HesaMag
#03
Social inequalities in health: the impact of work
Women and occupational diseases in the European Union
Daniela Tieves, guest researcher, ETUI

The report builds on a body of work done by the ETUI on the link between the struggle for equality and health at work. It draws on information gleaned through a network of contacts in a selected group of EU countries. It has the virtue of examining a set of national and European data on the impact of work on health through the filter of a gender perspective, highlighting the scale of discrimination in this area and offering useful insights both for policy makers and research.

ETUI, 2011
Soon available in French
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Newsflash…

**Union calls for sandblasting ban**

The global union representing garment workers has called for a ban on the practice of sandblasting jeans, arguing that it can cause silicosis and even death. According to Patrick Itschert, General Secretary of the International Textile, Garment and Leather Workers’ Federation (ITGLWF), 550 former sandblasting workers in Turkey have been diagnosed with silicosis since 2005, including 46 deaths.

Speaking ahead of a 20 January meeting in Brussels of unions and major brands and retailers, he said: “In Turkey, the world’s third largest exporter of jeans and the only country so far where the impact of sandblasting on the health of workers has come under scrutiny, 550 former sandblasting workers have been diagnosed with silicosis since 2005 and 46 have so far died of the disease. These officially-documented cases are just the tip of the iceberg both in Turkey and globally.”

Calling on the companies to act, he added: “Even if brands and retailers adopt rigorous standards regarding sandblasting, there will always be suppliers that do not enforce those standards, thus putting unsuspecting workers at risk. Therefore the best policy is to ban sandblasting altogether in the garment industry. Several leading brands have already done so and we believe others should now do the same.”

Crystalline silica exposure can cause silicosis, lung cancer and autoimmune diseases. Sandblasting is a technique used to give jeans a fashionably faded or aged appearance.

**Denmark: trade union campaign to cut airport pollution**

A Danish study commissioned from Aarhus University by the 3F union has found that workers on airport tarmacs are breathing in extremely high levels of ultrafine particle emissions from aircraft engines, at a high cost to their health. A case of bladder cancer in a baggage handler has been recognized as an occupational disease. Danish trade unions are calling the national and European authorities to account by campaigning for a series of demands including an exposure limit value.

The study’s authors measured the air concentration of ultrafine particles (diameters below 100 nanometres) on the aircraft parking aprons and manoeuvring areas at Copenhagen airport. Measurements in one area studied showed concentrations above 500,000 particles per cm³. For comparison, recorded levels in the Danish capital’s most heavily polluted avenue have never topped 40,000 particles/cm³. The chemical properties of these ultrafine particles are still being analysed and the findings will be published in a new report.

The union launched a “Clean-Air” campaign and struck up contacts with the ETUC and Manchester and Arlanda (Sweden) airports to up the campaign to EU-level.

**Work is adversely affecting the health of 25% of European workers**

The first results of the fifth European Working Conditions Survey were unveiled in November 2010 by the Foundation for the Improvement of Living and Working Conditions (Eurofound). Currently, 8.4% of EU-27 workers report that they are satisfied or even very satisfied with their working conditions – an increase of 2% over 2000 and 2005. However, one quarter of European workers still feel that work is having an adverse effect on their health. All these indicators vary according to the position occupied in the social division of labour: manual workers are more likely to consider their health to be at risk and affected by their work than clerical workers. There is nothing surprising about this: blue-collar workers are – as the results of the survey once again confirm – more exposed to physical and professional risks overall than white-collar workers.

When it comes to the major physical risks, the survey results provide little cause for celebration. The proportion of workers forced to make repetitive hand or arm movements continues to increase. In 2010, the share of workers exposed to this risk stood at 63.5%, an increase of 7.4% in ten years. Exposure to chemical products and substances is also on the rise, albeit to a lesser extent. Currently, an average of 15.3% of EU-27 workers are exposed to them, compared to 14.5% in 2005. Among skilled manual workers, almost one worker in three is so exposed.

The proportion of workers who are forced to adopt painful or tiring positions for at least a quarter of their working time has risen by 1% over 2005, and now stands at 46%. Exposure to this risk is far higher among manual workers (72% among skilled workers and 59% among unskilled workers). Finally, the 2010 results show a slight decrease in average exposure to vibrations. However, this figure masks an opposite trend among skilled manual workers, whose exposure to vibrations has increased by close to 10% over 10 years. Ultimately it is no surprise to find that while on average, 60% of European workers say that they would be able to continue doing their job after the age of 60, this is the case for less than half of manual workers.

Source: ITGLWF

Source: Dublin Foundation

Read more on [http://projektcleanair.dk](http://projektcleanair.dk)
Birth defect risk more than doubled by solvents

French researchers have found disturbing new evidence of the harm solvents may do to pregnant women and their unborn child. In a study of over 3400 women in Brittany followed up for two years after the twelfth week of pregnancy, 30% of the study group self-reported as being exposed to at least one solvent in the course of their work. Most of the exposed occupations were in health care (nurses, nurses’ aids), maintenance (cleaners), laboratory workers and the hairdressing/beauty professions.

The findings point to a link between the frequency of occupational exposure to solvents in early pregnancy and the occurrence of serious birth defects. Birth defects are relatively uncommon in the general population, affecting 2-3% of newborns. The study done by researchers from Inserm found that women with the highest exposure are at about 2.5 times higher risk of giving birth to a child with a birth defect than unexposed women. The main defects concerned are oral clefts (harelip), kidney and urinary tract malformations and male genital malformations.

Source: Occupational and Environmental Medicine, July 2009

Hair and beauty professionals: social partners aim to bring down skin diseases

European hairdressing and beauty industry employers and unions (UNI Europa Hair and Beauty and Coiffure EU) sealed an agreement on the health of workers in the sector on 27 and 28 September 2010. The agreement is known as the "Dresden Declaration" after the city where it was signed, and aims to prevent the skin diseases that hairdressing workers are particularly prone to.

Hairdressers daily handle hundreds of different chemicals found in shampoos, hair dyes, lotions and other hair bleach products. With repeated use, these products gradually break down the skin barrier and can cause irritation and allergies.

The agreement provides for better training and information about the hazards of cosmetics and hair dyes, and also aims to improve the use of personal protective equipment.

The "Dresden Declaration" falls within the SAFEHAIR project run by the European social partners for the hairdressing sector in association with the University of Osnabrück (Germany).

Source: FGTB

2nd ETUC resolution on nanos

On 1 December 2010, the Executive Committee of the European Trade Union Confederation (ETUC) adopted a second resolution on Nanosciences and Nanotechnologies.

The resolution is a result of the work done by the ETUC Working Group on Nanotechnologies and of the discussion during the seminar “Nanotechnologies in national and European trade union strategies” organised by the ETUI on 19-22 October.

The aim of the resolution is to call for the protection of workers potentially exposed to nanomaterials in all sectors. It contains contributions that reaffirm the principles set out in the first ETUC resolution of 25 June 2008, such as the precautionary principle and the "no data, no market" principle.

The second ETUC resolution incorporates new subjects related to the technical and regulatory developments on the definition of nanomaterials, the need to adjust the legislative framework to integrate the principles of hygiene and traceability, and the role of standardisation.

In particular with regard to the definition of nanomaterials, it should enable and support the generation of information and its dissemination in the supply chain in such a way that workers and consumers are informed when nanomaterials constitute an integral part of a substance (or a mixture) and whether nanomaterials can be released from related products.

One of the ETUC’s demands is the development of concrete measures in the workplace to identify who is exposed, to what extent and to what type of nanomaterials, and which prevention measures to install to avoid exposure. Moreover, the ETUC invites Member States to set up a register of workers’ exposure to nanoparticles in association with health surveillance programmes.

Source: ETUC
Cuts to the Health and Safety Executive (HSE) and to local authority budgets announced in the spending review will make it easier for rogue employers to take unacceptable risks with the health and safety of their workforce, the Trade Union Congress (TUC) said on 22 October 2010.

TUC General Secretary Brendan Barber said: “In the last seven days health and safety has been hit by a triple whammy. The Young Review, which last week seemed to rule out any commitment from the Government to the occupational health agenda, was followed this week by deep cuts to spending which will make it easier for employers to avoid their obligations under the law to keep their staff safe and well at work.

“This week the HSE saw its budget cut by 35 per cent and that, combined with a 28 per cent cut in local government funding, will have a damaging impact on safety in workplaces up and down the UK.

“Workers need their safety and health protecting now more than ever. More than a million workers are currently suffering from an illness or injury caused by their work, and last year over 30 million days were lost due to work-related sickness absence. This time off work cost employers £3.7 billion, yet much of this could have been prevented if they had taken better care of their staff.

“Cuts of this magnitude cannot be achieved through ‘efficiency savings’ but will mean job losses for large numbers of frontline staff. That will mean fewer visits to workplaces, less enforcement of safety law, and reduced health and safety guidance for employers.”

Source: TUC

The Autonomous Community of Castilla-La Mancha (Central Spain) has published official findings on the causes of fatal work-related accidents in the region from 2005 to 2007.

The report’s analysis of 90 cases gives a clearer picture of the causes involved in these accidents. It identifies different groups of causes, the two most implicated in fatalities being work organization and poor prevention management.

The biggest concentration of fatal accidents in the building industry is among manual workers (86 of 90 accidents), and men (89 of 90 accidents). The under-25s run double the risk (19% of fatal accidents for a group comprising 9.5% of the workforce). Being an immigrant worker multiplies the risk by 1.5.

The fatalities were found to occur in firms with serious shortcomings in the organization of prevention. Of the 90 fatal accidents, only 2 happened in companies that had fulfilled all their statutory health and safety duties. 30% of firms had done no risk assessment. Half of the firms that had done a risk assessment had failed to identify the risk that resulted in the accident. Where it was identified, 30% of the firms concerned had not identified a preventive measure. When a preventive measure had been identified, most of the firms concerned had not implemented it.

The report also highlights the increased risk of fatal accidents in very small undertakings (1 to 5 persons) and for subcontracted workers.

Source: ETUI

Read more on www.csc-en-ligne.be
The initial data from the fifth European Working Conditions Survey were published in November 2010. The mine of information yielded by a survey of 44,000 workers clearly cannot be summed up in a single page. But one important thing stands out – when asked if their health and safety was at risk from their work, a quarter of workers answered “yes”. It was a view held by more than one in three manual and nearly one in five non-manual employees.

Another striking thing is how much so-called “presenteeism” goes on, i.e., people feeling obliged to go to work when ill. Presenteeism comes about from two kinds of pressure: direct pressure from employers, and that from the social security system (sub-income benefits, no pay for the first or first few days off sick, etc.). Nearly four in ten European workers went to work whilst ill in the twelve months up to the survey. Women are more often under such pressure than men.

Of the factors that harm health, the percentage of workers exposed to chemicals has been virtually unchanged since 1995. Substitution of hazardous substances remains a top priority for improving occupational health.

There are clear risks related to work organization, too. When asked if they will be able to do their current job when they are 60 years old, less than 60% of workers thought they would.

This is an average figure that varies widely by where they stand in the division of labour. Most of the lowest-skilled manual workers did not see themselves still being able to work at age 60 – just 44% think they can hold out. Things are little better among the highest-skilled manual workers – only half thought they would be able to do the same job after hitting 60. For the lowest-skilled non-manual workers, the percentage was higher at 61% and up to 72% among the highest-skilled non-manual workers. So the picture is undeniably better for white-collar than blue collar workers - but still not perfect.

What the survey does show is that the long-term impact of work on health may be much more worrying than its immediate effects. Women who predominantly work in jobs and sectors where the immediate consequences of work are less noticeable lose any advantage looked at over a full career. They are more tightly-controlled at work: fewer women than men can take a break when they want, or have prospects for career advancement. Not just that, but they more often have to hide their feelings at work than their male colleagues.

The data show up things that are often disregarded in the Europe-wide debates on retirement age and employment among the over-50s. Extending working life has different meanings depending on which rung you stand on in the job ladder. For the least-favoured groups, the build-up of poor working conditions over life often makes it a physical impossibility to keep working. The way things are, a building worker, cleaner or call centre worker will have difficulty keeping their job and their health after the age of 50 or 55. Adjustment schemes for older workers will not be enough given the build-up of ill health throughout working life.

Without a big improvement in working conditions and more control of them by workers, delaying retirement is little better than a cynical ploy for cutting the pensions of those already on the lowest incomes.
Union action can make the difference

Workers have little or no say in the organization of their work, and it is time that their views were properly recognised as being equally valid as those of employers and self-styled experts. What unions have to do is support their members in wrestling back ownership of their labour.

Laurent Vogel  
Director, ETUI Health and Safety Department
For upwards of a century, occupational health has developed more as the purview of specialists. The hazards of work have been pigeonholed into different disciplines. Occupational medicine, industrial safety and industrial hygiene have developed as separate areas. After World War Two, ergonomics and occupational psychology gradually marked out their territories. More recently, psychosocial factors have come to the fore, addressed through different approaches by professionals more often in competition than cooperation.

The union approach does not preclude what each of these disciplines has to bring provided those concerned act for occupational health rather than putting it second to other concerns like employee selection, productivity and discipline. What gives union action its uniqueness and potential is that it starts by recognizing that workers have their own perceptions and knowledge of working conditions and how they affect health. In some cases, that perception is immediate: having a bad back or joint pain, feeling tired or demoralised, seeing that scaffolding is unstable or that the pace of work cannot be kept up. In other cases, the perception needs to be organized. It may take different forms from one person to the next according to age, gender or other factors, and it may be difficult to see the collective dimension of the problem. Sometimes, a link needs to be made between the experience of workers from different generations where long-term effects are concerned – immediate perceptions can mask a less visible problem. The large-scale advent of computers into offices in the late 1970s, for instance, prompted widespread fears that the new work equipment might cause miscarriages. This seemingly irrational response was in many cases an indirect signal of being ill at ease with an increasingly impenetrable work organization and the dangers of increased employer control bypassing the means for workers to fight back handed down by union struggle.

In one region of Italy, some hospitals assess the risks to reproductive health and take preventive measures, while others do not. The activity of union health and safety reps is clearly key to getting this result. In France, workers in firms with a health and safety committee are twice as likely to have been given health and safety information or training on a like-for-like basis (i.e., comparable sectors and company sizes). Examples abound in Europe, as elsewhere. The existence of proactive trade unions with specific health and safety reps often makes the difference between real prevention and a management tick-box exercise. These facts are important, but do not explain the why and the how. In other words, why is trade union action so important, and how can it be effective?

Health at work was a central factor in making workers conscious of forming a class distinct from other classes of society in the early period of the industrial revolution. Intensive exploitation of the first generations of industrial workers left its marks on their bodies. All 19th century accounts point to a very high rate of early deaths among industrial workers. Organised labour had to act immediately and urgently to do something about these life and death issues. The unions actively rebutted attempts to portray accidents as inevitable in the late 19th/early 20th century. In the closing third of the 19th century, joint initiatives were launched beyond national borders, including for shorter working times and the replacement of certain hazardous substances like white phosphorus in match manufacture and lead in paint.

Even today, most surveys that ask workers what they want trade unions to do find that improving working conditions comes high on the list. Yet problems and pitfalls abound. There is no hard-and-fast guarantee that union action will achieve improved working conditions. It takes critical thought, discussion, strategy formulation and experience-pooling. It may sometimes seem to conflict with other priorities of union action for pay or jobs. It raises many immediate questions, some of which require long-term answers. The current situation where EU health and safety policies have petered out has increased the role of trade union action. “Top-down” reform through EU directives is unlikely to drive major changes until bottom-up pressure evens up the playing field.

Getting them to talk about working conditions is to make a start on regaining dignity for all those who have such conditions forced on them by others.

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There may be no quick fix, but there is a solid baseline: empower workers, not let specialists annex matters relating to their health. It is an important starting point because it calls into question one of the major elements of work organization: the division between managers who devise and operators who put into practice. Getting them to talk about working conditions is to make a start on regaining dignity for all those who have such conditions forced on them by others.

Workers’ unique experiences can fill the gaps and overcome the biases of number-counting scientific methods when it comes to exploring new issues. In the 1970s, workers’ complaints about the limits on exposure to certain organic solvents were often looked at as askance. The protocols agreed on by scientists found no biochemical abnormality below certain exposure levels. Yet the workers complained of memory lapses and irritability. Investigations instigated by some unions found that these complaints reflected genuine health problems. Over time, a section of the scientific community developed more accurate analytical methods that identified the problems. The employers and public authorities used the uncertainties and controversies as an excuse for doing nothing. The late 1980s saw a rash of newly-named diseases like chronic painter’s syndrome, solvent encephalopathy, and psycho-organic syndrome. It took a further few years for a handful of countries to recognize these conditions as occupational diseases, while others continue to ignore them. The tenacity with which some unions campaigned on the issue and the alliance they forged with a section of the scientific community helped improve the conditions of prevention. In the late 1990s, union networks launched EU-wide projects to replace hazardous chemicals, particularly in the building industry.

This is anything but an isolated example, and is an object lesson in what is specific to the union approach. Giving visibility to what is invisible, identifying the collective dimension to what is often seen as an individual health problem, turning that collective consciousness into interest articulation.

**Pitfalls...**

Obviously, not all stories are success stories. There is also a catalogue of failures that are just as instructive as the successes.

It took the labour movement in many countries generations to demand a ban on asbestos. A sorry tale, but one that reflects the pressure from industry holding jobs to ransom. Any significant improvement to health at work has been portrayed by employers as a threat to competitiveness. Apocalyptic howls have greeted everything from taking children out of the mines, to banning asbestos or requiring an assessment of health risks before putting chemicals on the market. Employer pressure has had its biggest effect when it has relied on a productivity-driven ideology that automatically sees output growth as creating social progress. The obsession with productivity often goes in hand with the illusion that science will solve problems as they arise.

In the late 19th/early 20th century, the issue of compensation for health damage pushed the need for prevention in the workplace into the background. New laws picked out specific risk factors, creating compensation schemes (work accidents first, a small number of diseases later on). To some extent, the focus on these issues took the momentum out of challenges to work organization and demands designed to eliminate risk factors and give workers control over their working conditions.

Compensation for accidents and certain diseases apart, the most visible and recognized forms of health damage may be included in wage setting. Night work and some particularly hazardous exposures can result in a direct (through so-called “danger pay”) or indirect (where certain health risks are treated as part of the job) wage adjustment. In these cases, job blackmail may be combined with threats to income, whereby better working conditions almost automatically means forfeiting pay or bonuses. Looking beyond this key material aspect, risks may be hard-wired into the occupational identity of some categories of worker. Short of being able to eliminate them, the risks are played down or given a positive spin. This is a false defence mechanism to protect health by playing down unease and developing practices to “manage” some risks; but it can also produce a kind of fatalism. In many cases, it is turned against workers by some experts who treat it as irresponsible risk-taking without inquiring into where it comes from.

Another obstacle has been the unequal influence of different categories of worker within unions. Women, migrant workers, young workers, workers in contingent jobs or with less recognized qualifications had little say. In certain eras, women were not allowed to join trade unions, and the occupational health solution offered was to bar them from certain jobs like mining, night work, etc. By and large, the most exploited categories are those where occupational health problems are most disregarded. This second obstacle also shows the huge potential of a dynamic, union-led workplace health policy. It is both key to getting a foothold in new, less organized sectors or categories and goes to make for sound internal democracy in action. It is also vital to create solidarity between workers in different firms working on the same job. One probable criterion for successful trade union action is the ability to address the issues raised by subcontracting, and identify the least well-represented categories with the worst working conditions. A close look at major chemical industry accidents shows that in many cases, subcontracted workers from other industries are exposed to the most hazardous situations.

... and many problems

While most available data point to a significant link between trade union action and prevention, the practical outcomes vary by company, type of risk and other conditions. This makes it relevant to consider the conditions for effective trade union action in this area.

The autonomy and strategy-formulating ability of unions are key factors. From the blanket level of inter-industry policies right down to workplace safety reps, enormous pressures are in play to reduce the trade union role to that of carrying out policies set by others. In occupational health management systems, company management will often set the priority objectives and ask the workers’ reps to “pass them on” to their colleagues. The poor performance of health and safety representation systems in non-unionised workplaces evidences this problem. The role of a safety representative can be confused with that of a “mini-technician” or, worse, an overseer.

An integral part of union autonomy is their ability to independently determine things they agree on with the firm (e.g., preventing industrial disasters), things where compromise can be reached, and things they cannot agree to. On this basis, union action can be thought of as a sort of pendulum movement: starting from workplace health needs, exercising the leverage needed to get agreements that will change work organization, assessing the outcomes and organizing labour action over the sticking points. In
that process, any real improvement, however small, increases workers' confidence in their own strength and the importance of organized action.

Other things can play into the success of that movement, including: a defined framework of statutory rights, training, adequate and accurate information, effective control by the Labour Inspectorate.

Two factors arguably play a particularly important role. Unions' ability to build networks that can identify problems, develop the preventive solutions applied in some workplaces and effect regular exchanges of experience between safety reps. This avoids endless repetitions of the same obstacle course, and also helps to create bonds of solidarity between trade unionists in different firms and support their activism through improved knowledge.\(^1\)

Another major thing is the union's ability to tie occupational health issues into other aspects of its agenda both in the workplace and in broader society. In collective bargaining, leveraging the experience of safety reps from the initial demand formulation stage helps avoid the frustration of getting agreements that sacrifice the quality of working life to other claims. Linking occupational health requirements to the fight for gender equality is also important. Giving recognition to the work hazards that women workers are exposed to is part and parcel of action for job desegregation. Pay differentials can only be tackled by challenging stereotypes that deny some of women's professional qualifications. This is one lesson of the grievance disputes staged by nurses in Europe over the past twenty five years. They were able to mount blanket protests encompassing occupational health, recognition of qualifications and better conditions to ensure more effective health care for patients. Such actions helped to raise questions about the authority structure in hospitals and health budget cuts. Similarly, trade union action to get the most hazardous chemicals eliminated is calculated to improve occupational health, public health and environmental protection.

### On the offensive on work organization

Dividing workplace health into boxes dealt with by experts from different disciplines goes against workers' correct perception that health is bound up with work organization. A survey of ceramics industry workers in Spain found that: "Unlike the distinctions usually made by the specialised language of prevention techniques, workers generally instinctively see the hazards of work as being an inter-related whole where, for example, dangers to safety or hygiene are linked to specific forms of organization and their physical manifestation is perceived in the form of health damage (...) In the discussion groups where a less media–spun collective perception of risks emerges, workers voice different problems and priorities from those identified by technicians. Particularly striking is the importance that workers attach to health problems related to work organization, as compared to the almost exclusive technical focus on safety and workplace accidents".\(^2\)

Generally, there is no mechanical link between exposure to a risk factor and its health impact. The division of labour, the company management structure, the amount of control workers collectively and individually have on how to organize work, the ability to give opinions, make demands and influence decisions are all factors that can lessen or worsen the health impact. This is illustrated by occupational accident figures which show that agency workers have a higher accident rate than employed workers in the same jobs and production sectors. The same trend is found in some outsourcing situations where the scope for influencing working conditions is reduced by the existence of a dual power relationship: that of the employer and the work specifier. The absence of democracy in the workplace has a negative effect on two fronts. It makes it harder to put knowledge to work for prevention; and it affects the overall quality of life at work and can dramatically limit its positive potential for personal self-fulfillment and development.

### Huge potential

An offensive trade union policy on occupational health holds tremendous potential because it forges a daily practical link between broader societal issues and workers' daily lives. There is a constant interplay between the "macro" level of diseases, accidents, premature aging of the body, psychological distress and the "macro" level of social inequalities, where work fits in, economic development strategies and the way our societies work generally. It is also a daily class in how absurd and damaging the traditional division is between those who are purported to know and order and those who are purported to do and produce.

Two important developments bear a moment's attention. There is some unease about the very meaning of work. The ground-swell of discussion on psychosocial factors to some extent shows the quality of work to be an issue in industry as much as in services.\(^3\) Many of the changes in management systems have provided answers that do not work because they are based on a vertical approach (top-down from management to the workforce), they are immediate-profit-driven and apt to discount the collective dimension of work. The warning signs abound: recall after recall of vehicles even though the car industry subcontracting chain is meant to ensure top quality at least cost; unease in public services at the constant pressure on resources, be it in health or education.

There is a growing awareness that our development model is incompatible with environmental constraints: global warming, water issues, the growing mountain of waste, disastrous urbanization in many parts of the world. Embracing human working conditions and social equality are two areas ripe for a union approach. Getting back to the vision of human work in balance with its natural environment is a central challenge for any environmental policy whose aim is more than just greening capitalism. In this way, the union movement can tie the immediate defence of the workers it organizes in workplace with the global aspiration to change society.
Social inequalities in health: the impact of work

People’s health varies widely with their rung on the social ladder. This is an established universal and timeless fact. Life expectancy gaps narrowed greatly in western European countries in the forty years after the end of World War II. But in the last two decades, the gap between the affluent and working classes has widened again. In a review article, Laurent Vogel points up the impact of working conditions and new forms of work organization on these health inequalities. The Director of the ETUI Health and Safety Department argues that the public authorities must give proper weight to these factors instead of focusing exclusively on preventive public health measures that lay all the blame for health inequalities on lifestyles (smoking, drinking, diet).

Gender is equally absent from public health policies. But traditional family role distribution patterns are apt to completely overlook the impact of housework on women’s health. Again, social position is key here: while employment contributes to health and personal development for qualified women, it can actually end up leaving low-skilled women in worse health.

Social inequalities in health have increased substantially in the EU’s new Member States since going over to the market economy. For all that the official figures show a net reduction in work accidents, a survey in Romania finds occupational health to be the “lowest priority” while access to quality care is the prerogative of those who have managed to accommodate the new economic model.

Is a return to a more engaged approach to medicine like the schemes of the early 1970s the only way to close the health gaps again? Some of these survived the self-centredness of the 1980s and are more valid than ever, as illustrated by a report of an occupational health service in the industrial city of Sheffield. Another avenue worth exploring is having GPs be better informed about the impact of work on their patients’ health. But that means general medicine and occupational medicine really working together, and there is too little of that at present.
Work and health: How some are more equal than others

Social inequalities in health are growing in most European countries. And with public health policies tending to ignore how working and employment conditions play into this, the rise of non-standard forms of employment could widen the gaps further still.

Laurent Vogel
Director, ETUI Health and Safety Department

Although now retired, Aldo still holds a deep affection for his old job despite the scars he bears from it. A manual worker has a much shorter healthy life expectancy than a manager everywhere in Europe.

Image: © Martine Zunini
Spain has mortality atlases broken down by small geographical areas. The higher the mortality, the darker the shading. If the maps for very different causes of death (cardiovascular disease, different cancers, suicides, infectious diseases, etc.) are overlaid, the dark areas tend to match up. A baby in Glasgow (Scotland) can have a life expectancy 10 years longer or shorter simply because of the social characteristics of the neighbourhood it was born in. Behind these geographical inequalities lie social inequalities. The darkest areas tend to be those where social conditions are least favourable: higher unemployment, higher proportion of manual workers, derelict industrial sites, etc.

The public health figures tell the same story. A 35-year-old French female manual worker has a disability-free life expectancy of 27 years, compared to a senior manager’s 35 years - a healthy life expectancy difference of eight years. Where total life expectancy is concerned (including years lived with disability), female managers can expect to live almost three years longer than female manual workers. Male manual workers die six and a half years earlier than male senior managers. Social inequalities in health are not just about mortality - they cross all health-related conditions and most injuries and disorders, both physical and mental, and are a major factor in disabilities, the ability to live an independent life, the rate and consequences of aging. They stretch the idea that health is mostly conditioned by individual behaviour or genetic factors. Whether as commonly-held beliefs or scientific speculation, these beliefs mix simplistic guesswork with a deliberate whitewashing of the most inhuman and unacceptable aspects of employment relations.

Social inequalities in health are not a black-and-white contrast between the haves and have-nots, but a scale of changing shades of grey going up the social hierarchy. In epidemiology, these are called social gradients. They can be based on educational levels, occupational classifications, income categories, or social status of other family group members. All the data point to the glaring conclusion that property, power and work are distributed unevenly and health is largely determined by these social relationships.

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A range of factors play into social inequalities in health, mutually reinforcing one another throughout life. What specific role do working conditions play in these inequalities? How can action for health at work reduce them? These are questions that tend to be underplayed. Working conditions are missing from a large part of the literature on social inequalities in health, while the overall impact of social relationships on health often slips off the radar of the stakeholders in health at work. Some traditional contributors to social inequalities in health have receded for the great majority of Europe’s population. Access to care is more or less guaranteed, albeit not equally or fully. Access to drinking water, a healthy diet and housing can be a problem for some highly marginalized groups, but these factors account for only a small part of all the social inequalities that are in evidence. The burden of infectious diseases remains a reality, but their role in overall inequality is far less than a century ago. This relative reduction in a combination of factors suggests that working conditions play a particularly important role. The worldwide EMCONET research network has released a report giving a good overall picture of this issue. To appreciate the scale of the problem, it needs examining on several levels.

**Physical working conditions**

Working conditions can create physical risks. Hazardous machinery, awkward postures and handling of toxic chemicals, noise, vibration—all these factors are unevenly distributed between occupations. The general trend is that the lower one goes down the job ladder, the more hazardous exposures tend to increase, often with a combination of exposures and a lower standard of prevention. This accumulation of hazardous exposures that are evident at a point in time of working life interact over the total length of a person’s career. Broadly, it can be said that someone who has been exposed at work to carcinogens at the age of 25 has a much greater probability of being exposed to carcinogens at the age of 50. In some cases, the exposures will be identical, in others, they will be different. Most often, they will be combined with other health-endangering factors.

Relatively robust data are available on point-in-time occupational exposures in different European countries. Data on the build-up throughout working life are much patchier. Where they exist, they reveal the link between work activities and the stratification of society into social classes. An analysis of a set of factors on physical and mental wear has found that point-in-time data for a working life did not differ very significantly from data that incorporated changes in working conditions at different periods of workers’ lives. This suggests that there is an overall contextual consistency of individual life stories in social relations which marks the different stages of working life.

**Work organization**

Behind the physical conditions of work stands an organization of work in various forms. Human labour is a social activity. It is never confined to the relationship between an individual and their natural environment. It posits relationships of cooperation and hierarchy, a division of labour and different social valuations of activities. Flying an aeroplane, caring for babies in a nursery, preparing a meal, collecting refuse or selling drugs are all activities - legal or illegal, paid or unpaid – carried out on very different social terms. The description of their physical attributes will mark them out by the different actions, tools, materials, cognitive activities, etc. Their social position will set them within a hierarchical and unequal structure which will determine the links between the different persons involved in those activities, and between them and the rest of society. There is a continuity between social relations in and out of the workplace.
Work organization can also be seen to be a key health determinant. Data on cardiovascular diseases show that problems increase in severity the lower down the social ladder one goes. The same applies to most mental health problems.

The role of work organization has often been studied on the basis of two sets of criteria – one focused on task discretion or degree of control, the psychological demands of work and social support, the others on the potential imbalance between the input and the reward. Data from numerous surveys show these criteria to be relevant and complementary. They help explain the wide gaps between occupational groups in areas as different as cardiovascular mortality and musculoskeletal disorders. They are sometimes used by separating psychosocial factors from the place occupied in the social pecking order. That kind of approach tends to reduce work organization analysis to perceived individual characteristics. UK research on public service workers argues a close link between these individual dimensions of work and socioeconomic status which appears to be behind both an uneven distribution of the relevant factors (autonomy, recognition, etc.) and their greater health impact on the lower socioeconomic groups.

One of the most worrying developments in work organization is the increased time-pressure of work. This has a wide range of health impacts. It is a major contributor to musculoskeletal disorders which afflict almost one in four workers in Europe. It also adds to what can only be described as work-induced accelerated aging (see table).

<table>
<thead>
<tr>
<th></th>
<th>Never worked under pressure</th>
<th>Under pressure in the past</th>
<th>Currently under pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>53%</td>
<td>65%</td>
<td>66%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>43%</td>
<td>55%</td>
<td>61%</td>
</tr>
<tr>
<td>Sleep disorders</td>
<td>35%</td>
<td>46%</td>
<td>51%</td>
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<tr>
<td>Memory disorders</td>
<td>24%</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>Health deteriorated in recent years</td>
<td>23%</td>
<td>35%</td>
<td>41%</td>
</tr>
</tbody>
</table>


Health disorders and work under pressure among workers aged 50 and over

Job insecurity is bad for health

A second level of analysis is the employment relationship. There is an intrinsic insecurity in wage labour as an institution. History shows that the free market in labour developed only through duress. Impoverished populations were forced by the twofold impact of hunger and government violence to put their labour under the dominion of others. From the onset of the industrial revolution, the labour movement held that insecurity in check by creating balancing forces in the form of individual rights, collective rights and specific forms of organization and struggle. Social security has to varying extents in different countries loosened the constraints to decommodify human labour, enabling withdrawal from the labour market in particular circumstances like old age, illness or disability. Through unemployment or early retirement schemes, it permits workers to distance themselves to some extent from worsened working conditions. Vested rights can be undone. Over the past thirty years, the deterioration of employment relationships has worked against a real improvement in physical working conditions. This has played into growing inequalities. Three things are worth noting.

Unemployment is a key factor in declining health. This observation might seem counterintuitive if one were simply to list the physical factors in the workplace that affect health. However, the link between unemployment and poor health can only be explained by looking at three features of what unemployment is:

1. Unemployment rarely means doing no work at all. It is a legal status. For women, it usually means adding yet more of the family work to their load. In the general population, it may go together with undeclared work in particularly poor conditions;
2. Unemployment is almost never a permanent status throughout adult life. It can often occur after spells of work which have already involved health damage. It is common among people rendered vulnerable by poor health, including from non-work-related factors. So, unemployment rates are generally found to be higher among people with mental illness, cancer or who have suffered a work accident even though still healthy enough to work. It is as if by excluding cancer patients from work, employers were second-guessing future productivity losses or the nuisances of adapting working hours or jobs;
3. Unemployment is not just a legal status. It also partakes of social relations. In addition to lost income, it often also undermines social networks, increases isolation and feelings of worthlessness.

Insecurity is on the rise in the working world, and may take specific forms for young people,
women and immigrants. It may be reflected in a special legal status. European Union (EU) countries have witnessed a startling rise in so-called non-standard forms of employment which are now becoming the norm for some groups! In the Netherlands, three-quarters of women work part-time, compared to an all-EU average of about one-third. This reflects the lack of public childcare provision and the unequal division of family labour. But it is not just that: part-time work is often imposed by employers and denotes worsened working conditions and reduced career opportunities. Young people face myriad kinds of non-standard jobs ranging from apprenticeships to a wide variety of work placements, a much higher incidence of agency work and less job stability. Immigrant workers, and the descendants of immigrant workers of certain nationalities, are also facing rising insecurity.

Work can be subcontracted under a fixed, full time employment contract. But there is a clear link between subcontracting and worse working conditions. Cost-cutting considerations are mainly behind increased outsourcing by business. It tends to impose a division of labour whereby the outsourced activities lead both to over-exposure to occupational hazards and employment uncertainty. Unit outages for maintenance and repair in nuclear power stations incur significantly greater exposure to ionizing radiation for outside subcontractors than permanent employees. In the carmaking industry, lean production imposes work rates that are hard to sustain over time for workers who make the different components of a car which is generally assembled by the work specifier. Multi-tier subcontracting is a major cause of fatal accidents in the building industry.

Working and employment conditions interact in many ways. For individuals, a lower level of job security is generally reflected in worse working conditions. Spanish research based on a large-scale trade union survey has developed a comprehensive precariousness scale that takes a range of factors into account. These include conditions of employment but also the exercise of rights, pay levels, the ability to influence working hours, the risk of unemployment, etc. The study found a close correlation between adverse health outcomes and insecurity. It shows higher levels of insecurity in the lowest socioeconomic groups and among women, young people and immigrants. One merit of the study is to highlight the importance of workforce-driven approaches in the workplace.

Nuking personal development
Health is an ongoing process played into by socially constructed expectations and the ability to adapt and repair anything that limits them. It is not so much a state as a balance that is constantly under challenge from various factors and may, under certain conditions, recover or improve. While many physiological and psychological processes operate subconsciously, maintaining health is related to the individual’s life objectives. The centrality of work for adults in our society means that more than direct damage to health, work plays an important positive and negative part in maintaining health. Swedish studies report often worse health conditions

Male manual workers die six and a half years earlier than male senior managers.

7. The Whitehall II study was set up in 1985 by Professor Sir Michael Marmot to investigate the importance of social class for health by following a cohort of 10,308 working men and women. Read more on: www.ucl.ac.uk / whitehall2


among women homemakers for reasons that are probably less due to the physical conditions of what they do than being trapped in the home and having fewer and less diverse social ties than women in paid work. Contingent employment status and poorer working conditions have an impact beyond the individual risk factors found in the work itself.

The American sociologist Richard Sennett has highlighted the role of flexible working in undermining personal development and all forms of long-term commitment. It is a useful analysis for recontextualizing what are sometimes called individual risk behaviours. A big part of public health policies focuses on changing individual health behaviours largely in isolation from their social determinants. Nagging building workers to eat more fruit or stop smoking even though they are hugely exposed to carcinogens in their work is disingenuous at best and smacks of an individualistic approach that ignores the collective factors that determine health.

...physical conditions can encourage smoking or heavy drinking. The failure of many preventive campaigns can be put down to a wilful disregard of the way working conditions contribute to shaping specific types of behaviour. Perhaps the best picture to take away is a set of overlapping circles over large areas. Physical working conditions, work organization, employment conditions and life objectives all interact with one another. Each of these spheres has individual and collective dimensions. All are cut across by gender relations. The links between work and social inequalities of health point to an ownership of human bodies through a social rational of wealth and power accumulation at one extremity of our societies. They show the limitations of policies that disconnect occupational health from public health.


Nurses and bricklayers – one fight

Question: what do hospital nurses and building workers have in common? Answer: not a lot, you'd say. Nurses work with people, builders with materials. Demarcation of construction and civil engineering trades is lost in the mists of time. Nursing as a profession emerged a bare century ago.

What they do share is that none of us can do without these two occupations. Buildings of one kind or another are everywhere in our daily lives. It is hard to conceive of any human being having no contact with a hospital between cradle and grave. Both activities have long been imbued with now-vanished sacred or religious overtones.

Comparing the impact of working conditions on the health of these two groups throws up some interesting things. A big part of the workload in both groups is eclipsed by gender segregation. Manliness, physical strength and endurance are depicted as qualities that building workers naturally have, while caring, comforting, communicating, dedicating to the welfare of the sick, doing a "touchy-feely" type of job are portrayed as supremely female characteristics. These are stereotypes that press heavily on both. The real workload soon sorts out those who will and will not cope after hiring. The build-up of stresses and strains over the years makes it impossible to do these jobs for a working lifetime. Many construction workers and hospital nurses pack in long before retirement age.

What this shows is that not all men have the "natural" manliness required for building work and that by no means all women can juggle the multitasking roles of mother, wife and daughter they are supposed to reproduce in their work. Not only that but both occupations involve exposures to multiple risks: hazardous chemicals, heavy lifting, ergonomic constraints. On top of these shared factors, nurses also have what may be taxing contacts with patients and their relatives, highly unsocial working hours, and a rigidly hierarchical organization where their skills are often undervalued by doctors. Building workers contend with job insecurity, multi-tier subcontracting, and outdoor work in all weathers.

Some factors make a positive contribution to health. For nurses, these include social recognition that results from long struggles linking better working conditions with the quality of care. Their struggles are what have won nurses their high public profile. Despite an increasing time-pressure of work, building workers enjoy greater autonomy than in many industries, work-bred feelings of mutualism and traditions of organization. The scope for overseeing or computer-tracking builders' work is far less than in industrial production, but something that nursing is much more prone to.

Health damage in building workers shows up in a high early death rate, dramatically so for three causes of death: falls, cancer and mental health problems. There is also a very high work disability rate. A Swiss survey found an average percentage disability rate of 15% among men aged 45-65 - 4% for architects, engineers and technicians, but 40% for construction workers.

A study in ten European countries shows that generally, a very high percentage of nurses aged between 30 and 40 frequently think about leaving their job, usually because of declining (mental and physical) health due to poor working conditions (especially working time arrangements and burnout). The study also found that in most cases, those who thought about leaving the profession actually did so. Nurses suffer working conditions that wear them down without necessarily resulting in higher mortality, although some causes of mortality (like breast cancer associated with night work and exposure to certain chemicals) remain a concern.

Learn more


Working for better health for workers

In the city of Sheffield, birthplace of Britain's stricken steel industry, an occupational health surgery carries on a pioneering scheme started over thirty years ago. In that time, the thousands of workers it has seen have mainly presented with the typical "smokestack industry" diseases of lung diseases and deafness. Now, it is psychosocial illnesses that are taking the toll.

Rob Edwards
Freelance journalist, www.robedwards.com
Yuki Hussein is crying. She plucks paper towels from the box on the clinic table and dabs her eyes. "It's really hard", she keeps saying. "I'm sure that nothing is going to change. They are just going to carry on making my life miserable. I just want some sort of way out of the place, but it's really hard."

Yuki, a 20-year old student brought from Somalia to England for a new life by her uncle, sounds desperate. She has been off work suffering from stress and vomiting for the last two weeks. She has come to one of the regular clinics run at doctors' surgeries by the Sheffield Occupational Health Advisory Service (SOHAS) in northern England. And she is pouring her heart out, pleading for help. She is just one of over 1,000 workers with problems seen every year by SOHAS, a groundbreaking project that has won plaudits for its pioneering work in combating occupational ill-health.

Yuki is employed by a nursing home near Sheffield, and asked for shifts that would enable her to keep attending college in the evening. But, despite an agreement to that effect, she has been repeatedly put down for shifts that she can't do, she says. This happened after her usual manager had changed, and that, combined with long hours, had caused her great upset. "They didn't approach me in a nice way, and never said hello or thank you", she claims. Yuki became ill, and had to take time off work. "I was accused of inventing my illness", she recounts. "I was told that I was just messing about when I was sick."

Now she is looking for another job, but she is worried that her current employers will give her a bad reference because of the complaints she's been making. "It's your word against theirs and it's really hard", she says, her voice breaking. SOHAS adviser Simon Pickvance gently tells her to keep in touch with her union, Unison. He offers to write to her employers reminding them of their promise to make her shifts compatible with her college work. Simon asks Yuki to email him a detailed list of her grievances, so he can pursue the matter. He also says he will ask the doctor for another note saying that she is sick.

Yuki is one of six cases being seen by Simon in a smart new clinic in a suburb of Sheffield on a cold, snowy afternoon in February 2010. Others also complain of stress, overwork and exploitation, and Simon offers whatever advice he can, listening carefully and speaking softly.

The demise of steel

Sheffield, with a population of more than half a million, is one of Britain's great industrial cities. It was born as a centre for steel-making in the 19th century, and now is still trying to recover from the collapse of the heavy engineering industry.

When the Sheffield Occupational Health Project, as it was first called, was being set up in 1978, the steel industry was still one of the city's main employers. A group of trade unionists and concerned scientists got together, keen to help workers to make more use of the rights they had gained under the 1974 Health and Safety at Work Act.

The first problem they focussed on was industrial deafness. Steelworkers were exposed to a great deal of noise at every stage of the manufacturing process, including welding, rolling and forging, with some becoming stone deaf after years of work. So the Sheffield project made an audiometer and devised a series of tests to check workers' hearing. As steel plants started to close in the early 1980s, and thousands were made redundant, this snowballed into a nationwide campaign for compensation. "Anger at what was happening in the steel industry sparked workers into finding out about health and safety", says Simon Pickvance. "Making claims became an act of solidarity."

Insurers accepted that the deafness prevalent amongst workers over 45 was caused by the high levels of noise at work, and thousands started to win financial compensation. A team of former steelworkers put together by the Sheffield project toured the country, urging workers from other steel plants to get tested and put in their claims. For those involved, it was a galvanising and educative experience, and it laid the foundations for the work that SOHAS has done since. As well as deafness, the project has discovered a high prevalence of respiratory problems (later to be termed Chronic Obstructive Pulmonary Disease) amongst former steel-workers, and campaigned for its recognition as an industrial disease.

Through the 1980s, the project's work broadened to encompass other health problems like asthma, vibration injuries and muscle, back and joint damage. It identified the pains that could be caused by what we now know as repetitive strain injuries, and began to work with ethnic minorities. By 1989, the project had acquired funding from the National Health Service (NHS), and was employing people as advisers to work in 20 doctors' surgeries across Sheffield. In the wake of the large-scale redundancies in steel and other heavy industry, they had to deal with a great deal of depression, and loss of purpose amongst workers.

According to Pickvance, trade unions had come under fierce attack from the Conservative government led by Margaret Thatcher, who was prime minister from 1979...
Jay Laver can remember the day back in 1989 when it happened. One of his co-workers at a metal plant in Sheffield picked up a vacuum cleaner, put it into reverse, and blew billowing clouds of dust into his face. "It was full of particles cleaned up from the plant - chromium, tungsten, nickel and so on", he said. "It was a cocktail of heavy metals, a fine clinging dust that got everywhere."

Eighteen years later, Jay had a loose tooth. After it was removed, his gums kept bleeding so he went for tests. The results, in October 2007, gave him a shock that changed his life. He was diagnosed as suffering from a rare form of nasal cancer, known as maxillary sinus cancer. The passages inside his face were being consumed by an aggressive and malignant tumour.

Jay, now 40, was told that he had a 30% chance of surviving. In November 2007 he had a 13-hour operation which removed part of his upper jaw. He then had to endure dozens of debilitating radiotherapy and chemotherapy sessions, and lost 20 kilograms in weight. But the treatment didn't work, and by December 2009, the cancer had returned and spread to a lymph node in his neck. He then had to undergo another major operation, removing the lymph from the right side of his neck, and more radiotherapy.

In February 2010, he was feeling fine and talking animatedly about his attempts to get justice. He was being greatly helped by the Sheffield Occupational Health Advisory Service (SOHAS), he said. He has won a disablement benefit and a reduced earnings allowance, which were helping him live. He has also persuaded the Industrial Injuries Advisory Council to recommend the inclusion of chromium as a potential cause of nasal cancer, which should enable others to qualify for benefit.

Jay is convinced that his cancer was caused by the heavy metal dust blown into his face in 1989. He's been pursuing legal avenues in an attempt to force his employer at the time to take some responsibility, so far without success. He accepts that it's hard to prove that his cancer was triggered by an event all those years ago, but he is determined to fight on. "The cancer is usually blamed on smoking, but I've never smoked a cigarette", he said. "I'm 40 years old, and I need to achieve something."

Lead poisoning

Gerry Hadfield sometimes can't remember where he is, or what he is doing. "I can't see things which are right in front of me. I don't recognise them", he said. "Apparently I can see them, but the message doesn't get through. And that happens a lot. I find myself in front of the cupboard with the door open. And I don't know why." On one occasion Gerry, a plumber in Sheffield for 44 years, forgot what his wife looked like and panicked. "When she was actually coming down the street I didn't know it was her until she got right up to me and spoke to me", he recalled. "It was quite upsetting, quite scary."

According to the Sheffield Occupational Health Advisory Service (SOHAS), from which he sought help, Gerry's symptoms are due to the lead he has been exposed to in his work. Lead is common in old pipes, and low levels inside the body are known to cause a range of disturbing neurological symptoms.

"He has had memory problems and mood changes, digestive problems, exhaustion and many other non-specific symptoms", said Simon Pickvance from SOHAS. "It would be very surprising if he didn't have lead poisoning, given the high levels of lead that he has had over a long period of time."

Pickvance estimated that there may be well over 100,000 workers in the UK suffering from lead poisoning as a result of their work. The toxic metal was widely used in batteries, plastics and paints and is a particular hazard in the scrap and demolition industries.

Recent scientific studies have suggested that people with very low levels of lead in their blood - down to 10 micrograms per decilitre or below - could suffer serious illness. Scientists at the University of Pittsburgh, for example, found that older women with more than eight micrograms of lead per decilitre of blood were more likely to die from coronary heart disease.

As a result some countries like France, Germany and Denmark have tightened their lead standards. But the UK has failed to take action, saying recently that it had no plans to review the safe limits for lead.

But the UK's main occupational health agency, the government's Health and Safety Executive (HSE), was forced into an embarrassing U-turn when the plight of Gerry Hadfield and other lead workers was investigated by Channel Four News in 2009. The agency withdrew an online leaflet suggesting it had no plans to review the safe limits for lead.

To help reduce unemployment figures, many workers were defined as long-term sick, meaning that all advisers could do was to ensure they claimed the right benefits. In the 1990s, however, Sheffield project workers began to challenge this, by increasingly trying to get the long-term unemployed back to work.

"We all found it difficult", Pickvance recalls. "It was like we were taking on the whole capitalist system in an individual advice session. What can you do? There are things you can do, but you have to work at it. We're still working at it."

Funding for the project varied in the 1990s, and some tough decisions had to be taken about its collective structure. In 1999 the Sheffield Occupational Health Advisory Service was formally set up as a limited company, with a manager.

Barefoot doctors

Now, the project employs seven advisers, who run clinics in 30 of Sheffield's 100 doctors' surgeries, and is still funded by the NHS. "In the Noughties our work has shifted towards helping people hang onto their jobs when they are off sick, particularly those with mental health problems", says Pickvance. "It was the workers who taught us about deafness. Then they told us about lung disease. Now they are telling us about mental health problems.

Pickvance, who turns 62 this year and is an honorary research fellow with the School of Health and Related Research at Sheffield University, has been with SOHAS since its inception. "I'm not clinically trained", he explains. "None of us are. But we have access to the whole clinical machinery of the NHS."

Part of the inspiration for the work he does came from communist China's famed barefoot doctors - farmers who brought basic health care to rural villages. "We are para-medics", he says. "It's widely accepted now that you don't have to be a doctor to make a major contribution to someone's care."

SOHAS provides an advocacy service, a welfare rights service and a lobby on behalf of the worker. "What we do is traditional trade union work. It's representing people, trying to help people negotiate their rights within the grievance procedures", he adds. "We're a bit like health and safety representatives on the loose. Some countries have roving safety reps, but Britain doesn't."

Pickvance points to the important role that SOHAS has had in highlighting a series of occupational health problems. As well as hearing and respiratory conditions, advisers can pick up on hidden health issues, like the large number of workers still exposed to dangerous..."
levels of lead or the cancers that could be caused by contamination at work (see panels).

SOHAS has also made representations to the Industrial Injuries Advisory Council for recognition of steelworkers’ lung diseases, for bladder cancer due to exposure to dye and cadmium and for nasal cancer due to nickel and chromium exposure. This helps more workers gain access to financial compensation. Pickvance gives a long list of the project’s other achievements, including how it exposed other industrial diseases and how it helped shape the government’s latest occupational health strategy. SOHAS has also hosted several major meetings on occupational health issues, including the European Work Hazards Conference in 1992.

Bullying

Another SOHAS adviser, Noreen Moore, has only been in post for two years, but she is equally adamant about the value of her work. “It’s a great job”, she says. “It’s about the people, and the knowledge you can give them.” She cites several cases where she has helped people with disabilities gain their rights, including more allowances. The problem is that people just don’t tell others about the real difficulties they are facing, she argues. They try quietly to cope instead.

According to Moore, who comes from a trade union background, bullying at work is now commonplace. “Restructuring or a new manager is often to blame”, she says. “People become over-assertive, they constantly pick on others’ flaws, undermine their experience, ignore them. But it’s really just a sign of insecurity.” Again, people are reluctant to say they are being bullied as it makes them look weak. The victims, Moore points out, are often older men, but no-one is immune. Just as managers can bully staff, so staff can pick on managers and make them unhappy at work.

But Moore doesn’t think that her work is grim as a result, rather the opposite in fact. “We do have bright spots”, she says. “Part of the job is to enable people to win, and overcome their problems. They make decisions to walk away, and you do see people getting better.”

Her colleague Adel Taylor, another SOHAS adviser, agrees. She recounts how she was able to help a woman who came in complaining of tennis elbow, one of the original repetitive strain injuries. She visited her workplace and found that she was frequently having to turn and lift heavy files. So she helped her work out a way of reducing the strain on her arms, and so solved the problem. “It was quite a refreshing case”, says Adel. “But not every one is that simple.”

In 2007-2008, the highest proportion of cases seen by SOHAS - 31% - were psychological. The next biggest category, covering 20% of cases, were those who were suffering from problems with their muscles, joints or backs, including repetitive strain injuries.

<table>
<thead>
<tr>
<th>Health problems</th>
<th>Number of workers</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Psychological</td>
<td>348</td>
<td>31%</td>
</tr>
<tr>
<td>Muscles, joints, back, repetitive strain</td>
<td>219</td>
<td>20%</td>
</tr>
<tr>
<td>Asthma, chest complaints</td>
<td>75</td>
<td>7%</td>
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<tr>
<td>Hearing</td>
<td>74</td>
<td>7%</td>
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<tr>
<td>Injuries</td>
<td>32</td>
<td>3%</td>
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<tr>
<td>Heart, circulation</td>
<td>28</td>
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</tr>
<tr>
<td>Vibration syndrome</td>
<td>26</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>102</td>
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<tr>
<td>Health problems not related to work</td>
<td>207</td>
<td>19%</td>
</tr>
<tr>
<td>Total</td>
<td>1,111</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Sheffield Occupational Health Advisory Service

The main health problems of workers seen by the Sheffield Occupational Health Advisory Service in 2007-2008

Need to know more?

Sheffield Occupational Health Advisory Service:
www.sohas.co.uk

School of Health and Related Research at Sheffield University:
www.shef.ac.uk/scharr

1974 Health and Safety at Work Act:
www.hse.gov.uk/legislation/hswa.htm

Industrial Injuries Advisory Council:
www.iiac.org.uk

Health and Safety Executive:
www.hse.gov.uk
Work and family: "double workload" overburdens women's health

Although completely out of tune with the realities of today's workplace, the ingrained stereotypes of man as breadwinner and woman as homemaker are proving hard to root out. They downplay how much running a home affects women's health. The combination of gender and social inequalities takes its worst toll on the physical and psychological health of women on the bottom rungs of the job ladder.

Lucía Artazcoz, Imma Cortès, Carme Borrell
Public health agency, Barcelona
Biomedical, epidemiology and public health research consortium (CIBERSESP)

Laetitia Matisse is a carpenter in Dijon (Burgundy). It's no longer unusual to find women doing "men's work" nowadays. Attitudes are slower to change than the world of work.

Image: © Philippe Merle, AFP
Occupational health research has tended to focus on exposure to safety, hygiene, ergonomic and psychosocial hazards at the workplace, but overlooked the impact of home and family work on health. Unpaid work no less than paid work involves exposure to a wide range of risks, but domestic work-related injuries and associated illnesses are neither systematically recorded nor prevented. This is singularly important for women, because the prevalence is much higher among females. The home can be a source of hazardous chemical exposures – there is a reported link, for instance, between cleaning tasks and asthma1. Domestic work also implies exposure to ergonomic and psychosocial hazards, like those related to caring for a person with disabilities which often takes a high emotional toll on top of the physical and mental demands.

The gender division

As well as a potential source of exposure to different hazards, work is also one of the main shapers of life and identity. But while paid work is a source of status, power and opportunities, domestic labour is undervalued and unpaid. Melanie Bartley, Professor of Medical Sociology at University College London, has pointed out that in considering the social determinants of women’s health, it would be mistaken to forget influences emanating from the wider society beyond the workplace, such as the pattern of power and subordination in the home, since women do not have the power to oblige men to undertake an equal share of domestic labour and child care, no matter how high the status of the employment.2 The ways in which women’s health continues to be affected by traditional norms, beliefs, and role models cannot be disregarded. More recently, it has been emphasized that a consideration of the traditional male breadwinner role may offer important insights into the influence of employment conditions such as temporary work, long working hours or unemployment on their health.3

Gender division is present in all societies and means that men and women are ascribed different duties and responsibilities, as well as different entitlements. Although the precise definition of this division varies between societies, there is a high degree of consistency in the sexual division of labour, with females bearing primary responsibility for household and domestic work and males having a primary role in paid work and as breadwinners. In the rigid sexual division of social life, men have more power and social recognition, while women are relegated to invisibility and lack of social value. Both life courses are considered to have been legitimated as being both inevitable and appropriate, so that the transition to adult life for centuries has for men been into paid or productive work, and for women marriage and motherhood, or so-called reproductive work. But while the former leads to economic independence and full citizenship, the latter implies dependence and a delegated citizenship.

Health impacts

Research into the social determinants of women’s health has been dominated by the role framework in which women’s primary role is as housewives and mothers, and paid employment is an adjunct. Most studies into the role framework support the role enhancement hypothesis, whereby women with multiple roles enjoy better health. For example, it is widely recognized that paid employment has a beneficial effect on women’s health, with those in paid work being in better health than those who are not.4 The job environment can offer opportunities to build self-esteem and confidence in decision-making, social support for otherwise isolated individuals, and experiences that enhance life satisfaction.5 Additionally, income provides women with economic independence and increases their power in the household unit. Yet, it has been reported that whereas employed women have better physical and mental health than full-time homemakers, a lack of sleep and leisure time and physical activity are more frequent among employed women due to their lack of time derived from the combination of job and family responsibilities.

Other studies support the role overload or role conflict hypotheses. It is likely that when the total workload is high, combining different roles damages women’s health. Moreover, the influence of social class should also be taken into account. For example, in a study carried out in Catalonia (Spain) among a sample of married or cohabiting workers, family demands measured through household size were related to poor self-assessed health, long-standing limiting illness, more chronic conditions, less leisure time physical activity


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and sleep deprivation among less advantaged women, but not among men regardless of social class, nor among women of more advantaged social classes. These results are explained by the low involvement of men in domestic work and as the ability of employed women from the more affluent social classes to hire resources in order to lighten their domestic burden, thereby averting the negative effects of a heavy workload on their health. Consistently, another study reported that while among men, part of the association between social class and poor health was accounted for by psychological and physical working conditions and job insecurity, the association between social class and health among employed women was also explained by material well-being at home and amount of household labour.

Part-time

Many women work part-time in order to balance job and family demands, but this can also have negative effects on their health and well-being. Obviously, this kind of arrangement does little to improve gender equality in terms of the division of unpaid domestic and family work. Moreover, in Europe, part-time jobs are segregated into a narrower range of occupations than full-time jobs and are typically lower-paid, lower status (such as sales, catering, and cleaning), more monotonous and with fewer opportunities for advancement. Most studies carried out in the United States have shown that part-timers usually earn less per hour than full-timers, even after controlling for education, experience and other relevant factors. It has been widely reported that part-time work limits women’s career prospects. For example, a study carried out among nurses in the UK’s National Health Service found that when flexible and family-friendly policies are promoted it is mainly female employees who continue to utilise such policies since few male nurses work part-time or flexible hours. It also showed that working part-time and taking career breaks, usually because of caring commitments, resulted in female nurses falling behind male colleagues in terms of career development and promotion prospects, with managers selecting males over females (particularly those who work part-time) in functional role allocation in hospitals. The authors concluded that so-called ‘family friendly’ policies must target both sexes, and that the underlying attitudes of men to childcare and the domestic division of labour must change before the sexes can compete on equal terms in the workplace. Until this happens, men will continue to advance the development of their nursing careers more rapidly than women.

Domestic roles and employment conditions

Many studies on the influence of family demands on women’s health have not considered the potential interaction with employment status, i.e., having a number of children is not the same for a full-time homemaker as for an employed woman. Moreover, the effect of family demands on health may not only differ by employment status; even for the same employment status there may be an interaction with socio-economic position. It has been reported that among married or cohabiting women, household size is associated with poor health among low-skilled employed women but not among women homemakers regardless of social class or among highly qualified employed women. Although research into the effect of family roles on men’s health is scarce, men’s roles at home also influence their health, and this influence should be understood through the interaction between their traditional breadwinner role and their employment situation. The impact of unemployment on mental health provides a good example of such an interaction.
One of the most extensively studied health effects of unemployment is that of psychological distress among the unemployed. This association can be mediated by the social context in which individuals live, which is largely determined by family roles and social class. Moreover, the role of these factors may differ by gender since they have different meanings for men and women. A study on the impact of unemployment on mental health in a Spanish population confirmed this complex framework of interactions. The higher impact of unemployment on men’s mental health was accounted for by workers with family responsibilities, with marriage increasing the risk of poor mental health for male manual workers, while for women, the fact of being married, and particularly living with children, acted as a buffer. No gender-differentiated impact of unemployment on mental health was found among unmarried workers. From these results, it can be inferred that being married can be a source of serious financial strain for unemployed men from less advantaged social classes who usually assume the role of breadwinners – often the only providers of economic resources – at home. Moreover, their traditional low involvement in nurturing roles means that family responsibilities cannot successfully replace a job as an alternative goal and source of meaning in life for males. Conversely, most Spanish women who have children and become unemployed live with a man who is the breadwinner and, since they still have a principal role in the family, family roles could replace the rewards that were once provided by employment.

Understanding the influence of temporary contracts on psychological and social health also requires a consideration of gender differences in family roles. A study in Spain reported that the effect on mental health of flexible contractual arrangements, other than fixed-term temporary contracts, was higher among less advantaged groups (women and male manual workers), and that the impact of flexible employment – either fixed- or indefinite-term contracts - on living with a partner or having children (two indicators of social health) was more pronounced among men regardless of social class. In most countries, employment is an important predictor for cohabitation, marriage and parenthood among men. Moreover, in countries with a strong breadwinner model, long-term and full-time employment for men is deemed essential to provide the firm financial basis considered as necessary for these life transitions.

Working time and its relationship with health status is also mediated by family roles. Consistent with the gender division in the domestic sphere, with women responsible for housework and caring tasks and men usually assuming the breadwinner role, living with children is related to part-time work among women, while among men it is associated with long hours.

It was mentioned above that part-time work – much more frequent among women – is associated with poorer working conditions. On the other hand, research into the relationship between long working hours and different areas of health is still sparse and the results are often contradictory. Nevertheless, there is evidence that once again

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Workers finding themselves economically vulnerable are encouraged to work long hours to earn more, and fear of unemployment prompts them to accept poor working conditions.

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this relationship needs to be considered in terms of the interaction with family roles. Two recent studies examining the relationship between long working hours (40 to 60 hours a week) and a variety of health indicators among Spanish workers found a consistent association with poor mental health, hypertension, job dissatisfaction, smoking, no leisure-time activity and sleeping 6 hours or less a day only among separated women and married or separated men. The authors explained their findings through a possible association between long working hours and family financial stress among breadwinners. The need of family breadwinners to work long hours due to financial strains could explain this relationship. Pressure to work long hours in order to increase income and/or acceptance of poor working conditions - including long working hours - due to fear of losing a job when in a situation of economic vulnerability may go towards explaining this consistent pattern of a link between long working hours and various health outcomes in some groups defined by their marital status.

### A new approach

Preventing the potentially damaging effects of work on health requires that the current focus of occupational health policies on paid employment and work as a potential source of exposure to safety, hygiene, ergonomics and psychosocial hazards be expanded. The impact of work on health also includes the hazards of the domestic environment, as well as those derived from the gender division of work and the fact that work is a source of status, power, and opportunities and, as such, a determinant of social inequalities in health. Regarding the domestic sphere, the gender division of work imposes a primary responsibility in domestic and caring tasks on women, and the breadwinner role on men. Both roles can have potentially damaging effects on health, in which social class is a key factor, and generate gender inequalities in health.

Changes in occupational health information systems, occupational health policies and training and research programmes are required for this new approach. Where occupational health information systems are concerned, national and European working conditions surveys should include more questions about family characteristics, not only in order to examine the influence of domestic and family demands on women’s health, but also to understand the impact of some employment conditions on health status through the interaction with family roles in both sexes.

It seems clear that in this broader framework, traditional occupational health policies focused on prevention of job hazards and based on occupational health services and safety departments of Labour Ministries are not enough. Occupational health should be put on the government agenda, especially in equality, labour market, and economic policies that should take into account the impact of political decisions in these areas on workers’ health.

Training and research on occupational health should be consistent with this broader framework that integrates paid and unpaid work, considers the influence of work beyond the exposure to workplace hazards, and puts the gender division of work and occupational social class inequalities at the centre of this new approach.
GPs and occupational doctors: Talking is key

Wide social inequalities in health are found in all European countries, but they are rarely put down to work. The social invisibility of the interplay between health and work is exacerbated by the lack of contact between works doctors and family doctors. How can these two key players for the health of workers interact more effectively? Two Belgian doctors give their thoughts and some pointers to improvement.

Interview by

Denis Grégoire
Editor

General and occupational medicine are often portrayed as two worlds indifferent to one another despite working to the same end of promoting people’s health. Why is that?

Dominique Roynet – Much of the reason there is so little communication between GPs and occupational doctors is because workers don’t see the works doctor as standing up for them so much as siding with the boss. Our patients act as a sort of filter between the two medical professionals. Very often they confuse the occupational doctor with the examining doctor sent by their employer. There is a huge lack of awareness of the world of work among GPs. GP training is still focused on medical treatment in the strict sense – the social, occupational, psychological and legal aspects are still overlooked today. As far as I am aware, occupational medicine is not taught on medical degree courses for general practitioners.

Florence Laigle – There is a huge knowledge gap among workers about what occupational doctors do, and it is not much better among family doctors. There are so many misconceptions going around about us, like supposed not being independent of employers. Occupational doctors are not forthcoming enough about their job and the profession suffers from a poor image.

What circumstances in your daily practice might bring you into contact with your opposite number?

DR – Very broadly, I can say that I only come into contact with occupational medicine in two cases: where a pregnant worker has to be moved away from a dangerous work environment, or where a job adaptation is needed so my patient can keep on working. Hardly ever do I have a patient asking me to contact his works doctor. I have had it only once in 31 years of practice, and that was a graduate who was well-versed in all the ins and outs of the procedure.

FL – When I ask for information from a family doctor it’s usually to do with redeployment in the company, and obviously with the worker’s consent. It’s a purely practical approach, i.e., I need to collect objective information on the worker’s health from the practitioner who best knows his health, which is either his family doctor or a specialist. I always make the request in writing, and always emphasising that there are two scales to balance – health on one side, the job on the other. The company I provide services to (in the waste management sector – ed.) has a very high immigrant workforce, many of whom can neither read nor write. That makes it very hard to find a job that does not involve heavy physical labour, like a clerical post for example. But even in a case like that, my priority aim is to keep them in the firm. That makes partnership – and mutual trust – with the worker concerned, the remedial treatment sector and company decision-makers essential.

Can they always be kept in the firm?

FL – The tendency of firms to hyper-specialize can obviously be an insuperable obstacle to redeployment. And without wanting to downplay the impact of the current economic crisis on businesses, I do sometimes see employers using the crisis as an excuse to avoid redeploying workers whose health prevents them from doing the things they were hired to do. The point is that redeployment asks questions about work organization, and that’s something not all employers are happy to do.

DR – With this crisis, my feeling is that people are putting their job before their health. I am increasingly faced with patients who refuse point blank to be signed off. They don’t want to stop work for fear of losing their jobs. Some patients say: “Just give me something, but I want to go to work tomorrow.”

"Some patients say: Just give me something, but I want to go to work tomorrow."  Dominique Roynet
to work tomorrow.” And those who agree to a medical certificate want to be signed off for the minimum possible time. This isn’t something you found ten years ago.

The European working conditions surveys report a huge rise in musculoskeletal disorders (MSDs) and the emergence of psychosocial problems. Are you finding that at the sharp end?

**FL** — You could say I’m beset by MSDs morning, noon and night. The first thing to say is that these are multifactor conditions. Apart from the biomechanical factors related to forceful work like carrying heavy loads, organizational factors like just-in-time working play an important role, as do psychosocial aspects. Effectively tackling work-related MSDs means acting on the way the work is organized. We have to persuade employers to look again at their work organization, reminding them that it is in their company’s interest to have healthy workers. Surprisingly, the same awareness-raising job also needs doing with shop steward committees who often instinctively negotiate with employers for financial compensation rather than a change in working conditions.

**DR** — People don’t want to know that their working conditions are what are giving them a bad back. They shut out the thought because admitting it would lead to the worst-case scenario of losing their job or a promotion. And GPs are seeing that its managers as much as manual workers that are in denial. Sadly, by the time they have to face the fact that their work is affecting their body, it is often too late to do anything. Where psychosocial risks are concerned, on the other hand, my patients more readily admit the link with their work but don’t always distinguish between things like pressure, overwork, stress, harassment, etc.

Work-related cancers often don’t appear until after workers have retired. Are there any procedures for exchanging information between works doctors and GPs to uncover their occupational origins?

**FL** — None. Occupational health records are normally kept by the company occupational health service, but the workers most at risk tend to be those who regularly change jobs. It would take real detective work to track back their entire career, let alone identify exactly what carcinogens they were exposed to. Theoretically, the Occupational Diseases Fund (ODF) should do this, but sadly we are a million miles from that in reality.

**DR** — In thirty years of practice I have never had a retired worker ask me to make an application for recognition of an occupational disease, and few enough from active workers.**

**FL** — On this specific point, you should know that in Belgium the occupational doctor is not notified when a worker applies for recognition of an occupational disease through their GP or a specialist. Nor do we get told of the Occupational Diseases Fund’s decision. We’ve been pressing for it for a very long time, but clearly, the ODF is not that way inclined.

"There is a real risk of turning occupational doctors into a sort of 'healthy living' guru." Florence Laigle
The unclear work-related origin of many cancers is obviously not helping to get movement. Do we need to break down the barriers between public and occupational health?

**DR** — Information campaigns on health at work would certainly help make patients and even doctors more aware. I have found that TV advertising has a significant impact. Information campaigns run in recent years by the authorities to cut antibiotic consumption had a significant effect on people. Many of my patients are now pressing not to be given antibiotics if they aren’t strictly necessary. Work simply doesn’t feature in health education campaigns in Belgium. From a political perspective, it’s obviously easier to guilt-trip people by playing up lifestyle factors like smoking, diet, etc. People who feel guilty are more manageable...

**FL** — I think we need to keep a distinction between public health and occupational health because of the real risk of turning occupational doctors into a sort of “healthy living” guru along the lines of “eat so many portions of fruit a day”, “quit smoking”, etc. I’m not denying that this kind of message is useful, and I do put it across, but I don’t see it as the occupational doctor’s main job to come out with them. I am sensing a strong trend towards getting works doctors to carry out this health education duty at the expense (within a fixed budget) of looking for primary prevention measures in the workplace. Personally, I won’t do it, but I recognize that some of my colleagues are more supportive of it.

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**Florence Laigle**
Occupational doctor — ergonomist / Brussels

1978 Graduated as Doctor of Medicine in Paris
1979 Certificate of Special Studies (CES) in occupational medicine in Paris; employed by Santé et Travail (not-for-profit organization)
1988 Bachelor’s degree in ergonomics (Catholic University of Louvain, UCL)
2002 Bachelor’s degree in ergonomics (Catholic University of Louvain, UCL)
2004 Visiting Lecturer at UCL (teaching occupational doctors, ergonomists and labour sciences)

**Dominique Roynet**
General practitioner / Brussels

1979 Degree in General Medicine from the Free University of Brussels (ULB); With fellow GPs, founded the Maison Médecine Verte in Schaerbeek, a working class borough of Brussels with a very large immigrant population. Also a founder of the Planning familial des Marolles family planning clinic located in a deprived inner city borough of Brussels.
1992 Founded the Planning familial de Rochefort family planning clinic in the rural town of Rochefort in southern Belgium. It is a non-denominational centre which performs abortions.
2006 Senior Lecturer and then part-time lecturer in the Department of General Medicine at the ULB.

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**Dominique Roynet sees a growing number of her patients going to work despite being ill.** Image: © Martine Zunini
Romania – work still bad for health

The country’s work accident figures may be falling and working conditions improving, especially since joining the EU and coming into line with its laws in 2006, but work is still not a safe nor yet healthy place to be for Romania’s five million employees.

Marion Guyonvarch
Journalist, correspondent for Planet Labor
in Bucharest

Coal miners prepare to head into the mine, Petrita, Romania (7 December 2006). Since Romania joined the EU, dozens of unprofitable mines have closed. In the south-western Jiu Valley, coal mining was the only stable form of employment. Twelve of the mine’s workers were killed in a firedamp explosion in November 2008.

Image © 2006, Getty Images
The number of new cases of occupational dis-eases recorded each year is also down: 1766 in 2000 – chiefly in the mining, metallurgical and car-making industries – from 2750 in 1980. The main diseases identified by the National Institute of Public Health are bronchial asthma, silicosis and musculoskeletal disorders - the latter being on the rise. The Institute puts the slight decline down to improved working con-ditions, particularly with regard to exposure to toxic chemicals for example, and improve-ments in the surveillance network.

But Corneliu Constantinoia, the Confederation of Free Trade Unions of Romania's general secretary for social issues, caveats these figures.

While good on the face of it, the results have to be qualified by the possibility that some labour inspectors may be open to corrup-tion – endemic in government agencies – and that the potential dangers of certain risks, particularly in commerce, may be ignored.

The same lack of certainty surrounds the occupational disease figures. The National Institute of Public Health, which manages the 600 occupational doctors, says that many former industrial workers now work in agri-culture and may be ill but not included in the official figures. Occupational medicine also of-fers a good illustration of the broader processes at work on these health and safety issues. First, the reshaping of the labour market is leading to the emergence of new risks and new diseases that occupational doctors have to learn to de-tect. Also, the legislation is not yet being fully implemented: annual employee health checks and pre-employment medical examinations are still a rarity, especially in small businesses.

On paper, Romania has the rules and tools to establish an effective health and safe-ty policy. The realities are under-resourcing, a poor understanding of the situation, and lit-tle interest in these matters.

One factor in play here is the weak posi-tion of Romanian workers, who are hard-put to stand up for themselves. The switch to a market economy coupled to a deep economic crisis has led to high unemployment, insecure attachment to the labour market made worse by off-the-books work, and an under-mining of workers’ rights.

Despite the strong growth that pumped up the economy in the 2000s up to the crisis in 2009, employees still stand in a weak posi-tion, made worse by the lack of clout wielded by trade unions with dwindling memberships. Employees, even though aware of the poten-tial risks, will often not stand on their rights, therefore, for fear of being sacked. And with the crisis pushing unemployment up from 4 to 7.3%, employees are more than ever making “compromises”.

More importantly, the Romanian economy is affected by widespread cash-in-hand work. A recent report estimated the number of rightless workers at between 1.4 and 1.7 million, mainly in agriculture and
Care is never free if you factor in the "backhanders" paid to healthcare staff to ensure proper treatment. This makes it harder for the lowest paid to access care.

**Stress and burnout**

Not just building sites and production lines, but offices can be dangerous, too. Stress, free overtime, the build-up of fatigue, aggression towards public-facing workers all take their toll.

The death in 2007 of Raluca Stroescu, a young staffer with the Ernst & Young consultancy group, awoke public opinion to the situation of employees in these big firms. Working sometimes up to 14 hours at a stretch including on weekends, these young professionals are subject to sustained stress and work pace. In March 2010, Ramona Ciciu, a young mother who worked for the international market research firm Ipsos, collapsed at her desk and died after four days in a coma. Her family blamed an excessive workload and overtime working. There is no proof that stress and overwork were directly responsible for these deaths, but they have highlighted the emergence of these psychosocial risks. Sociologist Mircea Kivu talked in the press about the many young people "made to work at a gruelling, fast pace (...) who do not realize they are going beyond their limits". A recent poll showed that one in two employees was doing overtime every day, mostly for fear of losing their job.

Labour inspector Ionut Barbu confirms that these problems of "fatigue, tension and dissatisfaction" are increasingly frequently cited by employees "even though we have no figures on them at present". Occupation-al doctors see the impact of these factors in bringing on cardiovascular diseases or digestive disorders. The Labour Inspectorate launched a study to measure the impact of stress in 2007. Run first of all in the northern Satu Mare department on two target groups – civil servants and clothing industry workers – the study has been extended to other departments and the issue has since 2009 been in the labour inspectorate's action programmes. Psychosocial problems are likely to be classified as occupational risk factors before long. A large-scale inspection and prevention campaign on overtime working was set to be run in late March in big audit, consulting and computing firms.

**Informing employees**

Preventive and information measures are desperately needed in Romania. Smoking, pollution, alcohol, diseases and the rest – Romanian workers generally know little of the risks they run. "This is especially true in things like commerce which is thought to be harmless but is not without hazards", says Corneliu Constantinoaia. He and his union (among others) are working on a project to develop health and safety committees. All companies with more than 50 employees are meant to have these, but many either do not or have one in name only.

Some sectors like construction also have set-ups to promote awareness and pre-vention of occupational risks: since 2007, the construction workplace safety fund set up by two industry unions has been running "no penalty" checks on worksites, providing firms with consultancy services on workplace safety, and chiefly informing employers and workers about safety.

The Romtens Foundation set up by doctors has become a European contact point for promoting health in the workplace. It has, for example, run campaigns on smoking, assessing firms' situations and looking with them at what measures to take to educate employ- ees in the risks of smoking. "These are risks they often do not know about", says Eugenia Barbu, Project Manager at Romtens. Because while EU directives and recommendations have been taken over into law, it takes much longer to change behaviours. "The level of information – be it about smoking, drinking, diet, or whatever – is very limited. The occupational doctors we work with are more treatment- than prevention-oriented. We're getting good reactions from the workers, and while there's still a long way to go, it is an improving trend" she says. The foundation's campaign particularly plays up the commitment of some businessmen – those that use the foundation's services – to give a proper place to these issues in the business world. Perhaps a sign of an awakening to the impor-tance of providing a healthy and safe working environment.

**Very unequal access to care**

There is a huge gap between workers in health monitoring and access to care. All workers are covered by the public health system and must also undergo regular health checks by the oc-cupational health service. "In reality, though, the situation varies with the firm", says Cor-neliu Constantinoaia. The case of two young women illustrate this: one is a civil servant with entitlement to free treatment in public hospitals; the other works in advertising and has the same entitlements plus access to employer-funded private hos-pital treatment, annual health check and re-imbursement of a list of treatments.

The problem is that Romania’s health system is in a very poor state. In particular, it is riddled by corruption and care is never actually free if you factor in the "backhand- ers" paid to healthcare staff to ensure proper treatment. This makes it harder for the lowest paid to access care.

The case of Viorel, a Bucharest junior executive who had several weeks' sick leave last year clearly illustrates the problems of accessing care and the resulting inequalities. He had to make the cash-in-hand payments to public sector doctors he consulted out of his own pocket; was able to have some tests done and see doctors in a private hospital under his employer's health care plan; but for want of the right equipment, had to have extra in-vestigations done in another private hospital where he had to pay the full cost. This makes it hard for most employees in a country where the average wage is between 250 and 300 euros to get proper treatment. The planned reform of the health system signalled at the end of 2009 but repeatedly put back aims to introduce the co-payment system, leaving pa-tients to foot the bill for the cost of their care over a certain amount (yet to be defined). Al-though this measure aims to curb the chronic failing of the health system, it could further worsen the two-tier health situation.

Despite new laws in line with European standards and a relative improvement in the situation, the Romanian working environment is still not by any stretch healthy or safe. The rules are there on paper, and some of the tools; what is needed now is funding and to make this issue a real priority. The economic crisis hitting the state as much as business means this could well not happen for some time to come.
Sweden: regional safety representatives, a model that is unique in Europe

Does Sweden, with its famous "social model", still represent the example to be followed? When it comes to preventing occupational risks, the answer remains Yes. The country is successfully carrying on an experiment which began over 60 years ago. Over 2,000 regional safety representatives, appointed by the trade unions, are making sure that "prevention" is not just an empty word in SMEs.

Hans Olof Wiklund
Work environment reporter, Tema Arbetsmiljö AB
Most of the regional safety representatives' activities are made up of routine tasks in everyday working life in Sweden. But even that can sometimes have far-reaching consequences. One memorable example occurred in 1994, when Transport Workers' Union regional safety representative Gerhard Wendt examined plans for the conversion of Shell's petrol station in the Rosengård area of Malmö: it ended in a government decision and a changed attitude to the risk of being exposed to third-party violence, and to solitary work.

Gerhard Wendt, who started as a regional safety representative in 1986, reacted immediately when he saw Shell's plans. The idea was that the petrol station in Rosengård would be open 24 hours a day, with only one employee working at night. This was an area with gang problems and other problems even then, so both the station manager and his employees were worried.

He tried to negotiate double staffing, but Shell consistently refused. In autumn 1997 he gave up negotiating and requested intervention by the then Labour Inspectorate under the provisions of the Work Environment Act. The Labour Inspectorate flatly prohibited solitary work, but Shell appealed to the National Board of Occupational Safety and Health (now the Swedish Work Environment Authority) against solitary work at different petrol stations unless the night-time pass-through window requirement was met. Employee safety and reducing the risk of robbery and third-party violence were regarded then and now as more important than the employers' interest in keeping down staffing costs or avoiding safety-enhancing investments. And that view has spread to other industries and operations, such as all-night 7-Eleven stores.

"Gerhard Wendt? Yes, he influenced supervision in the entire country with his actions in Rosengård", says Professor Kaj Frick, formerly active in the now closed National Institute for Working Life. "That was an exceptional event, but the main thing is nevertheless what regional safety representatives achieve in their ordinary, daily work", he says. "That is what brings the greatest benefit." Asked to specify the extent of this benefit, Kaj Frick notes that the task is more or less impossible. "There are no measurements of 'the benefit' of safety representatives' activities, no research about it either, that I know of. The chains of cause and effect, the time between action and result, are long, and there are also strong incidental impulses such as cyclical fluctuations and technological breakthroughs. To get an idea of the benefit you have to rely on assessments instead of measurements", he explains.

"Work-related ill health is very expensive; it is usually estimated to be equivalent to 3-4 per cent of gross domestic product. The risk level is greater for small companies because they are not as good at dealing with their risks. So relatively small efforts there should have a great effect, and be extremely beneficial", believes Mr Frick, who is now professor of OHS Management and a researcher at Mälardalen university. "And those who reach these small companies are the regional safety representatives. If they can get something to happen there, such as setting up training, systematic work environment management or a discussion on getting rid of overtime so that employees don't get burnt out, well, then, they are bringing great benefit", he adds.

350,000 workplaces covered

Sweden has had safety representatives since 1912. The trade union organisations have been able to appoint regional safety representatives (RSRs) since 1949, but at that time there were several kinds of constraint. Only when the old Workers' Protection Act was modernised in 1974 were these constraints removed, and the system of regional safety...
hardly ever reaches really small enterprises, with 1-20 employees”, says Christina Järnstedt, the coordinator for the LO affiliates’ regional safety representatives’ activities and the Swedish trade union representative on the Advisory Committee for Health and Safety in Luxembourg, a body aimed at assisting the European Commission in the preparation and implementation of decisions taken in the field of safety and health at work.

The other central trade union organisations, the Confederation of Professional Employees (TCO) and the Swedish Confederation of Professional Associations (Saco), also conduct RSR activities. Together they have over 600 regional safety representatives and deal with about 80,000 workplaces. Swedish RSR activities are to a great extent government funded, but the various trade unions have to contribute a substantial (and growing) amount themselves to ensure the functioning of the activities.

The amendments to the Work Environment Act in the 1970s gave regional safety representatives two main tasks: monitoring employers’ compliance, and endeavouring to get employees to participate in local health and safety work. The preparatory work for the 1974 legislation also emphasised the importance of the regional safety representatives activating local health and safety work.

The regional safety representatives are the contacts that note and sound the alarm about trends and new risks and dangers, they resolve local disputes and blockages, and they make demands and put a stop to things when necessary.

**Kick-starters**

How the assignments are carried out, as well as how the activities are organised, can vary between different national trade union organisations and over time. In my interviews with different regional safety representatives, with representatives for trade union organisations and employer organisations, and with researchers and work environment inspectors, there were, however, a few things that came up again and again. The regional safety representatives are seen as distributors of news and knowledge, kick-starters, mediators, mentors, advisers and consultants. They are the contacts that note and sound the
From the unions 4/4

From the unions 4/4

alarm about trends and new risks and dangers, they resolve local disputes and blockages, and they make demands and put a stop to things when necessary.

"Quite often a safety representative will need help when they reach a deadlock locally", says Göran Wattenberg, regional safety representative for the Swedish Building Maintenance Workers’ Union in Gothenburg. "We come in from outside and it can then be easier to set a process in motion and get something to happen." "But as a regional safety representative I can’t arrange everything, and that may sometimes be difficult for people to understand", says Eva Pålsson, the regional safety representative for the Municipal Workers’ Union in the Scania province (southern tip of the Scandinavian peninsula).

"Obviously I have gathered experience and knowledge over all these years, and I can give them suggestions and help them to get going, but they have to do the spadework themselves locally. That needs training, for both the members and the employers. Training, initiating systematic work environment management at workplaces and supporting the local safety representatives are some of the most important tasks", points out Eva Pålsson. "Let the safety representatives grow and blossom, that’s my private philosophy. I don’t disappear just because I let others come to the fore."

Jan Johansson works with work environment matters at the employers’ organisation Almega. "I think it’s a hard job being a regional safety representative, especially at new companies", he says. "It requires a good knowledge of human nature, and the ability to listen. As a safety representative you must be tough when necessary, yet it is important to show humility. The most important thing is to get employers and employees to interact", he points out.

The RSRs I have spoken to emphasise that most employers want a safe and secure workplace with a good work environment, but many lack sufficient knowledge. "We have examples of companies with between 50 and 70 employees where no one at the company has any basic knowledge of work environment issues", says Göran Wattenberg, regional safety representative for the Swedish Building Maintenance Workers’ Union. "And we have ‘sold’ work environment training for both managers and employees at several such companies."

Never seriously questioned

Kenn Nilsson, regional safety representative for IF Metall, the Swedish Industrial and Metalworkers’ Union, in central Scania, has similar experiences. "We devote a lot of work to training the local safety representatives, but we also provide training for managers at the companies", he explains. Gunnar Rosén, Professor of Work Science at Dalarna University, has worked on several projects examining health and safety work in small companies. "The regional safety representatives are an extremely important source of knowledge for small enterprises", he notes.

Knowledge of local conditions, understanding of production and operating conditions are important for RSR activities. Ingyar Lindahl started his mechanical engineering workshop in the small city of Eslov (Scania) in 2008, with four employees and great plans for the future. "Two months after the start came the downturn. I was forced to give people notice and cancel the purchase of expensive machinery, milling cutters and other things which would have been used in the workshop. It was actually not a matter of a downturn; it was an economic meltdown, a catastrophe. These have been horrible years", he notes, "with all energy devoted to the survival of the company. Work environment issues were not a priority. When anything came up I phoned Mats Pålsson, who is the regional safety representative at IF Metall. I have only good experience of that cooperation. It’s easy to talk to him."

The regional safety representative system is now such a matter of course that it has never really been seriously questioned. That is precisely why the question must be asked: Why do we have regional safety representatives in Sweden? "To ensure that trade union health and safety work can also be conducted in small workplaces that do not have their own safety representative or safety committee. Because all employees have the right to safe, secure and fulfilling work", says Christina Järnstedt at the Swedish Trade Union Confederation.


"The Chile 33": the lessons that must be learned

The happy ending to summer’s Chilean rescue saga and its hijack by politicians and the media have overshadowed the issue of the miners’ working conditions. A total disregard for safety measures and profit-chasing driven by copper prices were key to the accident happening.

Magdalena Echeverría
Sociologist, Chile
In August 2010, a tunnel collapse occurred in the privately-owned medium-sized San José mine located in the desert of northern Chile.

The story quickly went worldwide. After 17 days, the news came that the miners trapped more than 620 metres below ground were still alive with a note sent up from the bottom of the mine shaft: "All 33 of us are fine in the shelter". The government marshalled all the resources and technical capabilities available in the country and abroad, and the last of the trapped miners emerged from the bowels of the Earth after 71 days.

The rescue operation became a global event. Broadcast live by TV stations, the plight of the miners and their families was turned into a reality show. Over a billion people across the world watched as the workers were brought to the surface one by one during an operation that took 22 hours.

This was a new experience for Chile. A strange feeling for a country whose own image is that of a strip of land at the world's end, isolated, poor and poorly understood, but abruptly thrust into the limelight as the focus of media attention.

Displaying business acumen and a keen sense of public relations, President Piñera immediately seized on the situation to extract maximum advantage from it during various tours in Europe and Asia, where he met with various heads of state and business leaders to play up the technical achievement of the rescue and promote Chile to investors. His spin was that Chile had become a developed country where things are done right. "Made in Chile" means "a job well done" is the essence of his message to business leaders.

But has it made Chile a better country? Should we really be so proud of the "Chilean way"? Does this near miracle – or near tragedy – give a better purchase on the reality of mine work?

An accident waiting to happen

All Chileans were deeply moved by the feat achieved by their country, including the authorities, the courage of the 33 miners and their families, and the national and international solidarity. To that extent, the accident helped strengthen social cohesion, bringing all energies to bear on a single goal: drilling in the right place to reach the shelter and bring the workers out. In that sense, Chile is a better country today than it was before. All resources were brought to bear in a setting of national unity.

But continuing to blazon the achievement is pointless. Fortune smiled on us. There are still questions to ask and answers to be given, and most importantly, lessons to be learned from the event.

It must never be forgotten that what produced this long-running saga was not a natural disaster but a foreseeable tunnel collapse whose consequences could and should have been avoided. The San José mine was worked in conditions that do not meet the basic standards of national mine safety regulations, ILO Convention 176, or the safety standards that apply to underground mining anywhere in the world.

Accident investigations are not yet finished, but it is clear that the mine had no emergency exit, the miners found no ladder with which to escape up a ventilation stack and, more importantly, the ore was being mined from the copper-rich supporting pillars, which the mine owners were avid to get out. This is what caused the galleries to become unstable and ultimately collapse.

This accident is an object lesson in production at any price in a small mining company improperly granted the status of...
a medium-sized mining company (which in Chile brings a range of financial benefits). A company that neither did the necessary works nor used a sustainable ore mining system, but simply worked the structure of the mine.

It was an accident waiting to happen. Between 2001 and August 2010, three fatal accidents occurred and two workers lost limbs in this and another nearby mine (since closed) worked by the same company, San Esteban, following a gallery collapse in one case and a rock explosion in the other, showing the utterly unsafe conditions in which these miners were working.

The unions complained to the mine owners and government regulators, securing several operating bans and closure orders, but were unable to prevent the mine subsequently being reopened. To ensure their members’ safety, they made a “protective appeal” to the Court of Appeal in 2004, which was dismissed, and filed a complaint with the Lower House’s Labour Committee. But still the accident happened.

The very few public statements so far made by a handful of the 33 rescued miners show that they had warned the company of the risk of a collapse that very day, but the work was not halted and the trapped shift was not allowed to leave.

There are three key things about the San José mine:

1. The workers had little length of service – why is made clear by the admissions of most that the job was a means to an end (funding a child’s higher education, buying a consumer durable);
2. A well above-average percentage of old and very young workers, which is uncommon in mining;
3. Pay that is relatively better than the industry average, acting as a perverse incentive to stay with the firm for a while at least.

### Fatalities and copper prices

The condition of the San José mine, while extreme, is not exceptional. The severity of the collapse notwithstanding, fatal accidents are still happening. Between 5 August and the end of last year, five miners died and one lost an eye during equally unsafe mining works.

National data and studies from different countries show that work accidents are pro-cyclical in nature. They increase when copper prices rise, mine production activity rises and mining accidents with it. In a country where mining is important to the economy, copper price trends should act as an epidemiological threshold for the relevant authorities to investigate working conditions and ensure safety in mines.

Are Chile’s working conditions structurally deficient? Are mining and other economic activities altogether unsafe? The answer is no. Conditions in large scale mine workings and in most large companies meet high safety standards. The point being that mining and other high-risk activities can only be carried out in safe conditions which are bound up with the activity.

But working conditions vary widely up and down the country. There are good quality stable jobs, but also high job insecurity. Chile’s labour market is characterized by wide disparities in general working conditions, pay and social protection, including safety and health at work.

It is sometimes said that Chilean businessmen know how to produce but are not necessarily familiar with labour standards.
There are also workplace safety regulatory bodies, which in the case of mining, have a specialized service, SERNAGEOMIN, besides the general functions of the Ministry of Labour and Health regulatory agency. These regulatory agencies bear third-line responsibility as regards standardization and inspection. They are essential links in the chain of responsibility and can allow a works to open or shut it down. At present, the State has only 18 inspectors to keep watch over nearly 3,500 mining companies, which is too few and needs putting right. But unless firms commit to abide by the rules, an army of inspectors will be needed to enforce them.

The development of a national occupational health policy setting priorities and responsibilities, a revision of the Work Accidents Act to ensure effective prevention in particular, and an overhaul of all government agencies that regulate working conditions are all urgent labour policy reforms that the country must tackle as a result of this mining accident. A raft of initiatives have been taken: the government has set up a safety committee which is starting to produce results, while the Unitary Labour Federation (CUT) has established an alternative workers’ health committee which has also made proposals.

But the issue that needs immediate attention, but was not highlighted when the accident happened, is that the primary responsibility to protect life at work lies with firms, their owners and those who run them. The first duty of Chilean companies is to update and integrate their production processes and management of their policy for protecting the safety, health and life of their workers, as do firms in most OECD countries — of which Chile is one.

Likewise, the Chilean labour movement must put the active protection of workers’ health on its agenda and make a reality of a fundamental right not explicitly provided for in national legislation: workers’ right to stop work in dangerous situations to protect life and limb.
Resolving the equality equation

Epidemiology is not a hot topic outside specialized circles. It does not feature in coffee-table books or paperbacks. Its insights never inform electoral campaigns. Wilkinson and Pickett’s book *The Spirit Level* is a standout exception. A bestseller in its field, it has been cited – not always in context - by both the UK’s current Conservative PM David Cameron and the new opposition Labour leader Ed Miliband. It has been embroiled in controversy and endless debates in the United Kingdom and beyond since its release.

*The Spirit Level* refers both to labour and to one of the most engaging movements of England’s 17th century revolution: the Levellers and the radical democratic demands they embodied.

The authors discuss the relationship between rising income inequality and a set of indicators that reflect the quality of life in developed capitalist countries. They review the existing data across a wide range of fields - infant mortality, obesity, violent deaths, imprisonment rates, etc. – and use studies that are valid and homogeneous enough to enable comparison.

They are clear on the fact that quality of life in a society is dictated not by wealth creation as reflected in gross national product, but much more directly by levels of income inequality. The 23 countries examined can be ranked by scale of income inequality. The least unequal countries are Japan, Finland, Norway and Sweden, where the incomes of the richest 20% are three to four times higher than the poorest 20%. At the other end of the spectrum are Singapore, the United States, Portugal, the United Kingdom and Australia with differences ranging from 7 to 10. Most of the EU countries fall between the two extremes (5.2 for Germany, 5.6 for France, 6.7 for Italy). Looking at the quality of life performance of the same countries, it is clear that basically, the more unequal the incomes, the worse the outcomes are for society: illiteracy, infant mortality and prison population rates all rise. The same trend is found for mental illness, teenage pregnancies, cardiovascular diseases, drug and prescription medicine abuse, low social mobility and educational failure rates.

The pattern is similar for the United States. Quality of life is observably better in those of the 50 states where income is least unequally distributed. With comparable per capita levels of wealth but more equality, life is much better in Minnesota, Vermont and Iowa than in California, Georgia or Texas.

While it contributes no new data, what *The Spirit Level* do has going for it is to provide an accessible summary of data generally found piecemeal across specialized studies. The first part of the book shows that there is an overall consistency in the way societies work and that income inequality is almost always associated with a wide range of seemingly unconnected negative developments. The inference is that sector-specific policies are likely to be less effective than an across-the-board policy to close equality gaps.

In part two, the authors outline a model that explains the link between inequalities and widespread social unease. They point to the role of stress, taking an approach that blends psychology, anthropology, medicine and social relations. The authors contrast the hierarchical dominant-dominated trend with the desire for communication, cooperation and feelings of gratitude and mutual support, and show how these tendencies to come together in partnerships of equals engender mutual trust, reduce psychological stresses and benefit both individual health and life in society. The explanations, while often compelling, nevertheless remain partial. Its brevity and urge to portray complex social relations as a sort of logic diagram means that the book sometimes underestimates the specific way in which capitalism ties into the social relations that came before it. Social and cultural history - be it slavery in the United States, the Lutheran Reformation in the Scandinavian countries or the links between the labour movement and social democracy in Western Europe - takes second place and is reduced to a backdrop of almost passing interest.

Political perspectives take up a third section of the book. The argument that it is more important to combat inequalities than to increase the production of material wealth flows logically from the analyses. Readers may, however, be surprised by the gap between the radical findings and the extremely cautious policy options proposed. The policy advocated is “a continuous stream of small changes in a consistent direction”. Producers’ cooperatives are given a big role in taking the economy and society forward. The authors seem to feel that a policy based on the clear force of the figures would be able to persuade the “haves” of the need for a society free of inequalities. The pragmatic arguments deployed for that do not fully take into account the complexity of the issues: it is not just about income, but also ownership and the power that confers on the lives of others. There needs to be a more specifically political debate on the faith that we are on an irreversible trend towards more equality. Relying on statistical and epidemiological data alone is not enough. There is no skipping a discussion on the goals of, alliances for and likely obstacles to societal change.

— Laurent Vogel

The Spirit Level. Why Equality is Better for Everyone

To join the Internet discussion: www.equalitytrust.org.uk
Most of us eat meat pretty much daily. But few of us know much about how our daily fare gets to our plate. Slaughterhouses work behind closed doors. In the early 19th century, they were exiled to the outskirts of towns, and later often confined to specific butchery areas or “shambles”. From time to time the curtain of obscurity gets pulled by the prying eyes of film-makers exposing the – obviously un-speakable – conditions in which animals meet their end. But the slaughtermen less often attract the same compassion.

"Slaughterhouses are places of violence and death, of legal bloodshed and exposed flesh," writes Séverin Muller to explain the repugnance they arouse in people. In À l’abattoir. Travail et relations professionnelles face au risque sanitaire, the French sociologist presents the findings of a five-year investigation into two industrial slaughterhouses in the western French region of Deux-Sèvres, giving a graphically detailed account of what it is at best an unusual trade.

It is a world governed by the rules of industrial production, but in many respects frozen in centuries-old time. First is the cast of characters straight off the pages of a Zola novel: the “drovers” who unload and sort the cattle, the “hauliers”, “old sweats” who scorn new health standards, safety instructions and anything the bosses say. Then there are the “susters” who render the animals unconscious, the “stickers” who bleed the animal, not forgetting the “meatcutters” (who remove the heads) and “splitters” (who cleave the carcass open and remove the innards before separating out udders and penises). Finally, there are the “jobbers” – itinerant butchers employed by outside firms paid on a piece-work basis or per kilo of boned meat. Moving between slaughterhouses as they do, they have also earned the nickname “the gypsies”.

It is a world with its own codes, vernacular, rites of passage and strict demarcations. "Not sticking with your workmates quickly excites suspicions of siding with the enemy," avers the sociologist. And potential enemies are everywhere at a time when problems filling vacancies are forcing management to hire contingent labour with a different profile – urban youth and women. Their advent "is seen by workers and supervisors as a threat and a challenge to the daily operation of the plant. This casualised workforce on temporary or training contracts foreshadows a de-skilling of jobs," says Séverin Muller.

Despite these sociological changes and others that come with the industrialization of food production and the grip that supermarkets have on the meat sector, the Taylorist system of work organization has left only a superficial imprint on the sector.

The difference comes from being based on a living, non-standard input that leaves little room for automation, what the author calls the "insurmountable diversity of the product, meat."

Here, unlike most mass production industries, the end product is the culmination of a disassembly process. "In a car plant, you take parts that are all the same, you assemble them, and that gives you something that moves. When you slaughter a cow, it’s exactly the opposite – you take it to pieces. And where it gets complicated is that you only find out what the parts are like as you get into it", says a quality manager.

This singular situation gives crews some leeway to organize their work and meet management’s objectives. "Production management tried to make the cutting station meet an hourly target, but the wide variety of tasks meant it was finally set per day," notes the author.

Carrying out his inquiry in the second half of the 1990s, Séverin Muller had direct experience of the impact of the "mad cow" crisis. This public health scare found slaughterhouses having to introduce traceability at short notice in 1996 after scientists confirmed that the disease could cross the species barrier to humans through eating meat products.

Traceability meant reorganizing work at all stages of the production chain, from receiving the cattle to meat packing. So pressurizing are these that they often force workers to choose between keeping up the pace of work and keeping to health rules, says the author.

With the fear of a health scandal never far away, workers come under pressure from above through a subtle blend of guilt and accountability. Management take a line that "appeals to the worker’s good citizenship (...) as being health-protecting (or life-saving) and may, in the event, be responsible for administrative closure and the prospect of layoffs.”

It is interesting to note in this connection that what directs preventive measures is the preservation of safety in the food chain, not the protection of workers’ health. In fact, workers are seen as nothing more than contaminants. "The risk management applied in slaughterhouses recognizes that the product has potential to contaminate the final consumer, whereas the worker who handles "hazardous material" falls outside the scope of endangerment: the fact that their chafed and grazed hands are in contact with brains or spinal cords is not characterized as a risk. Recognition of such a risk would mean having to award an allowance or regrading", says Séverin Muller bluntly.

With 262 work accidents per 1,000 workers compared to 54 per 1,000 in industrial activities, and three out of four new hires leaving before the end of their probationary period, it is high time the meat industry began to think hard about the working conditions in its slaughterhouses.

— Denis Grégoire
