Social Inequalities, Labor, and Health

Desigualdades Sociais, Trabalho e Saúde

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GOMEZ, C. M. & CARVALHO, S. M. T. M. ***Social Inequalities, Labor, and Health****. Cad. Saúde Públ., Rio de Janeiro, 9 (4): 498-503, Oct/Dec, 1993.*

This article presents a brief analysis of the social inequalities expressed in the relationship between health and labor. It focuses on the Brazilian context.
It begins by approaching the conceptions present in the lines of investigation and intervention in this field of health. It considers an entire range of thinking, from the eminently biological and individual level to an understanding of the relationship between labor and health as a reflection of essentially social processes.
The confrontation between conceptual advances, proposals for intervention, and the reality of health for Brazilian workers is the parameter for analyzing the activity of state institutions, companies, and workers' organizations. Based on the current situation outlined in this study, perspectives are identified for urgent and indispensable changes.

Key words: *Worker's Health; Occupational Health; Occupational Medicine; Work Environment; Work Accidents and Diseases*

Labor is a relationship both among human beings and between them and nature, and it takes place and is revealed through ambivalent dimensions. On the one hand, as a source of creation, recognition, and projection, it is praxis combining action, thought, and feeling. On the other hand, as an object of differentiated appropriation, place of suffering, and expression of alienation, it provides evidence of social inequalities and contradictions.

In its articulation with health, labor is the situation *par excellence* where men and women live and express with their bodies both the achievement of pleasure and confrontation with suffering, pain, and disease.

This text attempts to synthesize the trajectory of concepts and practices referring to the question of labor and health and to apprehend them in the dynamics of current relations in Brazilian society.

The relationship between labor and health.

Recognition of the relationship between labor and health/disease has been recorded since ancient times, even on Egyptian scrolls. What has varied over the course of history have been the ways of apprehending this relationship and of dealing with it. To ignore it as a field of systematic investigation and intervention was — and to a large extent continues to be — a common practice, as long as its effects have not become harmful to production or have not generated expressions of effective resistance by the workers.

Understanding the relationship between labor and health as the exclusive result of the isolated action of pathogenic agents on the worker's body or even of the multiplicity and interaction of various agents with more obvious existence and effects (that is, physical, chemical, mechanical, and biological agents) constitutes the theoretical and conceptual basis for conventional practices in

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industrial medical care and occupational health. "*Classical thinking in occupational health sees labor as an environmental problem, since it puts the worker in contact with chemical, physical, biological, and psychological agents that cause accidents and diseases. This conception clearly reproduces the traditional form of medicine that sees disease as a biological phenomenon which occurs in the individual*" (Laurell, 1981). Thus, in the face of the qualitative and quantitative exacerbation of the marks of labor's violence on the worker's body, a hegemonic model is adopted for restricted intervention through circumscribed actions taken in the workplace and certain curative measures taken on the sick body. From this perspective, the static perception of the workplace and the essentially technical perception of work processes go together to cover up the social relations present in them.

It is in the Latin American current of social medicine that the productive process as a general analytical category is introduced in order to allow one to "*study in a concrete reality the logic of accumulation (the valorization process) and its means — the labor process — as a specific model of working-and-wearing-out and as a class confrontation in terms of exploitation strategies versus resistance, which in turn determines specific exploitation patterns*" (Laurell & Noriega, 1989). From this point of view, the environment, labor conditions, and particularly the organization of labor, leading to differentiated burdens weighing on the health of all and each one of the workers. Thus, inequalities as to inclusion in the productive process add other possibilities for damage to the workers' health in addition to those they share with the populations subject to their same living conditions.

Moreover, emphasis on the form in which labor is organized, beginning with a Taylorist perspective, provides the basis for attempts to explain the impact of labor on mental health. The Taylor system acts giving rise to "*a clash between the individual bearer of a personalized history and the organization of labor, bearer of a depersonalizing injunction*" (Dejours, 1987). This reflection can also be extended to more recent trends toward reorganizing labor in ways that propose to reduce the worker's dissatisfaction in the face of monotonous, broken-down, "job-specific" tasks that obey prescribed rhythms and systems of control and power.

Furthermore, it is the questioning of the organization and division of labor and its tendency to produce and reproduce a hierarchical division of human beings that constitutes a new approach to the sexual division of labor. "*Thus, just as the essence of the division of labor is inequality, ...the sexual division of labor distributes genders according to unequal activities, where some are more highly valued than others in the world of production and reproduction*" (D'Acri & Brito, 1991). The gender issue has thus introduced a fundamental dimension into the evaluation of differentiated patterns of attrition in workers' health.

LABOR AND HEALTH IN BRAZIL

In the case of Brazil, one should observe a profound hiatus between conceptions and the formulation of proposals meant to intervene in the effects of the labor/health relationship.

The Brazilian legislation on work-related or occupational health problems itself is limited to defining extreme situations of work accidents and acute occupational poisoning as well as some occupational or work diseases.

Upon attempting to diagnose the reflections of the relationship between labor and the health/disease process in the Brazilian population, we ran up against an overall lack of systematic quantitative information on the problem's true magnitude. As a general observation, a result of the industrialization process has been a change in the population's epidemiological profile. The weight of infecto-contagious diseases, while still significant, has been replaced by cardiovascular diseases, the so-called external causes and neoplasms, which occur differentially and significantly in the working population, as studies from industrialized countries confirm. Still, the only general data available to us refer just to work accidents

and occupational diseases recorded by the official social security agency involved in workmen's compensation. According to statistics from Dataprev, during the 1980s there were over 10.5 million accidents. Of these, some 260 thousand resulted in permanent disability and over 46 thousand in death.

The validity of these figures is highly questionable, due to the defficient system for gathering information by the public sector, various forms of under-reporting existing in companies, and incorrect diagnoses that keep them from being included on the roster of officially acknowledged occupational diseases.

In addition to the human drama, which cannot be measured in economic terms, and the social cost, these accidents represent a loss of 6 billion dollars a year for the country, according to estimates by the Ministry of Labor. In addition, as taxpayers, workers bear a significant portion of this burden and are thus doubly penalized.

It is not possible to pinpoint to what extent this figure is underestimated. Yet it is in sharp contrast with the few clinical and epidemiological studies done on certain professional categories, which point to veritable epidemics of lead, mercury, benzene, and pesticide poisoning, dermatosis, silicosis, and asbestosis, among others. The difficulty in proving a causal nexus, even for the reduced number of diseases that find backing in the legal text, contributes in a very significant way to disguising the true impact of work on health. The worker is left with a long pilgrimage to have his condition recognized as a citizen who is ill: this calvary ranges from bureaucratic impasses to an almost total absence of institutional and professional support to meet this demand. And this, when the worker does not decide to cover up the possible diagnosis of his or her disease, a lamentable strategy in defense of employment, given the frequent layoff of sick workers without any guarantee of their rights.

In addition to being unreliable, the quantitative data are not representative of the working population as a whole. The universe refers to salaried workers with signed working papers, while according to 1989 data by the National Household Sample Survey - PNDA (Fibge, 1990) these workers represented only 40.7% of the salaried workers. Furthermore, within this contingent of the labor force there are great differences by region and economic sector. While 83.2% of salaried workers in the manufacturing industry had signed working papers, only 8.2% in agriculture did. Of the employees in services, who make up 53.3% of the employed labor force, only 37.2% had signed working papers.

This lack of minimum labor protection conferred by signed working papers is aggravated by huge wage disadvantages, which result in even more degrading living and health conditions. Employees without signed papers in 1989 received wages that were less than half of those received by workers with signed papers. An employee from Southeast Brazil with signed papers earned over four times the salary of a Northeasterner without signed papers, which represents one more expression of regional imbalance.

A comparison of income for labor reveals one of the most unequal distributions of income in the world. Taking 1989 as our reference, we observed that the top 1% of individuals in the economic pyramid earned 15.9% of the total income for labor. This was the same as that received by the bottom 60%. These figures are even more alarming if one considers the continuous deterioration of collective public goods and services, ranging from health care itself to the educational, housing, sanitation, and transportation systems.

Add to this precarious picture the fact that substances are still used in Brazil which have been banned in other countries. One observes a simultaneous generalized trend toward exportation of technologies and processes that are harmful to health from the industrialized countries to the underdeveloped world. The burden of such processes, as long as they are economically profitable, falls on the shoulders of the workers, and the deterioration of their health and lives is never taken into consideration.

Nevertheless, although proper attention is not given to the fact, such "dirty"

technologies are acknowledged to be noxious, yet not even this occurs with new technologies. The fetish of modernity and the enticing appeals to reduce heavy labor tend to cloud over the logic of their use, founded mainly on intensifying both production and thus human labor. "*A whole new way of producing — and thus of working — is being established, and it has farreaching repercussions on the working class. Certain professions are becoming or will become obsolete within a short time. Others will be created, but the skills needed to practice them will be very different from the present ones. The make-up of the working class tends to change ... The very nature of work and the relationship of the worker to the product are being altered*" (Carvalho, 1987).

The absence of socially shared planning processes can turn echnological advances into new work burdens and new forms of stress for the workers, which in a sense means repeating old historical mistakes under new premises. Since the beginning of the industrialization process in Brazil, the link between labor and health has never become a significant field of activity for Public Health. Given the magnitude of such problems, an analysis of the State's action shows a chaotic, ineffective performance. The government's most striking characteristic has been a lack of integration, as expressed in fragmented, unarticulated, and superimposed actions by institutions with direct or indirect responsibilities in the area. There is a clear bankruptcy of public policies for intervening in the labor/health relationship, both from the limited perspective of certain preventive activities (like some measures for upgrading the work environment) as well as for curative measures in the form of medical care.

In the early 1970's, Brazil's uncomfortable position as world record breaker in work accidents, a dramatically inside-out expression of the "Brazilian economic miracle", forced the government to create the Specialized Services for Safety Engineering and Occupational Health in the companies.

The health, engineering, and supervisory professionals involved in such services are hired and fired without any say by the workers or any legal backup to guarantee their autonomy in relation to the company. Under such restrictive conditions, health care becomes nothing more than control mechanisms used to avoid the recruiting or hiring of individuals with jeopardized work potential or to regulate absenteeism and cover up the wear-and-tear on workers inside the company.

As we can infer, the issue raised by Bernardino Ramazzini, the Father of Occupational Health, is still relevant almost 300 years later. Concerned over the damage that certain kinds of work caused to artisans, he recommended that one more question be included among those asked to sick individuals, under the Hippocratic principles: "What is your craft?" He concluded: "*I consider this question opportune and that it is even necessary to remind a physician who cares for men of the people to ask it. He should make use of it to get to the causes of the illness, even though it is rarely asked, even when the physician is familiar with it. However, if he had observed this, he might have achieved a happier cure*" (Ramazzini, 1988).

The same chasm separating expressed ends and concrete practice is also present in the vast majority of the Internal Commissions for Prevention of Accidents, legal mechanisms for relative workers' participation in the establishment of decent working conditions.

These commissions are influenced by an insufficient technical support that give priority to the use of individual protective equipment and intervention in so-called "unsafe acts". Consequently they are often forced to concentrate on controlling attitudes and behaviors that are considered uncompatible with "safe" work. This in turn reinforces the widely-held concept — which is frequently exacerbated by bosses and company professionals and hotly contested by broad sectors of the trade union movement — that work accidents and occupational diseases occur because of worker's negligence and not because of unsafe conditions generated by the work organization and work process.

The false dividing line between the internal and external environments contributes to the

disarticulation among agencies in charge of monitoring and intervening in each of them respectively, thus adding a new factor to the lack of efficacy in institutional activity in the field of the labor/health relationship. The chasm separating services, research, and teaching in this field adds the final touch to this lopsided puzzle, which can only be fit together using a logic that is the opposite of that which should guide the right to health at work.

CURRENT PROSPECTS

The 1988 Brazilian Constitution recovers the fundamental role of the Ministry of Health in the implementation of policies in the area of workers' health and environmental protection, including protection of the work environment. In order for this intent to become reality, it is indispensable that actions for workers' health be included in the basic health care network and that referral centers be established at the outpatient, hospital, and laboratory levels, and that they be qualitatively and quantitatively adequate for the magnitude of the problem. It is also fundamental that this set of actions bolster health.

In order to progressively eliminate insalubrity and discard it as a factor for monetarizing risk, and to ensure workers the full exercise of their right to refuse work under unhealthy conditions presumes breaking with the myth of risks as "natural" to work.

The effective integration between health services, teaching, and research in an unequivocal relationship between the production of knowledge and the needs of the working people is an indispensable compliment to this set of proposals.

However, its feasibility at the legal and institutional levels demands political will and above all the establishment of effective mechanisms for intervention by organized workers. In addition to being a recognized right, workers' participation introduces a fundamental kind and body of knowledge, since it is based on untransferrable, daily living experience with health and disease at work.

The last decade has been marked by a major advance in the understanding of the problems of workers' health in Brazil and the measures that will have to be adopted. Some practical forms have already been introduced, such as programs for workers' health, with differentiated levels of participation by workers and with repercussions that have been limited for political reasons. The trade union movement has set up technical advisory boards and training programs. New denunciations have been added to old problems. Yet the main challenge remains. To face it with political will demands that health at work become a crucial issue for Public Health, a social and political issue, as a result of which institutions, professionals, and workers' representative organizations interact.

Finally we could list proposals, many of which are implicit in the brief diagnosis of situations we have presented here. However, we have opted to observe here that the changes in the present state of workers' health are not related exclusively to the internal concerns of the institutional health sector. This merely reflects in a dramatic way the inherent consequences of an economic growth model which excludes broad segments of the population from the goods and services that are produced socially and which deepens the inequalities present in all spheres of Brazilian society.

RESUMO

GOMEZ, C. M. & CARVALHO, S. M. T. M. **Desigualdades Sociais, Trabalho e Saúde**. Cad. Saúde Públ., Rio de Janeiro, 9 (4): 498-503, out/dez, 1993.

O texto apresenta uma breve análise das desigualdades sociais expressas na saúde em sua relação com o trabalho, tendo por foco o contexto brasileiro.

Aborda, inicialmente, as concepções presentes nas linhas de investigação e intervenção neste campo da saúde. Trata de captar todo um percurso, desde uma visão eminentemente biológica e individual até um entendimento da relação trabalho-saúde como reflexo de

processos essencialmente sociais.
O confronto entre os avanços conceituais, as propostas de intervenção e a realidade de saúde do trabalhador brasileiro consitui-se em parâmetro de análise da atuação das instituições do Estado, das empresas e das organizações dos trabalhadores. Com base na situação atual delineada através deste estudo, apontam-se perspectivas para as urgentes e indispensáveis transformações.

Palavras-Chave: Saúde do Trabalhador; Saúde Ocupacional; Medicina do Trabalho; Trabalho-Saúde; Ambiente de Trabalho; Acidentes e Doenças do Trabalho; Riscos Ocupacionais; Legislação Brasileira Sobre Saúde do Trabalhador

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