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Faculty of Occupational Medicine

Position Paper

The Interaction of Health Inequalities and Work Status and the Potential for Work and Occupational Health Services to Help Reduce Inequalities

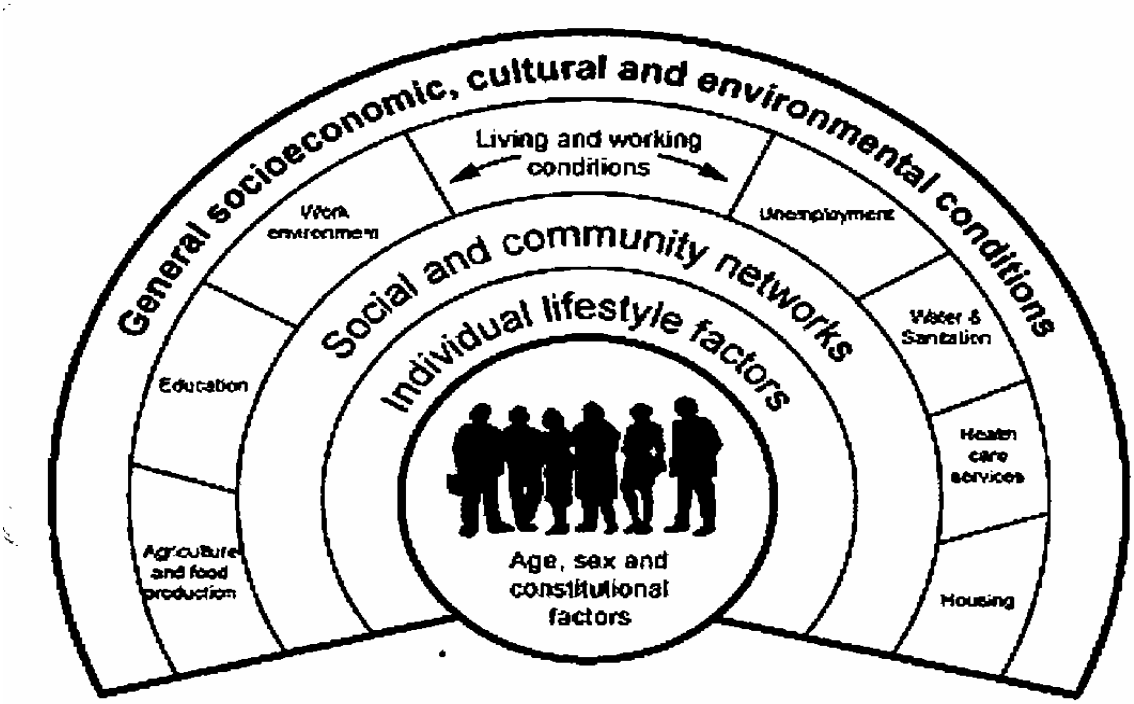
Work status as a health determinant

Socio-economic inequalities in health can be defined as:

"systematic differences in mortality and morbidity rates between individual people of higher and lower socio-economic status to the extent that they are perceived as unfair"

Addressing inequalities is a declared government priority. It is central to strategies on public health and an important element of the newly emerging occupational health strategies, all of which recognise the potential of the workplace to reduce health inequalities.

All such strategies focus on the key determinants of health. These are illustrated in the model below:



Source: G Dahlgren and M Whitehead, *Policies and strategies to promote social equity in health*, Institute of Futures Studies, Stockholm, 1991

The work environment, the working community and the social networks generated by work, are important determinants of health.

The link between health and work gradients

Life expectancy is shorter and disease more common in people who are economically disadvantaged. These effects are not however confined to those who are poor; rather, the social gradient in health runs across all of society, such that among middle class office workers, lower ranking staff experience much more illness and a shorter life expectancy than higher ranking staff. About a quarter of this social gradient is accounted for by smoking, obesity, high blood pressure and other aspects of lifestyle. Social factors, the work climate and genetic and early life influences account for the remainder. It follows that interventions which influence these health determinants have the potential to improve health and to reduce health inequalities.

The interaction of health with social exclusion and workplace discrimination

Poverty, social exclusion and relative deprivation have been shown to exact a considerable toll on health. Properly paid work can provide the pathway for people to become socially integrated, have a sense of their own value and improve their economic position which in turn adds to health. On the other hand those who are denied work opportunities such as disabled people, particularly those who suffer from a psychological disability, may fall further down the social ladder and be denied opportunities for health improvement. In a recent survey of employers, only 62% and 37% said they would take on a worker with a physical or mental disability respectively and it is estimated that only 13% of people with long-term mental health problems are in employment compared with around 33% of people with other disabilities.

The impact of unemployment on health

Higher rates of unemployment are associated with more illness and premature death. After adjusting for social class, the excess mortality for unemployed people is 25% for men and 21% for women. Both their psycho-social state and the lack of income with resultant debt, have a negative effect on health. The potential for health to be harmed starts when jobs are under threat. Job insecurity is linked to effects on mental well-being particularly anxiety and depression, self-reported ill health, and heart disease. There is an excess risk of suicide and parasuicide (‘attempted suicide’) among unemployed men.

The relationship between these increased rates is complex, with research suggesting that unemployment both increases the likelihood of other adverse life events and also decreases the psychological and social capacity of individuals to cope with these.

Impact of working conditions on health inequalities

Cancer

In industrialised countries occupational exposure is estimated to be responsible for 4% of all human cancers. Occupational cancer risks largely affect manual workers and individuals from the lower social classes. Using the 1971 census, it has been estimated that occupational exposures account for about a third of the difference in cancer incidence between high and low social classes, and for half the difference in lung and bladder cancer. Asbestos is the most important cause of work related deaths at present. Exposure to this carcinogen both in the past and at present is largely confined to working class men.

Coronary heart disease

Associations between stressful working conditions and a variety of cardiac outcomes including mortality and first episodes of coronary heart disease have been reported. Specifically the Whitehall Study of civil servants found that men and women in the lowest employment grade had a 50% increased risk of developing signs and symptoms of coronary heart disease compared to their higher grade counterparts. Stressful conditions include those where there is low control, excess demands, a lack of support and effort-reward imbalance. These types of working environment are more common among lower socio economic groupings.

Mental health

The Whitehall study has found that work characteristics including job discretion and decision making authority could explain most of the socio-economic gradient in well-being and depression in male and female civil servants.

Sickness absence

The Whitehall study also found an association between employment grade and sickness absence, with men in the lowest grades having six times the absence rate of their counterparts at a higher grade. A similar trend, though with a reduced gradient, was found for women. Although individual differences and external problems also made a contribution, analysis suggests that about 25% of the social gradient in men and 35% of the gradient in women is accounted for by work factors.

The Faculty of Occupational Medicine is committed to

1. Developing a health advocacy function for all people of working age including those who are in insecure employment and unemployed.
2. Equipping occupational health physicians with the tools to influence employers to address health inequalities in areas of policy including recruitment, working conditions, rehabilitation and “contracting out”.
3. Promulgating sound ethical guidelines which give primacy to the health needs of employees.
4. Promoting access to vocational rehabilitation for all those of working age, particularly those in occupations such as construction which is recognised as having a high prevalence of work limiting conditions.
5. Raising awareness of the contribution that workplaces can make to address health inequalities.
6. Working with the government and other bodies to optimise the contribution of work and workplaces in tackling heath and social inequalities.
7. Progressing the principle of equity of access to occupational health support; encouraging polices which ensure that services are provided and expertise is directed where the health needs are greatest.
8. Promoting an ethos of employability based on adapting the work environment to the individual and thereby contribute to reductions in inequality in job opportunities and to retention of employment in those who develop health problems during their working life.
9. Highlighting workplaces as settings for the promotion of all aspects of health
10. Supporting the smooth introduction of smoke free workplaces, which will impact positively on low paid workers in bars and clubs.
11. Arguing for research into health inequalities in those of working age and the effectiveness of interventions designed to reduce them.

The Faculty of Occupational Medicine is indebted to Dr Delia Skan FFOM and colleagues for drawing up this position paper.

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