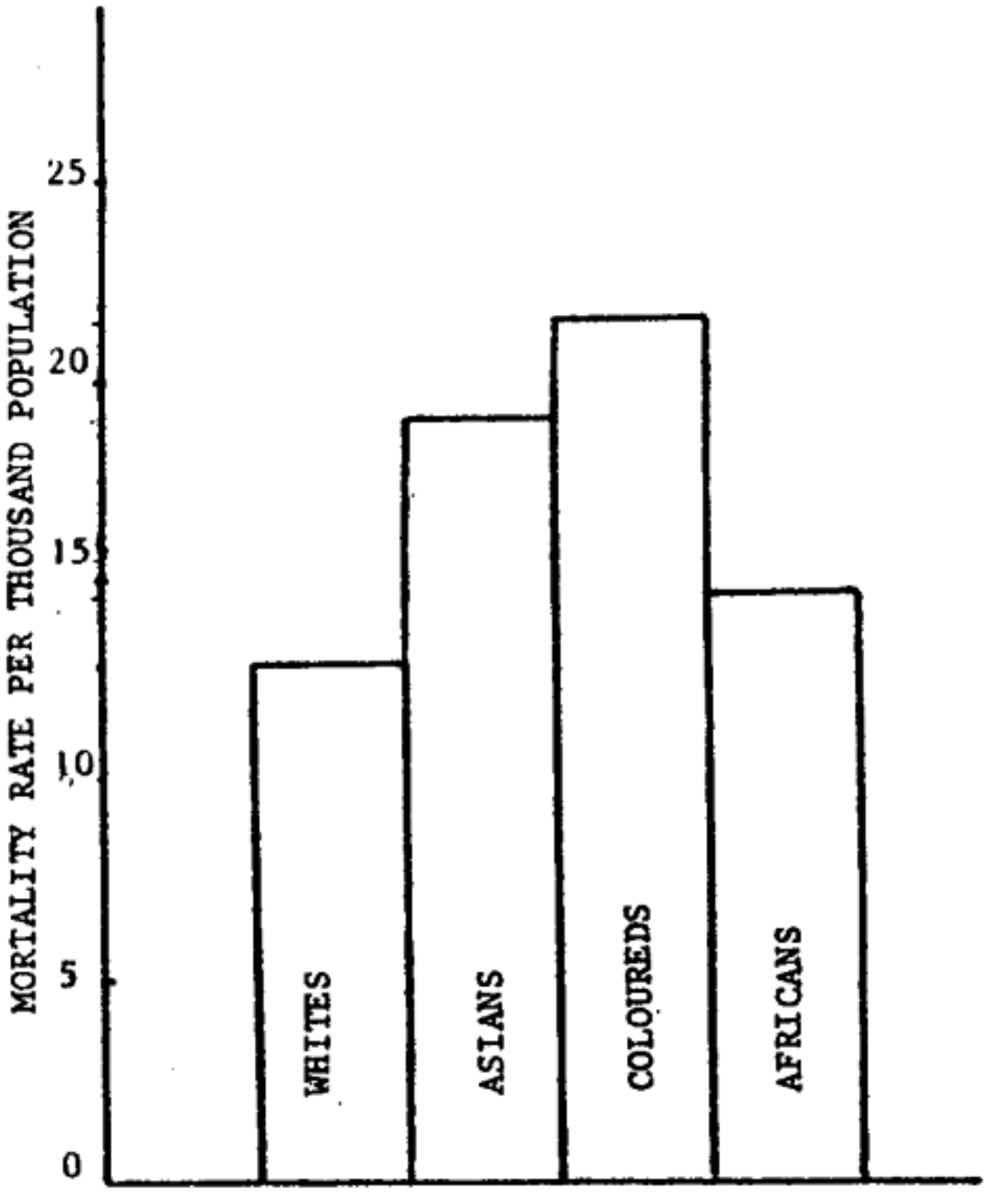
What is the relation between social class and race, Table 4 shows that black people in South Africa generally belong to the lower social classes or working classes (classes 4 and 5 according to the British classification) A total of 82% of africans and 62% of coloureds are semi-skilled or unskilled workers, 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.

PRODUCTION & HEALTH

Production in factories is responsible for the health of the working class in two senses. On the one hand workers are exposed to dangerous processes and substances while on the other they experience poor living conditions. The extent to which workers are subjected to these conditions depends of their collective ability to resist them.

A useful way to explain disease patterns is in terms of the class structure of society*. [Production in a capitalist society defines two major classes. The capitalist class owns land, raw materials and machinery and the working class owns only its ability to work which it sells to the capitalist class for a wage. The relation between these two classes is one of exploitation, in the sense that profit is made from the labour of the working class, and it is taken away by the capitalist class.]

There are other classes, of course, but this article will concentrate on the working class, which is by far the most important (at least 70 percent of the population in South Africa) and which bears most of the disease burden.

Production under capitalism is characterised by a drive to increase profit, which means, among other things, keeping wages as low as possible. Wages are set by the need to ensure the ability of the worker to work and to ensure that the worker can support a family which will provide future generations of workers. In other words, it depends on the cost of necessities of living (food, housing, clothing, transport) and the cost of training the worker.

The drive to keep wages low has corresponding effects on general working class health. Because workers get low wages they are subjected to poor housing, overcrowding, poor food, stress and so on. Machinery and work processes are designed with profit in mind. Health and safety are a cost to the

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* For a more detailed discussion of class structure see article on page 4

capitalists and a reduction in the hazards at work is generally only forced by the demands made by workers.

According to the National Occupational Safety Association, a quarter of a million South Africans are victims of accidents at work every year which are serious enough to keep them from work for at least a day.(1). Approximately 800 people are killed in accidents on the mines every year.(2).

The Erasmus Commission of Enquiry into Occupational Health, which reported in 1976, looking at dangerous substances to which workers are exposed, found that about 600 000 workers are potentially exposed to ammonia, 600 000 to benzene and 160 000 to lead.(3). These and other substances are known to be dangerous but they continue to be used because of the dirve for profit. The dangers of asbestos, for example, are well documented, but something like 22 000 mine workers and at least 6 000 factory workers are still exposed to asbestos dust, although there are well known substitutes for asbestos.(4). This is either because asbestos is cheaper to use, or because the companies which manufacture asbestos products are linked to those which mine asbestos. (See Critical Health, no. 4)

Thus health should be seen as an outcome of production in a double sense, both because the relations between the working class and the capitalist class make for poor living conditions for workers and because workers are exposed to dangerous processes and dangerous substances in the factories.

It is important to remember that even problems that are work-related do not stop at work. Deafness caused by noise probably affects home life more than it does working life. Shift work has serious effedts on family life, and dangerous substances like lead or asbestos can be carried home on the clothing of workers and affect family and friends.

It is also important to remember that all the above can be seen only as trends. The way they operate in reality is determined by the organisation of the working class and of other classes, and the extent to which they can press for their demands. In other words, the extent to which workers are actually exposed to these dangers depends on their collective ability to resist them.

This point can be illustrated with examples from other countries, where the struggles of workers have reduced their exposure to dangers at work. The Erasmus Commission found that if Swedish standards of exposure to lead were applied to South African industry, 45 percent of the workforce would be withdrawn because the levels of lead in their blood would be above the Swedish limit. forty-four percent would be withdrawn if American standards were applied and 26 percent if British standards were applied.(5).

Another example is the export of an entire asbestos textile factory from West Germany to Philippi in Cape Town.(6). This illustrates a trend which is increasing all over the world. Companies are forced to move their dangerous operations from developed countries, where workers and environmental groups have won high standards of protection which made production expensive, to underdeveloped countries like South Africa, Puerto Rico and Mexico where these standards are lower or do not exist at all.

The picture drawn so far is fairly simple. In the rest of this article we will look at the situation in more detail.

An in-depth look at the working class

The working class is not one large mass and the disease burden does not fall equally on all sections of the working class.

This can be partly explained by differences in skill. Most white workers are skilled and most black workers are unskilled. For example, in the metal, electrical and engineering industries, over 95% of artisans (skilled workers) are white.(8). Skilled workers are more valuable to capitalists because it takes time and money to train them. This means that they earn higher wages, and so they and their families are less exposed to disease. It also means that they are generally less exposed to dangers in production.

About 20 percent of workers in manufacturing are women. In the capitalist economy home life is cut off from production and work in the home is not recognised as work. This means that women have a double burden. Many working class women have to work in factories so that the family income is

sufficient. However, their wages are generally lower than those of men because their income is seen as suplementary to that of the male household head (the "breadwinner"). This double burden of work at home and in the factory has clear effects on health.

The capitalist economy needs a section of the working class to be unemployed at any time. this helps to keep wages low and prevents worker organisation through the constant threat of replacement.

In South Africa the 'army' of the unemployed is located mainly in the bantustans which are dumping grounds for women, the old, the sick and the unemployed - all those, who are not needed in production. These groups bear the worst burden of disease. Diseases like malnutrition and T.B. are rife in the bantustans.

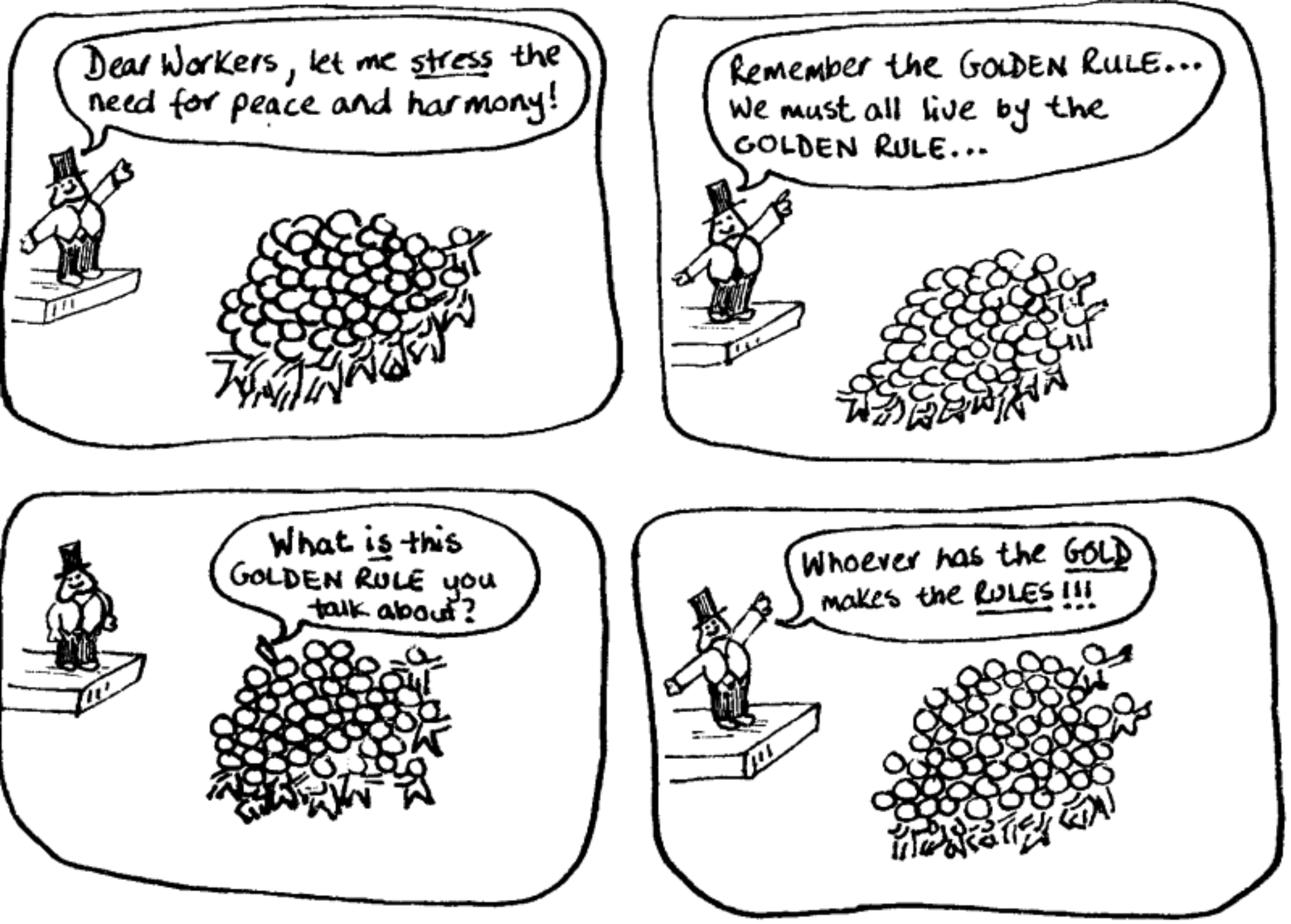
Thus, for a clear understanding of the link between production and health one needs to understand the differences in the working class. The differences pointed to here were skilled/unskilled workers, women workers and the unemployed.

An in-depth look at the capitalist class

The capitalist class is not one large mass either. There are important differences between factories and within factories, with regard, for example, to the size and structure of capitalist companies.

Some industries by their nature are operating grounds for big companies only, like most sorts of mining and textiles. These industries need expensive machinery and long production hours to produce enough for profit. Others, like the clothing and furniture industry have both big and small companies.

Big companies do not go bankrupt so easily because they control all the different stages of production from the supply of raw materials to the selling of the final products and because they have big reserve funds. For these companies, the need to keep wages at a minimum is less important and they can afford to spend money on safety, industrial doctors and nurses, training and better canteens in the



interests of a docile labour force.7 The same is not true of small companies and it is often in small companies that conditions are worse.

This article has suggested that health and safety have to be seen as a result of production, both in the sense that workers are actually injured at work, and in the sense that production structures general working class health. It is suggested that there are limits on the way this works in reality. The most important is the organisation of workers and other groups in society and the extent to which they can press their demands.

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page 41

ERASMUS COMMISSION :-

"... it has regrettably to be stated categorically that, excepi in the mining industry, industrial health not only occupies a secondary position in industry in this country, but that industrialists have put very little time, money, and organisation into the prevention of occupational diseases."

A WORKERS' CLINIC

The African Food and Canning Workers Union (AFCWU) established its own clinic in Paarl in 1981. The establishment of the clinic enabled members of the Union's medical benefit fund to receive treatment at the clinic. This has resulted in major savings to the Union and the Fund, and has enabled the Fund to provide a better service for all the workers who are members of it. Critical Health spoke to Denis Rubel, the doctor at the Union's Paarl clinic.

For the rest of this interview Critical Health will be referred to as CH and Denis Rubel as DR.

CH - What is the background to the establishment of the Paarl clinic ?

DR - The history goes back a long time. The Union established a Medical Benefit Fund over thirty years ago. Up to now the Fund has had a contract with certain private doctors to see those members of the Fund requiring medical attention. The increasing costs of medicines and the high profits of the doctors resulted in the Fund paying private doctors R30,000 - R40,000 per year.

The Union felt that much money could be saved by employing a doctor and providing all medicines at cost. The Fund has in fact saved a lot of money since the opening of the Clinic. This has resulted in improved benefits not only for the people in Paarl who use the Clinic, but also for members of the Fund in other parts of the country. For example, the average cost for medicines at the Clinic was R1.40 for each worker, whereas private doctors were charging the Fund an average of R4.70 per worker. The money saved in this way goes towards providing a better service for all members of the Fund.

CH - Besides the financial benefits, what other benefits have resulted from the establishment of the Clinic?

DR - We have been able to identify more precisely the health problems from which workers suffer. Back-pain and shoulder-spasm are very common amongst

workers on the conveyor belt line. People who have just started working on the conveyor-belts tend to get vertigo (a type of dizziness) . There are also various skin conditions which result from working with acidified fruit. The most common condition of this sort is known as "vrugte-vinger" (fruit-finger) which is a combination of inflammation of the skin and infection.

There are also some particular processes which have led to problems, for example, in the production of certain types of yoghurt. A chemical called sulphur dioxide is poured into the yoghurt to preserve it , and many workers have been burned on their skin by this chemical.

CH - Has the Union managed to take up these issues and demand improvements ?

DR - The Union certainly would like to take up health and safety issues. However, these can only be taken up when the Union is in a very strong position and able to demand changes from management. At the moment we have a number of difficulties in the Union, and we have felt it better that I use my expertise and status to influence management rather than rely on the strength of the Union.

CH - Has the Union Clinic attracted many more workers to join the Union?

DR - I think many people are proud of the Clinic and happy with the service it provides. However, a union cannot try to increase its membership by offering "fringe" benefits. A union is not a benefit society. People must join the Union because the relationship between union organisers and the workers is good and because the Union is able to represent their views.

Last year I devised a scheme whereby workers in a milling factory where we were trying to organise would be able to use the Clinic services. The Union rejected the scheme because workers are not organised around medical services - they are organised around factory floor issues. It was difficult for me to accept that decision initially,

because I had thought I could play a useful part in attracting workers to join the Union. I learned an important lesson - that the benefits a union provides must be benefits that the workers want, and not benefits that existed from the start in the hope that they would attract workers to join the union.

Summary of Effects of Shiftwork	Proportion of work-force liable to be affected
Fatigue	All
Digestive disorders	Two-thirds
Stomach ulcers	Increased incidence
Constipation	Increased incidence
Inadequate sleep	Half
Nueroses and nervous disorders	Two-thirds
Disruption of family life	Two-thirds
'Social isolation'	Three-fifths
Accidents	Increased rate

CH - What problems have you experienced in your work ?

DR - There are a number of problems relating to the Union's medical benefit fund. For historical reasons only a proportion of the Union members are members of the Fund. It is unfortunately only these workers who are able to use the Clinic. Also the Fund states that only the worker and not the worker's family

can receive medical benefits. This limits my ability to deal with the health problems of workers in a complete way. The facilities for referral are also poor and it is difficult to arrange X-Rays and other special tests. All of these things decrease the effectiveness of the Clinic.

CH - To what extent is the Clinic controlled by the workers ?

DR - Obviously this is desirable and the Clinic does represent a first step towards worker-controlled structures. In the past the Clinic was administered from the Union offices and workers could complain or make suggestions about the service to Union organisers. All complaints are taken very seriously and changes to the service made where possible.

We intend establishing a workers' committee that will be responsible for administering the Clinic. We would like this committee to report back to the other Union members regularly and also to get feedback from them about the service provided. It would be extremely advantageous to have open and public criticism so that the whole process is seen to be a much more democratic process. The Clinic staff and the services provided would be answerable directly to the workers. All these changes would lead to the service being under much more genuine control by the workers.

WORKMEN'S COMPENSATION

The Workmen's Compensation Act (WCA) was introduced to compensate workers for accidents or diseases which are caused at work. The Workmen's Compensation Fund is administered by the Workmen's compensation Commissioner, who pays out individual workers in the event of compensatable illness or injury. It is a type of insurance for the worker and it is compulsory for industrialists to participate in the scheme.

Industrialists contribute to the WCA Fund by means of a levy system. The more dangerous the work the higher the levy paid. For example, rock drilling and blasting are regarded as one hundred times as dangerous as hairdressing. This means that employers of rock drillers pay a levy of five rand for every one hundred rand paid out in wages whereas employers of hairdressers pay only five cents for every one hundred rand paid out in wages.

All claims for injury or disease against a company are met from the levy paid by that company. These claims cover medical expenses, temporary or permanent loss of earnings by the worker and up to four hundred rand towards funeral expenses if the worker dies as a result of the injury or illness.

Workmen's compensation operates on a rebate system. If there have not been too many claims then the employer is repaid a certain amount of money paid in as levies. This rebate may be as much as 50%. From this one can see that the industrialist has a strong interest in keeping the number of claims to a minimum. Accidents are therefore often not reported or claimed for.

One of the most effective mechanisms used by management for keeping claims low is the provision of a health service at work. This service generally processes all claims which would otherwise potentially go through the Workmen's Compensation for medical expenses, are dealt with by the sister on the spot, at no extra cost. Although the indus-

trialists bear the cost of employing a sister and running a clinic, their Workmen's compensation rebate can be more than sufficient to pay the sister, clinic costs and all expenses - even several times over.

An interesting point about Worker's Compensation is that it involves private medicine only, paying full private rates for all medical care. Workmen's Compensation patients cannot be treated as ordinary patients in state hospitals. This means that the costs are high and it is a further inducement to keeping claims low, as all claims are met from the particular company's levy and affect the rebate.

LIMITATIONS OF COMPENSATION

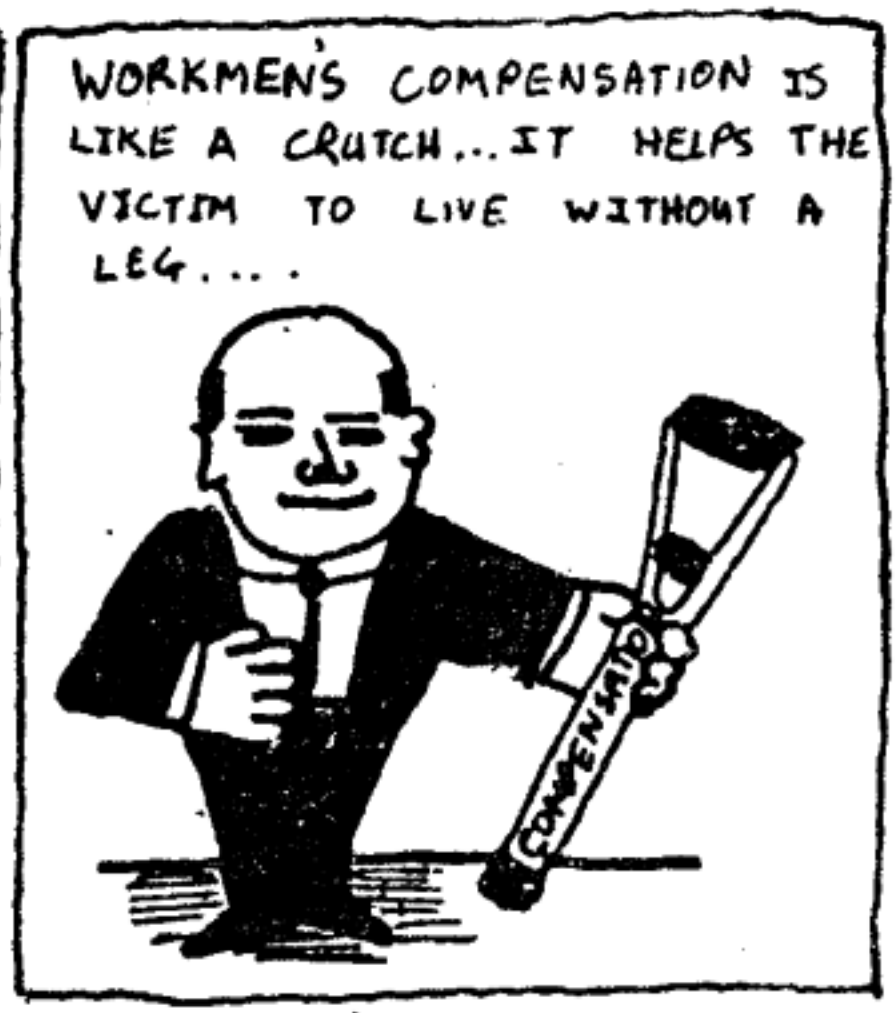
There are a number of limitations on the efficiency of compensation. Workers always lose income in addition to the pain and inconvenience of being injured. They are only paid 75% of their wages while off work. In addition they are not paid for the first 3 days unless they are off work for more than 14 days. The vast majority of claims are for less than 14 days. So, for example, a worker who is off work for 5 days will only be paid 75% of his/her wages for 2 days. Therefore he/she loses 3½ days wages which is a very serious disadvantage for a low paid worker. In addition, there is often a long delay between the time of injury and the time when compensation is received. Therefore, for sickness or injury which is no fault of the worker he or she is effectively punished.

Compensation is calculated according to the wage the worker receives. This means that a worker who earns a lower wage is paid proportionately less for exactly the same injury than someone in a higher income bracket. This situation is made worse in the case of permanent disability. The loss of a hand or arm for a manual labourer may well mean life-long unemployment yet the compensation he/she will receive for this injury is far less than someone whose hand is not as essential for continued employment.

Before compensation can be claimed for, there are a number of relatively complicated forms which need to be completed.

This makes it a difficult task for a significant proportion of workers who are illiterate or who are not used to filling in highly technical forms. This problem becomes very serious when the bosses, whose responsibility it is, fail to report the accident or disease. When this happens it becomes the responsibility of the worker to make the claim and complete all the relevant forms. The situation is further complicated by the fact that when an employer refuses to report the accident he often follows this up by firing the worker concerned. Frequently then injury is accompanied by unemployment.

COMPENSATION IS NOT ENOUGH!



A large proportion of South African workers are not covered by the Workman's Compensation Act. All domestic, farm and casual labourers have no legal recourse if injured at work. Furthermore mine-workers are covered by a different and less comprehensive compensation scheme.

Finally, no compensation is payable in the case of an accident which is attributable to the "serious and wilful misconduct" of a workman, which includes drunkeness and reckless usage of equipment. These categories of accidents are obviously subject to bias, and if a worker is not represented by a union accidents are more likely to be blamed on the "wilful misconduct" of the worker.

Another interesting aspect of WCA is that it protects an employer from being sued even if he/she has failed to ensure the necessary precautions for promoting health and safety in the workplace. It also protects an employer even if his/her negligence has been directly responsible for an injury. This is a very serious limitation and has done much to prevent employers from providing a safe workplace.

AIMS OF OCCUPATIONAL HEALTH (W.H.O.)

+ The promotion and maintenance of the highest degree of physical, mental, and social well-being of workers in all occupations.

+ The prevention among 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 condition.

HEALTH WORKER VICTIMISED

Mr Pravin Gordhan a qualified pharmacist, working at King Edward VIII Hospital in Durban, was detained on November 27 1981

Mr Gordhan, who is also an executive member of the Natal Indian Congress, was kept in solitary confinement until his release on May 7 this year. On his release he was served with a two year banning order and house arrest.

While in detention Mr Gordhan lost his job as a pharmacist, but was told that in all likelihood he would get his job back upon his release. He therefore applied to resume his position on the hospital staff on his release.

On July 7 1982, Mr Gordhan received a letter from the Natal Provincial Administration (NPA) saying there was no suitable post at the hospital to which he could be appointed. The Director of Hospital Services was quoted in the Daily News as saying Mr Gordhan was not considered a sufficiently "productive unit". The Chief Pharmacist at the hospital had alleged that a considerable amount of Mr Gordhan's time at work had been spent on "political activity".The provincial authorities have denied that Mr Gordhan's firing has had anything to do with his recent detention,and claim that the decision was taken on purely professional grounds.

Mr Gordhan,in his eight years at King Edward Hospital,had never been criticised for the way in which he had done his work.The hospital Superintendant,however,has said that the hospital was not obliged to employ people if it did not think them suitable.

The provincial authorities have also claimed that there "is no suitable post" to which he can be appointed despite the fact that a number of posts for pharmacists at Durban's provincial hospitals have recently been advertised.

Mr Gordhan has been offered jobs at private pharmacies outside the Durban magisterial district.He has made applications to the authorities for a modification of his banning order to be made to enable him to take up employment.This too has been refused.

Mr Gordhan has been detained,kept in solitary confinement for over five months,banned,house-arrested and now also denied the right to earn a living.Critical Health condemns this act,as well as all other acts of the authorities,against those progressives struggling for a democratic South Africa.

WOMEN AND HEALTH

The next issue of Critical Health will focus on "Women and Health". The issue will contain articles on women as health workers, women as consumers of health care, women workers and health, and the particular problems of South African women.

We would welcome any suggestions as to what should be included in the issue, and would value any articles or letters submitted for publication.

Write to Critical Health, POBox 2313, Johannesburg, 2000.

GHETTO HEALTH SERVICES

"Ghetto medical services" is a term used by many workers to describe the services provided for them by industry. It suggests that such services are hidden from public scrutiny behind the walls of industry. The term conveys the mistrust workers feel for these services.

This article will examine health services in industry and will present some of the reasons why workers often mistrust these services. It will then look at the people administering these services and examine the contradictory position in which they find themselves. In conclusion a few suggestions will be offered as to what can be done to improve these health services.

In many areas of production management provides health services for workers on the shop floor. These services appear to be advantageous to both workers and management. The workers are given a health service right where they work. They can get treatment immediately if they are hurt or feel ill at work. There is no waiting for hours in queues at government hospitals. No money is spent travelling. They do not have to take time off work which in some industries may mean not getting paid or losing their job. They may also receive (depending on the service provided) good health care.

However behind this benevolent face we find the real reasons why management will spend money on such a service.

Minor injuries are treated at the production site and the worker goes back to work. Very little time is lost which is advantageous to the owner.

Wages are calculated to cover living costs- the cost of food, housing, clothes as well as health care. In other words wages cover what a worker needs to live, to keep him/her healthy enough to work but wages are

also low enough to keep him/her coming back to work day after day.* By providing one of these (food, housing) directly employers can decrease the amount they have to pay in wages. By providing a health service management can pay workers less. If employers can provide this at less than they would have to pay workers to get it themselves it adds to their profits.

So it is economically profitable for management to provide a health service at the work place.

Providing a "caring service" also serves an ideological function. The health care service gives management a benevolent face. The workers are led to believe that such a service is provided with their interests at heart. This belief operates as an effective means of control. Workers who believe their employer is caring are more reluctant to make demands for improved working conditions.

It is possible then to conclude that the primary motivation for providing a health service is not the health of the worker but the maintenance of high productivity and therefore high profit.

WHAT IS THE FUNCTION OF THE PERSON RUNNING THE HEALTH SERVICE ?

Such a person is trained in the traditional medical model. This model deals with individual illness and disease and not with collective risk. It identifies the careless individual worker as the problem rather than the unsafe working conditions where any worker might be injured.

By approaching industrial accidents and disease in this way the health service does two things. Firstly it lets management off the hook. In this view it is the worker who is at fault for letting him/herself get sick or injured.

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*This is an idealised view and in many instances, in particular migrant labourers, the wage is not enough to live on. Workers then supplement their income by other means.

Management therefore appears to have fulfilled its obligation by providing a service which treats those who are sick or injured. The real cause of illness- the work conditions- are left unchanged but by providing a health service management legitimizes the poor working conditions.

Secondly by looking at accidents on an individual level the health service inhibits the development of collective action.
For collective action to develop workers have to have

FIGHT BACK!

A safe and healthy job is your right

information available to them about risk factors and about disease processes. They have to know that a continuous cough could be the first sign of chronic bronchitis or lung cancer. The worker also has to know that he/she is not the only person with the particular complaint. A cough is not an individual failing but a result of exposure to a particular hazard. In a factory this hazard is often part of the work environment.

This point is illustrated by the following example:- The person providing the health service has detailed records. She/he would know where most injuries occur in a particular factory. In a meat processing factory most injuries occur in the room where meat is cut rather than where it is packed or labelled It is unlikely that all the "careless" people just happen to be employed in that section. Rather it is the nature of the work which is dangerous. The work process should be blamed and not the individual worker.

As the injuries in this example are usually minor and the worker can be patched up in the factory clinic and sent back to work with little production time lost it is not in management's interest to prevent the accidents. But it is in the workers' interest. It is interesting then, that this information is available to management who will do nothing about it and not to workers who could demand saftey measures to protect thier health.

WHY DO THE PEOPLE RUNNING THE HEALTH SERVICE NOT PROVIDE THE NECESSARY INFORMATION TO WORKERS?

Most people employed by industial health services are qualified nursing sisters trained in hospital medicine. They themselves have little knowledge of occupational disease. They often do not know the provisions of the Factories Act,which sets down (minimal) protection for workers, as well as restrictions on overtime and shift work. They may know little about provisions of the sick pay funds, Unemployment Insurance Fund or Workmans Compensation. It is therefore unlikely that they will be aware of contraventions of these limited protections for workers.

To impart the information on prevention to workers

takes time, time during which workers could be producing. Management is reluctant to give up that time as it would decrease production for that day. The knowledge workers would gain would give them more bargaining power when confronting management and this is another reason management doesn't allow education sessions with health professionals.

Thus by preventing the awareness of collective risk managementalso prevents the resultant collective action.

Screening services are also provided by industry. Again this has two sides to it.

On the one hand should a worker develop an illness such as lung disease after being in a particular job for a few years, a review of his her pre-emploment clinical could help prove whether or not the disease is work related.

On the other hand the system weeds out susceptables. So in a mine asthmatics would not be employed. Again the health service is looking at the individual and not the collective risk. By excluding the asthmatics it will not prevent the other employees developing lung disease due to exposure to dust. Thus it is the occupational exposure to dust which needs to be eliminated and not the susceptables for example asthmatics. The health service would prevent more illness by monitoring dust levels than performing pre-employment examinations.

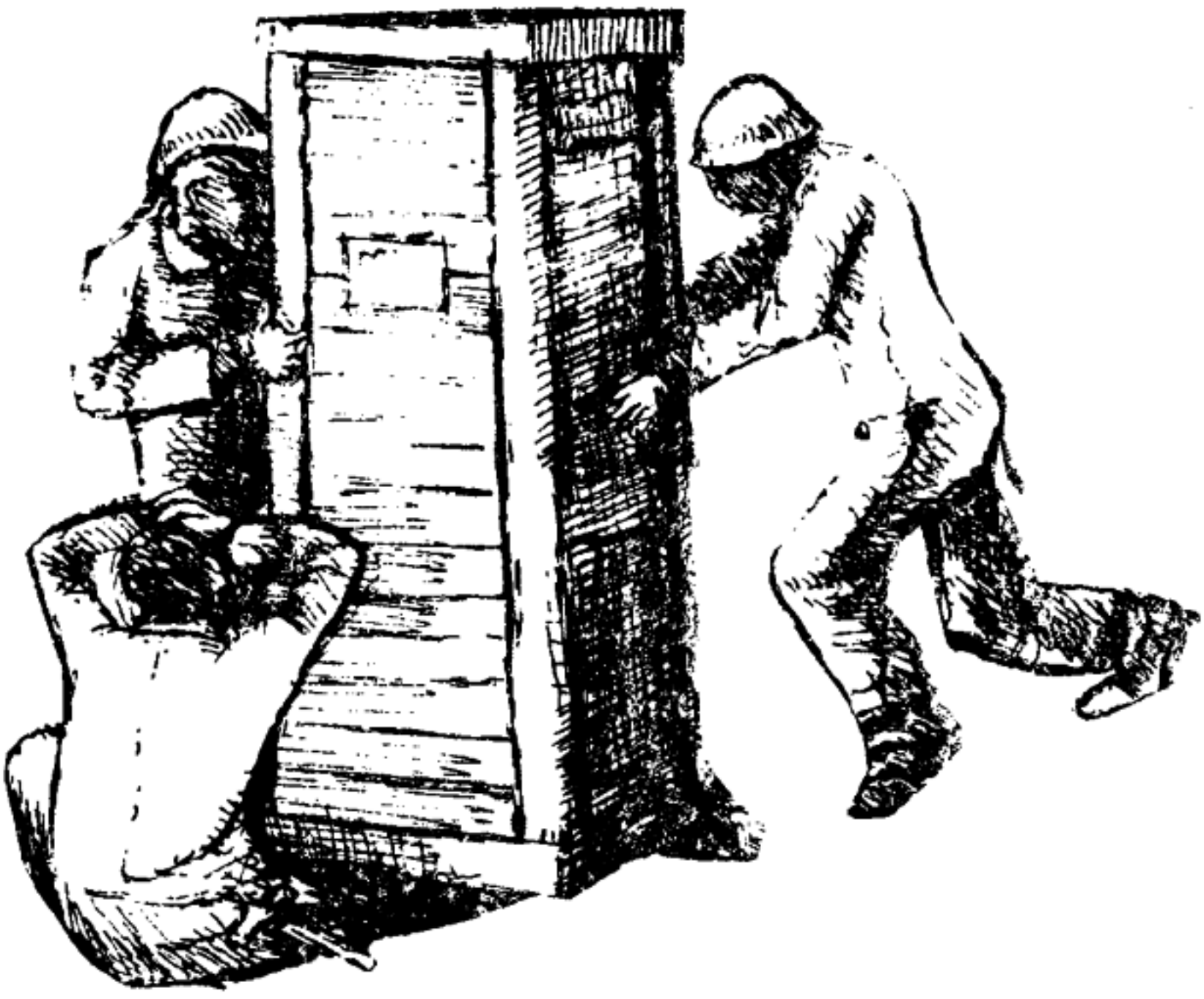
The health service also provides an efficient policing service for management. Factory health workers do home visits when workers do not report for work. They assess if,in their terms, workers are really ill. They decide on the length of time a worker may be off. Often certificates of outside doctors (those not working for industry) are ignored or the time off is decreased. The explanation given is that "outside doctors don't understand the problems of the factory, they are too gullible and much too generous with time off". This implies that the person providing the industrial health service has the problems of the factory as their primary concern and not the problems of the sick or injured worker.

HOW DO PEOPLE PROVIDING THESE SERVICES FIND THEMSELVES IN SUCH A PECULIAR POSITION?

There is no doubt that a significant proportion of people employed in the health service have the workers' interest at heart. Yet they find themselves making sure production is kept at the maximum level and running smoothly instead of looking after the health rights and needs of workers.

Most importantly they are employed by management who pay their salary and do the hiring and firing. These people earn a salary much higher than they would in conventional nursing (which is very poorly paid) and are obviously anxious to protect this improved salary. So the threat of being fired is very real.

Management is in a position of power and severely curtails the area of professional independance of these health workers. Often these professionals have to bow to the profit motive of management rather than adhere to what they believe is in the best health interests of the workers.



Thus the nature of the health service as well as the area of activity to which health professionals in industry are restricted make it very difficult for a person employed by industry in their health service to act in the interest of the workers.

WHAT CAN BE DONE TO IMPROVE THESE "GHETTO SERVICES"?

Firstly it is important for everyone, workers, management and also those delivering the health service to see it in its real light - to see the real function it serves.

Since these services do already exist and do have some benefit for workers, there is little point in advocating their dissolution. Rather the people delivering the health service should insist on total independance from management so they can serve the interests of workers. To acheive this occupational health workers will have to bargain with management, and their power in the bargaining process will only be realised if they group together and organise themselves

As has been emphasized already occupational health services are severely limited as they are provided by management. In countries all over the world, including South Africa,trade unions provide their own health services. This has proved to be cost effective and also does not have the inherent conflict between health and profit which management provided services do. Perhaps ultimately this is the best solution to"ghetto health services".

Anyone wanting to do more reading on this subject may find the following reading list usefull.

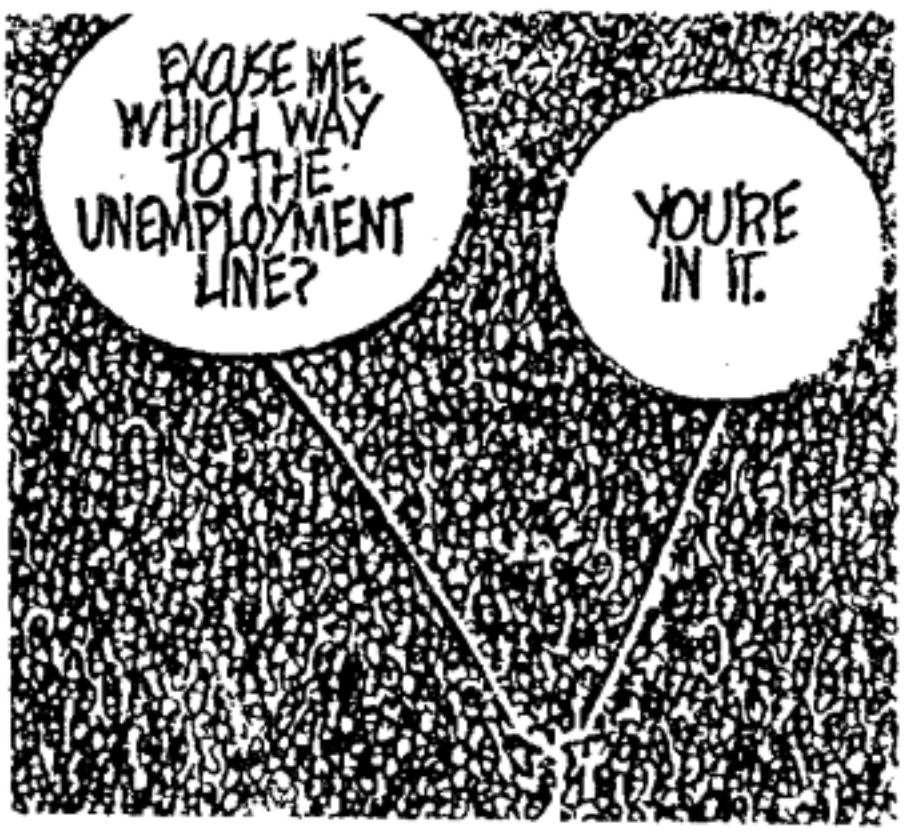
1 Sick Pay.South African Labour Bulletin Vol.6 No.8 pg.55
2 Hazards at Work and How to Deal With Them. P Kinnersley Pluto Press1978.
3 Cape Town Medical Students Conference Papers 1981. Page 122

SAMSA KEPT OUT OF IFMSA

In 1981, a few years after Natal Medical School, UCT and WITS both withdrew from the South African Medical Students Association. The primary complaint was SAMSA's refusal to come to grips with the major causes underlying ill health in South Africa . According to SAMSA, politics and health make "bizarre bedfellows." Especially noteworthy was SAMSA's reluctance to take any action concerning the behaviour of the doctors implicated by the death in detention of Steve Biko or to criticize the racist nature of their universities.

Following WITS and UCT withdrawal, the president of SAMSA preempted this organisation's expulsion from the International Federation of Medical Students Associations. This year however SAMSA (now comprising only the three Afrikaans medical schools - Stellenbosch, Bloemfontein and Pretoria) decided to reapply for membership. At the request of the Danish Medical Students,representatives of Medunsa, UCT, WITS and Natal Medical Students Councils, the WITS Black Students Committee and the NUSAS Health Directive met and drew up a memorandum. This enumerrated their objection to SAMSA with specific emphasis as to why the health of the population is a direct result of the political sructure of South African society. An ad-hoc national medical students committee was formed by the four medical schools concerned.

At the recent IFMSA annual general meeting, SAMSA's application for reacceptance was rejected by a "vast majority."



STRUGGLES AROUND INDUSTRIAL DISEASE

We have seen how management obstructs workers from gaining the full benefits offered by the Workmen's Compensation Act.

However, there are particular problems with the struggles around compensation of industrial diesease as opposed to industrial accidents or injuries.

Industrial disease is illness caused by the work environment. Many illnesses are known to be "related" to the work environment but often one is not exactly sure of the extent to which working conidtions are responsible for the ill health of workers. The major causes of such ill health are the inequalities of income, housing, nutrition and health care, as well as poor working conditions. It is against this background that the particular struggles around industrial disease are fought.

Firstly there is the struggle to get industrial diseases defined as being caused by certain work environments ie. scheduled*. This is a difficult task and requires adequate research and depends on accurate records being kept of who worked where doing what. Many factors interfere with this difficult task.

Most workers have irregular medical check-ups while changing technologies at work create new hazards for workers all the time. There is insufficient funding for research and suppression of unfavourable results of research by employers.

Secondly, there is a struggle for compensation for scheduled diseases. Even if a disease is scheduled a worker needs to know that his/her illness is in fact due to his/her work.

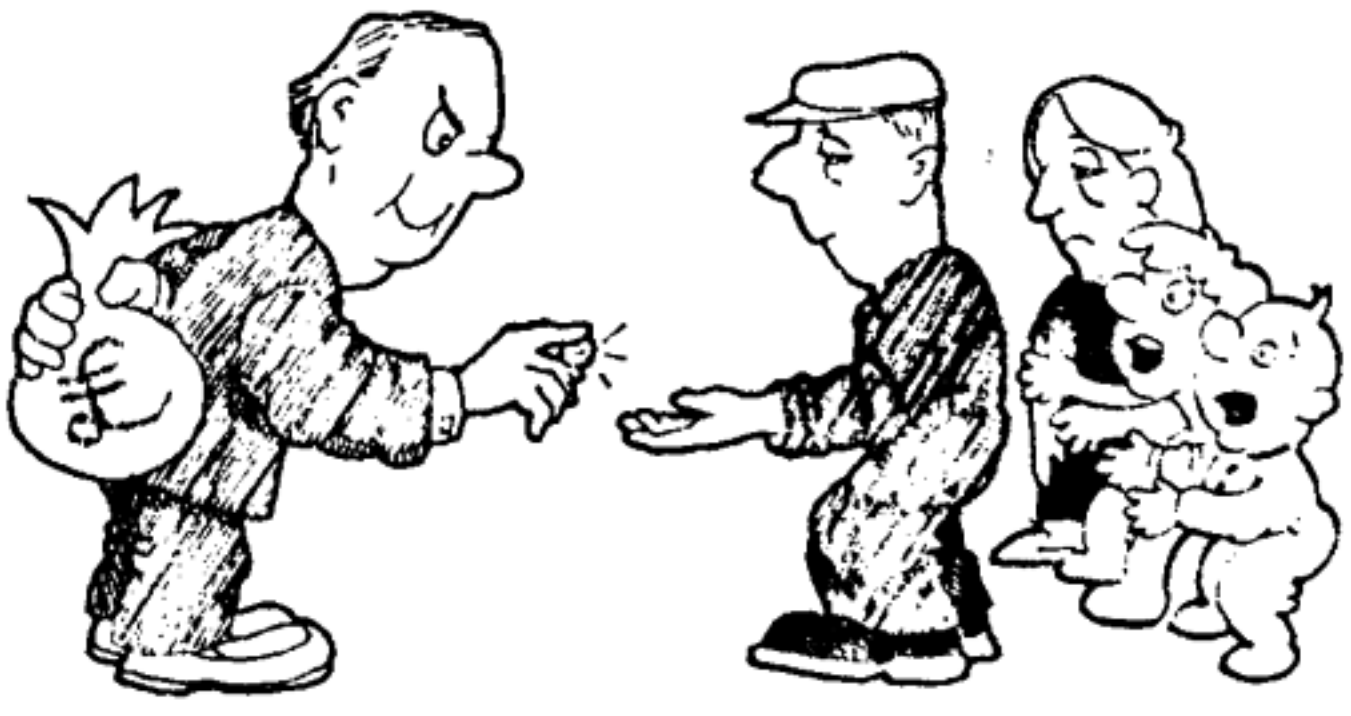
Furthermore, they need to prove it before being compensated. This requires a rigorous medical examination and for some diseases, proof of having worked in a particular industry or having done a particular job for a certain length of time.

There is often a time lapse in the development of a disease. Mesothelioma (asbestos cancer) may take up to 25 years to develop. Workers may well no longer be in the industry in which they contracted the disease. The migrant labour system aggravates this problem as worders are sent away to widely dispersed areas and may have no access to proper health services or the means necessary to claim compensation.

There is therefore a need for increased awareness of industrial disease amongst workers, health workers and the general public.

Very little information is available to those most at risk about the dangers of their work.

"Scheduled diseases" are recognised by the WCA commissioner as compensatable. Only the following 16 diseases are scheduled: hookworm (in workers other than indians and africans); anthrax; arsenical poisoning; benzene poisoning; cyanide rash; dermatitis; poisoning by halogen derivatives of hydrocarbons; lead poisoning; mercury poisoning; disease related to the use of radium or x-rays; phosphorous poisoning; disease related to the inhalation of silica dust, asbestos dust, or other mineral dust; chrome ulceration; TNT poisoning; cancer of the skin; and manganese poisoning. These are listed in more detail in Schedule 2 of the Workmens Compensation Act.



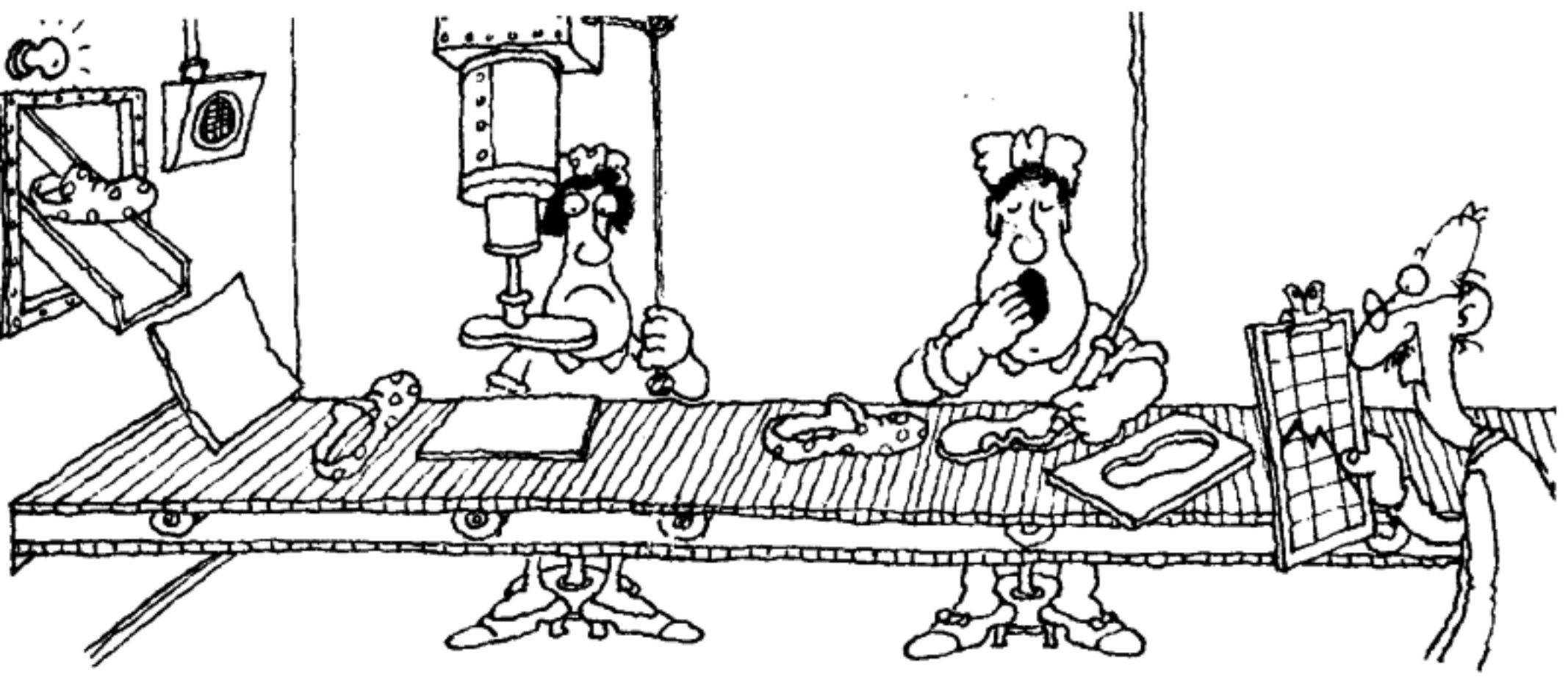
WORKERS & MENTAL HEALTH

Critical Health intends raising the issue of mental health in subsequent issues. To initiate discussion, we offer some ideas on mental health and its relationship to the working class in South Africa. Comment on the article will be welcomed; please send to P.O. Box 2313, Johannesburg.

Many people are called "mad" or "schizophrenic" or "mentally confused" by the medical establishment (the last label is the most common psychiatric diagnosis at Baragwanath Hospital in Soweto). There is a tendency to believe that such people suffer from some kind of sickness. We are told that some people, particularly workers, blacks and women, are somehow physically predisposed to "mental illness" in the same way that some people are vulnerable to T.B. We are also led to believe that, given the right cure - eg. drugs or institutionalization - the problem will disappear.

Recent research has shown, however, that just as T.B. is related to poverty and inadequate social services, and heart attacks occur almost totally amongst the affluent, so "mental illness" is a response to the social conditions under which we are forced to live. There is an increasingly strong view amongst mental health workers that what is called "mental illness" is often caused by a system of making profit for the few, and is not a sickness.

Workers, because of the particular conditions of their oppression, experience a great deal of mental suffering and breakdown. They spend most of their lives doing repetitive jobs in bad conditions for poor wages. This they do to produce goods which they will seldom enjoy using. Both inside and outside the workplace they are isolated from each other. For example, trade unions face a tough battle against the racial divisions of apartheid as they struggle for better working and living conditions for their members. The unemployed face boredom, frustration and a constant battle to survive. In addition, pass laws and harrassment create general stress for all.



BORING JOBS DRIVE PEOPLE MAD

Mental health workers are realising more and more that as long as they view mental suffering in isolation, divorced from its social causes, they continue to blame individuals for social and political injustices. In so doing, they protect the interests of the apartheid society that oppresses us.

WORKERS' RIGHTS LAW OF ITALY (1974)

+ Workers have the right to meet during working hours.

+ Workers have the right to protection against victimisation.

+ Doctors paid by employers have no power in the factory. These doctors are not allowed to give doctor's certificates for sick leave. Certificates are given by state health service.

+ Workers have the right to call in any experts they want to help them solve their problems.

+ Workers have a right to set up union health services in every factory.

POLIO EPIDEMIC

Recently, over 260 children have been paralysed and more than 28 children have died as a result of poliomyelitis (polio). The epidemic began in May this year, and like many other preventable diseases, has hit mainly rural "homeland " areas. Gazankulu, Venda and Lebowa have been most seriously affected by the disease, but patients have been reported in other parts of the Transvaal as well.

Polio is a relatively rare but highly contagious disease, which is spread by contact with those who are already infected with the virus. The initial symptoms of polio are often mistaken for a type of flu complicated by fever and diarrhoea. In most cases the disease is confined to the throat and intestines. However, in one in every 100 to 1000 cases, the virus attacks the spinal cord leading to paralysis, and if left untreated can prove fatal.

Last year there were very few cases of polio reported, and workers at State Health reported that polio appeared to be under control. The subsequent outbreak of this new epidemic came as something of a shock to the state authorities.

According to the state, the causes of the epidemic are the spread of polio from neighbouring states, failure of parents to immunize their children, ignorance, superstition and "disbelief of white medicine". As in the case of the cholera epidemic, the state has chosen to blame the victims for a disease they could never prevent.

The level of polio in a community is related to environmental factors and the effectiveness of immunization. Therefore inhabitants of areas with poor sanitation and water supply are far more susceptable to viral gastrointestinal infections such as polio. The disease can be easily prevented if people are effectively immunized with just three doses of the polio vaccine. It is essential that health services ensure that preventive health programmes are readily available.

The state reacted to the polio epidemic by restricting publication of information about it. In some cases immunization campaigns have been totally inefficient. Although the first cases of polio were reported in mid-May, immunization at Letaba Hospital only really started four weeks later.

The actual immunization programmes have been hampered by lack of personnel, vehicles and, despite claims to the contrary by the state, the scarcity of the vaccine itself.

Furthermore, most of the available vaccine was given to sch- school children, and by the time attention was devoted to the group most at risk (those under 5 years of age)there was little vaccine remaining. At the same time that the radio was telling mothers to bring their children for immunization, the clinics were already out of stock of the vaccine.

The failure of the vaccination campaigns was due to a number of misconceptions.Many rural blacks were suspicious of the vaccine and distrusted the health services. Usually health services cost money, so what was it that the state was giving out for free? Some people suspected that it might contain poison. Furthermore the radio had said that it was mainly Shangaans who had contracted the disease. People from other ethnic groups felt that it would therefore not affect them and did not want to be vaccinated.

Although polio vaccine is available from clinics around the country, many people were not aware of the need for or the importance of vaccination against polio. In addition, clinic in rural areas are so sparsely distributed and transport facilities so poor as to make it extremely difficult to utilize even those minimal services provided.

Effective immunization can eliminate the chances of getting polio. It has been found, however, that about 20 per cent of those currently suffering from the disease had previously been immunized. The reason for this is that the vaccine was not properly handled. It has to be kept at below freezing temperature until just before it is administered. Careless storage, handling and packaging can break this "cold chain" and make the vaccine ineffective. Dr Pretorius, the superintendent at Letaba blames the South African Railways for failing to notify the health authorities when the vaccine is brought up to Tzaneen, resulting in the vaccine being kept under incorrect conditions and becoming ineffective.

The outbreak of yet another epidemic disease in the rural "homeland" areas is of great concern. Tuberculosis, typhoid, cholera, and numerous other preventable health problems have recently flared up. In the same period the state has cut expenditure on health and has frozen the level of health personnel. The real reasons for the spread of these epidemics can be traced not only to the atrocious living conditions in rural South Africa but furthermore to state neglect of health services in those areas.

NUSAS Health Fact Sheet
Number 1 EXTRACTS

Accidents: In South Africa, industrial accidents in general do not present a major cost to management. Unskilled workers are easily and cheaply replaced, especially considering the high unemployment rate. Injured or "unproductive" workers can be endorsed out of the cities back to the "homelands" with little chance of obtaining substantial, or any compensation (see legislation). In 1976, 340 000 accidents occurred in work places in South Africa and 100 000 hands, 50 000 feet and 40 000 eyes were estimated to be seriously injured.

Legislation

Out of 8 million workers in South Africa, 71,9% are not covered by legislation relating to occupational disease.

The twin aspects of statutory regulation, namely, prevention and compensation, have been dominated for too long by the Factories, Building Works and Machinery Act 41 of 1944 and the Workmen's Compensation Act 30 of 1941.

Substances causing ill-health: Many substances are known to be hazardous to health, e.g. lead. A recent survey showed that 13 of 18 lead-using firms failed to meet industrial health standards, accepted overseas in one or more major respects. More than 40 000 workers who mine, produce or handle asbestos run the risk of serious or even fatal illnesses.

Farmworkers

"Farmworkers — the largest, lowest-paid group of workers in South Africa — also have less protection than any others against occupational diseases and accidents". In some areas of the Western Cape, wheat farmers were paying about R12 a week, while in the Free State, workers received half of this wage.

Major hazards to which farmworkers are exposed are:

1. diseases caught from animals (zoonoses).
2. poisonous pesticides.
3. accidents with farm machinery.
4. maltreatment by farmers.

Occupational Diseases caused by Gases and Chemicals:

A few examples:

Ammonia: wide range of industries where exposure may take place. Total of 6 794 factories employing 589 672 workers.

Ozone: long exposures to high ozone concentrates can cause oedema, haemorrhage and chronic bronchitis. 3 793 factories exist employing 175 605 workers.

Vinyl Chloride: tests have revealed cancer of liver, kidneys, lungs, brain. Potentially exposed population in 451 plastic factories is 23 767 workers.

☞ RESOURCES

1. BOOKS

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1.2 Doyal, The Political Economy of Health, Pluto, 1979.

1.3 Engels, The Condition of the Working Class in England, Panther, 1969.

1.4 Eva and Oswold, Health and Safety at Work, Pan, 1981.

1.5 Kinnersley, The Hazards of Work, How to Fight Them, Pluto, 1979.

1.6 Mager Stellman, Womens Work, Womens Health, Pantheon, 1977.

1.7 McDonald and Doyle, The Stresses of Work, Nelson, 198

1.8 Nichols and Armstrong, Safety or Profit, Falling Wall Press, 1973.

1.9 Stellman and Daum, Work is Dangerous to your Health, Vintage Books, 1973.

2. SOUTH AFRICAN PUBLICATIONS

2.1 Cornell, A Healthy Profit? Looking at Health in Industry, in The People and the Professionals, Conference Papers, Medical Students Council, UCT, 1981

2.2 Critical Health, Number 4, Asbestos in South Africa
Critical Health,,Number 8, whole edition

2.3 Fosatu, Foundries

2.4 Health Care Trust, publications
Noise
Workers Beware, Lead is a Poison
The Dangers of Asbestos
Cotton Dust and Brown Lung

2.4 Industrial Health Research Group, papers
A Guide to the Workmens Compensation Act
Health and Safety Organisation in Three Countries

2.5 Jinabhai, Occupational Health in South Africa, mimeo, Dept. Community Medicine, Natal Medical School

2.6 Meyers, Asbestos and Asbestos-related Disease in South Africa, SALDRU Working Paper , number 28

2.7 NUSAS National Directive for Health, Work and Health, Fact sheet number 2, 1981

2.8 South African Labour Bulletin, Volume 4, number 9 and 10, Special Issue on Occupational Health

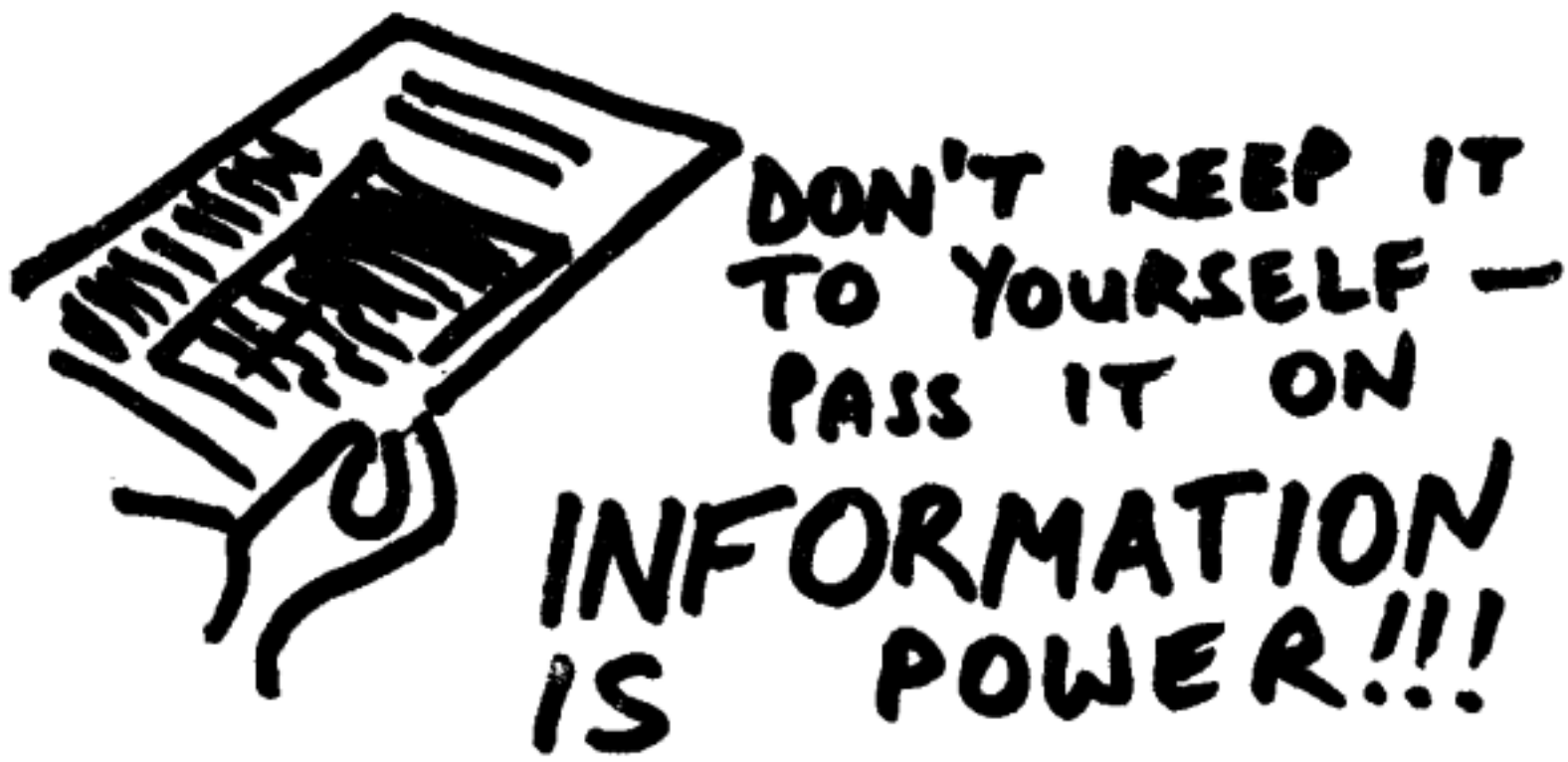
2.9 Westcott and Wilson (editors), Perspectives on the Health System - Hunger, Work and Health, Ravan 1980
2.10 Work In Progress, number 16, Industrial Health

3. ORGANISATIONS CONCERNED WITH OCCUPATIONAL HEALTH

3.1 African Food and Canning Workers Union, Paarl Union Clinic, c o AFCWU, Ray Alexander Union Centre, Klein Drakenstein Rd, Huguenot, 7646, Cape.
3.2 Community Research Unit, P.O.Box 48303, Qualbert, Durban.
3.3 Industrial Aid Society (IAS), 4th Floor, York House, corner Rissik and Kerk St., Johannesburg.
3.4 Industrial Health Research Group, c o Dept. of Sociology, University of Cape Town, Rondebosch,7700
3.5 Industrial Health Research Group, P.O.Box 491, East London.
3.6 Technical Advice Group, P.O.Box 44394, Linden 2104.
3.7 Urban Training Project(UTP), 5th Floor, Merlin House, 49 Simmonds St., Johannesburg.

4. OTHER

4.1 Critical Health is interested and willing to publish the names of other publications and organisations dealing with occupational health. Please write to Critical Health with the information you would like us to publish.
Critical Health is willing to assist any community organisations or unions to get in contact with people with skills that may be of assistance to them.
Write to Critical Health, P.O.Box 2313, Johannesburg.



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Deaths of People in Detention under Security Laws:

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ERNEST MOABI DIPALE 8.8.82