Working conditions and social inequalities in health

Social inequalities in health have been widely reported. In general terms, mortality and morbidity indicators are worse for the lower social classes. They also have less access to health services, live in urban environments less favourable in terms of health, work in worse conditions, and have fewer opportunities to engage in healthy life options.

It seems undeniable that social class is a powerful determinant of multiple exposures involving the majority of areas of daily life.[1] Social groups have, and maintain over time, characteristic patterns of disease despite the fact that the people of which they are composed may change group, suggesting that there must be something deep down promoting disease.[2]

The definition and measurement of social class is still controversial. Different variables are usually used in epidemiological studies—mainly the socioeconomic status, the level of education and the occupation, and usually measured at individual level. Frequently it is the availability of data that is the key determinant of what variables will be used. The use of these variables in occupational studies without the conceptualisation of what social class means is something risky, as they do not mean exactly the same and may fit one conceptual frame better than another. If social class means the sharing of something, then this is not captured by epidemiological studies that only use individual-based measurements. If social means some position in the production process rather than into the market, this is perhaps better captured by the occupation than by other variables. If social class has also to do with the decision making processes then this is not captured by looking only at the occupation workers have without measuring control at work.

This issue is especially important when looking at the contribution of work to social inequalities in health. Every worker has an occupation but workers of the same occupation do not necessarily work under similar conditions. So, the title of the occupation itself may not explain health inequalities among workers, inequalities that are related to the inequalities in working conditions. On the other hand, the meaning of work goes beyond the salary and the socioeconomic status of workers, including social relationships at work and, particularly, the access and participation in the decision making process.

In the Whitehall study, mortality rates among city council workers follow a clear gradient according to professional category.[3] Later studies with the same population have analysed other aspects (absenteeism for health reasons, and cardiovascular risk factors, fundamentally as outcomes, and psychosocial exposures) with identical results.[4 5] If we take into account that we are dealing with a population with stable jobs, basically doing non-manual administrative work, with no threat of unemployment, we must accept that the relations between social position, occupation and health go beyond simple purchasing power. In other words: social inequalities in health are of such a magnitude and conditioned by such forces that this relation is observable even in studies that only include working people without strong social needs.

If the relation between social class and health is so evident, what part does work play in social inequalities in health? Of course, the reply to this question has not been resolved, but it seems that the contribution of work could be central. In the first place, because the social division of work is at the origin of social class, and hence the difficulty—conceptual and methodological—of separating work and social class is logical. In the second place, because there is evidence of the unequal distribution of working conditions and exposure to risk factors among the working population, exposures that relate with a variety of health effects. Thirdly, because the work experience has an important influence in the socialisation of adults, and the learning and development of personality,[6] and thus its effects go beyond that attributable to physical/chemical exposures, directly impacting lifestyles, culture and social relations.

The growing interest in the study of the influence of the psychosocial environment of work upon health represents an important advance toward answering our question. The psychosocial characteristics of work are strongly associated with social class, such that the manual classes exercise a notably inferior level of control over their work than the non-manual classes. In fact, control over your work may play a mediating part in the relation between socioeconomic status and health,[7] although some authors consider that the relation between work and health is not attributable to job exposures, but rather to the concomitant social class.[8] Others consider that separation of work and social class is not only unnecessary, but even counterproductive.[1] From this point of view, job organisation has been considered a meta-exposure, the determining factor of all job related exposures and risks, as it is here that tasks—and consequently the associated exposures and risks—are assigned to workers.[9]

People in jobs with high demands and little control (high tension jobs, according to the Karasek's demand-control model) or those who receive low compensation in relation to the effort put into their work (according to the Siegrist's effort-reward model) have a higher risk of suffering cardiovascular disease.[10] High tension at work has also been related with mental health indicators, psychosomatic illnesses, and health related lifestyles, and the effect of the work organisation exposure over the working life.[11] More recently, it has been concluded that the psychosocial work environment, including skill discretion and decision authority, explain most of the socioeconomic status gradient in depression and well being in the middle aged civil servants included in the Whitehall II study.[12]

Another of the aspects relevant to the study of social inequalities in health is the health and working conditions of women. It should not be forgotten that the division of work is on the basis of not only the social classes structure (manual versus non-manual work) but on the basis of gender inequalities too (productive versus reproductive work). In this sense, we must consider several aspects: sex based horizontal (inter occupations) and vertical (intra occupations) segregation, and the unequal sharing of the reproductive load between men and women. Sex based occupational segregation is a plain fact: the majority of the workforce engaged in the sector of people oriented services is female, in contrast with the overwhelming masculinisation in construction and other industrial sectors. The sex based discrimination in the workplace continues to be a relevant fact in the majority of countries, in terms of access to jobs, in promotion and in the characteristics and conditions of work, and hence the prevalence of exposures to health risk factors. Women undertake, compared with men, more monotonous and routine jobs with less authority and lower salaries. There is also ample evidence of health inequalities between men and women in relation to

these factors and interactive exposures of home and work environments.[13]

Occupation reflects a particular social class position and particular conditions of exposure to risk factors in the workplace, generally of a physical/chemical and psychosocial nature, and that vary precisely as a function of social class, as it has been stated by Johnson and Hall.[1] According to them, manual workers have to deal with daily exposures to risk factors of the physical/chemical type, and with the lack of control over the work, while non-manual workers are exposed to increasing high performance demands, often internalised and idealised as work ethics. Blue collar work offers collective and compensatory mechanisms in the form of social support, while white collar work offers power and social status

In both cases, the social fact of working constitutes one of the key contributors to social inequalities in health, a contribution that goes beyond the concrete single and individual exposures that take place in the workplace to link with collective and social relationships. In that sense psychosocial epidemiology has probably much to say in the research of coming years, and health policies should consider the improvement of working conditions as a key objective to reduce health inequalities.

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