The Profits of Death: Workers' Health and Australian Capitalism

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> What could possibly show better the character of the capitalist mode of production than the necessity for forcing upon it, by Acts of Parliament, the simplest appliances for maintaining cleanliness and health.
>
> (Karl Marx, Capital, Volume I, Foreign Languages Publishing House, Moscow, p.452)

> Every working day (on average) one Australian is killed and 1,500 suffer significant personal injury.
>
> (Health and Safety at Work: A Review of Current Issues, C C H Australia Ltd., Sydney, 1980, p.v)

The general direction of much radical literature on the nature of capitalism has been to expose various dimensions of economic exploitation and the political repression of workers in both advanced industrial and third world countries. Only recently have some researchers turned their attention to less obvious but significant implications of capitalist modes of production, investment and consumption. One implication to be rediscovered - for it had been recognised by the earliest writers on social conditions accompanying industrialisation - has been in the area of health. This paper elaborates the ways in which capitalist social relations have influenced the identification of illness along with methods and priorities in treatment. The remainder of the discussion will then focus on the incidence of work-related injury in Australia which is indicative of an ongoing struggle between employers, the medical and legal professions, the state, workers and unions.[1]

HEALTH, INDUSTRIALISATION AND CAPITALISM

At a joint meeting held between the World Health Organization and the International Labour Organization in 1950, health was defined to be a state of complete physical, mental and social well being and not merely the absence of disease or deformity.[2] This ideal bears little relation to the realities of capitalist societies. The issue of health has been surrounded by considerable ideological mystification which obscures the incidence and underlying causes of illness. As a result, the determinants of health and illness are seen to be predominantly biological with medicine being viewed as a precise science. The value system of western society has ensured that health is perceived largely as the concern and responsibility of the individual. This belief has been attacked by Marxist sociologists such as H.P. Dreitzel who argues that illness is a social problem and public health a consequence of intentional social organization.

Contrary to popular belief, there is no objective irrefutable definition of illness. Account must be taken of the underlying interest groups such as

employers, the medical and legal professions, workers and the state which influence the definition. Given the unequal distribution of power, status and wealth in capitalist society, influence is not equally shared. This situation is reinforced and legitimated by prevailing ideological explanations of health and injury. For instance, the belief that health and greater production are allied has been thoroughly impregnated into the social consciousness of industrial society. Yet as Doyal notes,

> while the development of capitalism may have facilitated an improvement in the general health of the population (as measured for example in life expectancy rates), the health needs of the mass of the population continue to come into frequent conflict with the requirements of continued capital accumulation. This produces contradictions which are ultimately reflected in historical changes in patterns of morbidity and mortality.[3]

The implications of this for prevailing definitions of health is put succinctly by Dreitzel who states that

> in our capitalist societies, health is institutionally defined as the capability to help produce the very surplus the owners of the means of production appropriate.[4]

Little attention has been directed at the considerable health risks arising out of industrialization including the release of noxious chemicals and pollutants. The industrial process has endangered not only workers but the public in general. The radical perspective also explains why there has been little emphasis on the health of the aged and unemployed (who do not contribute to production) and the use of company doctors to discourage workers from taking 'sickies' in order to escape their job temporarily.

At the same time, the propagation of the view that injury is an accident of fate visited upon the individual legitimates the existing socio-economic structure and medical profession which serves it. In spite of this, a growing body of evidence indicates that the absence of health is not random but linked strongly to economic class and the income, education levels, environment, housing quality and occupations associated with this.[5] In particular, the working class, with its lower level of income and concentration in the most dangerous jobs, has suffered from higher rates of morbidity, mortality and mental illnesses such as schizophrenia.[6] Such findings are not new. In his early writings on the English working class, Engels noted the hazardous living and working conditions to which the proletariat was subjected.[7] In capitalist society, health becomes just another commodity - something to be bought and sold in order to maximize production and profits.

Capitalist social relations have influenced the identification, categorization and treatment of illness in a number of ways besides the propagation of an individualist ethic with regard to health and injury. As Kovel argues, medical examination does not occur in a social vacuum.[8] Disease is designated by social understandings and treated according to prevailing ideological values. Some pain is labelled as subjective, some injury as 'malingering' and some death is labelled as accidental or suicide. This has been used to treat as deviant, human behaviour and conflicts, which do not conform to societal norms. In essence, an illness has been manufactured for political purposes. At the same time, the social factors generating stress have been

ignored or reinterpreted in terms of the individual rather than the environment.

The evolution of high technology medicine which has led to spiralling health costs but little improvement in overall health, is usually seen as an indication of progress rather than a process largely inspired by the profit motive. The negative impact of investment in techniques of treatment (and research associated with this) on the basis of its contribution to a medical edifice rather than health, has been well documented in Australia and overseas.[9]

The mystification of disease is compounded by diagnosis or the classification of illness which mirrors social organization. Illich argues that diagnosis often serves as a means of transforming political complaints by workers against the stress of the existing system into demands for more therapies (themselves a costly and stressful output) which in turn legitimate the industrial system.[10] The worker's subordinate position is further established by his/her exclusion from the special language of the elite profession which makes illness into an instrument of class domination. The contradiction between health and well being with production and profits is most explicit.

THE INCIDENCE AND CAUSES OF OCCUPATIONAL ILLNESS: MYTH AND REALITY

Injuries arising out of employment occur on a massive scale, within industrialized societies. As with unemployment, official statistics tend to understate the size of the problem. In the United States, offical figures indicate that about 14,000 workers are killed and 2.2 million suffer disabling injuries each year as a result of their employment.[11] A more realistic estimate according to Navarro is that 4 million Americans contract an occupational disease annually of which 100,000 will subsequently die. Another 28,000 will die in work related accidents.[12] For Britain, Kinnersly estimated that 3,000 workers are killed, 1 million are injured to the extent of requiring at least three days off work and 10 million receive minor injuries each year.[13]

In Australian the major source of injury statistics are the Workers' Compensation Commission's in each state. These figures exclude Commonwealth government employees and self-employed persons including those working under sub-contract arrangements. At best, only rough estimates can be made of those minor injuries not involving a compensation claim. Further, no account can be taken of injuries that are unrecognised or hidden by the employee, are not deemed to be work related or result from a prior employment where proof of causation is difficult to establish. The question of causation becomes confused because some injuries (such as varicose veins) have their origin outside the workplace but may be aggravated by certain jobs. Other illnesses such as nervous stress can be seen to derive from factors both inside and outside employment. The Workers' Compensation Commissions must draw a largely erroneous distinction between life style and working habits - this distinction being legitimated by medical research and prevailing social norms. Even in the face of irrefutable evidence there is commonly a considerable delay between the comprehension of an occupational hazard, its legal recognition and provision of a remedy. In short, official statistics grossly understate the actual incidence of sickness at work. The reasons for this become apparent once the vested interests of employers, government, the medical and legal profession are considered.[14]

Since the basis of injury recording varies between the states it is impossible even to accurately collate national figures. The Federal Government has shown little inclination to rectify this deficiency. Work injuries, unlike

strikes, are not promulgated as a matter of national concern. Despite this neglect, even official statistics demonstrate that the impact of recognised work related illness is profound. Since the early 1960s there have been approximately a quarter of a million recorded industrial injuries each year in New South Wales alone. In the year ended June 1977, 368 workers were killed outright, 121,762 were incapacitated for 3 days or more, 45,886 were incapacitated for less than 3 days and 70,864 received minor injuries requiring medical treatment only.[15] Between 1964 and 1970 working days lost from industrial injuries rose from 1.5 million to 3.5 million working days. For the same years, strikes were responsible for the loss of 307,400 and 1.4 million days respectively.[16] During the past decade, injuries have cost N.S.W. more working days than strikes have cost the whole of Australia.

A survey comparing absences resulting from industrial disputes to those due to work injuries in Victoria between 1960 and 1969 disclosed that injuries accounted for three times the number of days lost through strikes. This gap was widening over time.[17] The effect on production cannot be directly imputed from such statistics. The disruption caused by both strikes and injury are offset by a number of countervailing factors. With regard to injuries the pattern of incidence is far more predictable than that for strikes, and employers can take this into account in their planning. Nevertheless, the comparison with strike statistics is useful in demonstrating how much the negative impact of work on health is accepted or overlooked. It evokes little public controversy. Unlike the conscious revolt of workers against their conditions of employment, the toll of sick and maimed workers is seen as an inevitable, if unfortunate, cost of production or price of progress.

The pattern of injuries varies between different industries, occupations, employers and groups of workers. Some sectors of the manufacturing industry (such as food, drink, heavy metal and engineering, saw milling and wood products), mining, abattoirs, building and construction have an incidence of injury far in excess of the average for the workforce as a whole.[18] Certain occupations give rise to specific types of injury.[19] The concentration of women workers in a narrow band of occupations has meant that they are highly susceptible to the particular hazards associated with these jobs. Thus, the clustering of women in jobs requiring quick, dexterous and repetitive movements such as speed typing, punch card operator, food processing, cleaning and electronics assembly, has caused them to suffer from a higher incidence of tenosynovitis (an injury affecting the tendons of the hands and lower arms) than male workers.[20] Muscular strains and sprains are a common injury amongst male workers engaged in jobs demanding prolonged and/or strenuous exertion. The higher incidence of injuries amongst blue collar workers is linked to the heavy manual nature of tasks and the presence of physical hazards such as noise, vibration, radiation, temperature extremes, chemicals and other harmful substances. Recognition of such hazards has been used to justify discriminatory legislation covering the employment of women given their alleged susceptibility and dual role as both producer and reproducer. This practice has, in turn, been used to restrict areas of female employment, excuse their retrenchment during or following pregnancy and legitimate unhealthy conditions which, in all likelihood, do not discriminate on the basis of a worker's gender.[21]

Physical hazards are not confined to blue collar workers. Any assumption that a smaller proportion of the workforce is being exposed to work hazards because of the progressive shift in employment to the tertiary sector must be examined in the light of the discovery of new hazards affecting office workers such as harmful chemicals released by photocopying equipment and the

use of asbestos fibres in ceilings.

Besides the plethora of physical hazards which may lead to illness, there can be added a list more directly related to the immediate social organization of work. These induce mental stress and fatigue leading to nervous instability and increased susceptibility to injury. Amongst such social factors may be included awareness of physical hazards, long hours, overtime, speed-up, piece-work payment systems, machine pacing, monotonous and repetitive tasks, isolation from fellow workers, job insecurity, supervision pressures and lack of control over the nature and conditions of work. Such features are not accidental but direct byproducts of managerial attempts to increase labour productivity.

These aspects of work have frequently been identified as a source of disaffection amongst workers leading to overt forms of conflict such as strikes, output restriction, absenteeism and sabotage. In essence, both illness and protests on the part of workers are the outcome of an incompatibility of employee and employer interests in the workplace.

Prevailing explanations of workplace illness have tended to ignore the fundamental conflict of interests and propagate myths which legitimate the existing socio-economic structure. This bias is embedded in the very terminology used to designate injury. The term 'industrial accident', for instance, implies that the negative impact of work on health is dramatic and aberrant. However, many injuries are not random but develop gradually as a direct consequence of the work process. They are not abnormal. Nor do they result from a single identifiable event. A worker's back may deteriorate through prolonged exertion. Disease may occur through the slow absorption of poisons, fibres, dust and be exacerbated by accumulated stress and resort to drug palliatives.

A second term which is in keeping with the individualized perspective of health and illness perpetuated in Western industrial societies is that of 'accident proneness'. This notion, popular amongst employers and some parts of the medical profession, alleges that certain workers are more susceptible to suffer an 'accident' irrespective of the task involved. Thus injuries are seen to be due to stupidity, carelessness or oversights on the part of the worker concerned. Historically, different ethnic groups have been singled out as being accident prone. The allegation that Italian and Greek workers had weak backs etc. has been supplanted to some extent by similar pronouncements upon the vulnerability of Lebanese and Turkish workers to injury. It is not by chance that the groups isolated for abuse are those who were (and still are) concentrated in the most physically demanding and hazardous types of work.[22] Accident proneness places the fault for injury with the worker and conveniently absolves management from any blame. While the term has been criticized as being largely meaningless if not positively misleading it continues to enjoy a certain vogue amongst employers for obvious reasons.

A rather more subtle myth propagated is that hazards to health in industry are gradually being eliminated over time. This belief is loosely founded on the burgeoning amount of legislation limiting standard hours of work, prohibiting dangerous work practices and specifying minimum safety standards with regard to particular industries, machinery etc; the increasing capacity of modern medicine to identify and cope with potential hazards and the introduction of seemingly less demanding and more efficient production

technologies. Some of these supposed benefits are illusory. A strong case can be made that many of the above changes have not automatically increased the health or social well-being of workers.

Historically, there has been a gradual, if interrupted, decline in the standard hours of labour for workers in industrialized societies. Shorter working hours have not necessarily entailed an equivalent reduction in the physical and mental demands placed upon employees by their job. Rather, the fall also involved a shift away from the extensive usage of labour to more intensive utilization of employees during working hours. Thus, the duration of physical exertion was reduced but the intensity of work grew in conjunction with the increasing division of labour. Work rhythms have become increasingly tied to machinery - epitomized by assembly-line mass production. Job functions and their speed are closely monitored through devices such as time and motion study. The specialization of tasks accompanying mass production, while reducing some aspects of physical effort, has tended to concentrate the physical and mental energies of workers into rapid repetitive processes. Research by Kornhauser, Ferguson and others has demonstrated the detrimental impact of such work patterns on the physical and mental health of workers.[23]

Even the reduction in average standard hours of work has been offset to some extent by the need of many manual workers to undertake overtime or second jobs in order to supplement their income. In addition, the more recent introduction of continuous production technologies requiring round the clock operation to be efficient has fostered an expansion of shift-work and night-work. A growing body of evidence indicates that both these systems adversely affect physical, mental and social well-being.[24]

A less apparent byproduct of profit orientated industrial growth can be seen in the absence of research into and standards governing the plethora of new substances used by industry. Legal exposure limits exist for only a fraction of the thousands of toxic chemicals. Even more disturbing is the information emerging on the negative impact on health of substances previously thought to be only slightly dangerous and in such widespread usage as to be difficult to replace. Two of the better known examples are asbestos and petroleum. There were no government regulations in Australia covering the usage of asbestos until 1971 although it now appears that all types of asbestos are carcinogenic (that is, cancer inducing) and even the smallest level of exposure may prove lethal.[25] By 1978 it was officially recognised that asbestos disabled more workers in N.S.W. than silicosis. The risks associated with petroleum do not merely derive from its lead content. Evidence suggests that it is linked to growth of a rare lung disease.[26] In the United States, the National Cancer Institute found there was an excessive risk of cancer deaths amongst workers employed in petroleum refineries and petrochemical plants.[27] Limited research done on the relationship of cancer to environmental factors indicates that the workplace is a significant factor causing the disease.[28] Thus, while some types may be eliminated by industrial development, a constant stream of new ones are emerging or achieving greater significance.

TREATMENT OF INJURY: THE STATE, UNIONS AND EMPLOYERS

In Australia, as in other advanced industrial societies, the state has intervened in the area of health and safety in a number of ways. First, it has established the legal norms of safe working conditions. At both the federal and (more importantly) state level a series of statutes have been enacted prescribing minimum standards with regard to working conditions, guards on machinery, ventilation etc., in particular industries and occupations.[29] In N.S.W. the responsibility for enforcing provisions of the Factories, Shops and Industries Act and the Scaffolding and Lifts Act lies with inspectors employed by the Department of Labour and Industry. The effectiveness of enforcement has been criticized on a number of grounds including the limited resources of the department to monitor the large number of factories, the preoccupation of inspectors with after hours trading rather than safety questions, the prior warning of impending inspection often given to employers and the inadequacy of fines imposed for breaches.[30] At best, policing has discouraged the most flagrant offences. It has not induced a fundamental rethinking on job hazards. This is well illustrated by the decision of the N.S.W. Government to revise proposed noise legislation (taking effect in June 1979) following complains that the progressive phasing in of an 85 db level was too stringent and costly. It has been estimated that the present legislation (90 db) leaves 28% of workers in noise affected industries inadequately protected.[31]

A second area of government intervention has been with regard to compensation for injured workers. The common law prescribes a duty of care for the employer to provide safe working conditions. Breach of this entitles the employee to sue the employer for negligence. However, this power proved so restrictive that specific statutory legislation has been enacted to establish compensation for workers injured during the course of their employment. Workers Compensation acts in each state prescribe monetary entitlements during incapacity including specified permanent body injuries, plus hospital and medical expenses. Weekly payments are made to employees while they are off work. Until recently, such rates in N.S.W. might be as little as half average weekly earnings. Employers have argued that compensation rates which are too closely tied to average earnings discourage workers from returning to their jobs and impose costs which may lead to workforce reductions. Unions have countered this by claiming that without such a level of payment the permanently incapacitated worker is placed under undue hardship while less severely injured employees may be forced to return to the job prematurely.

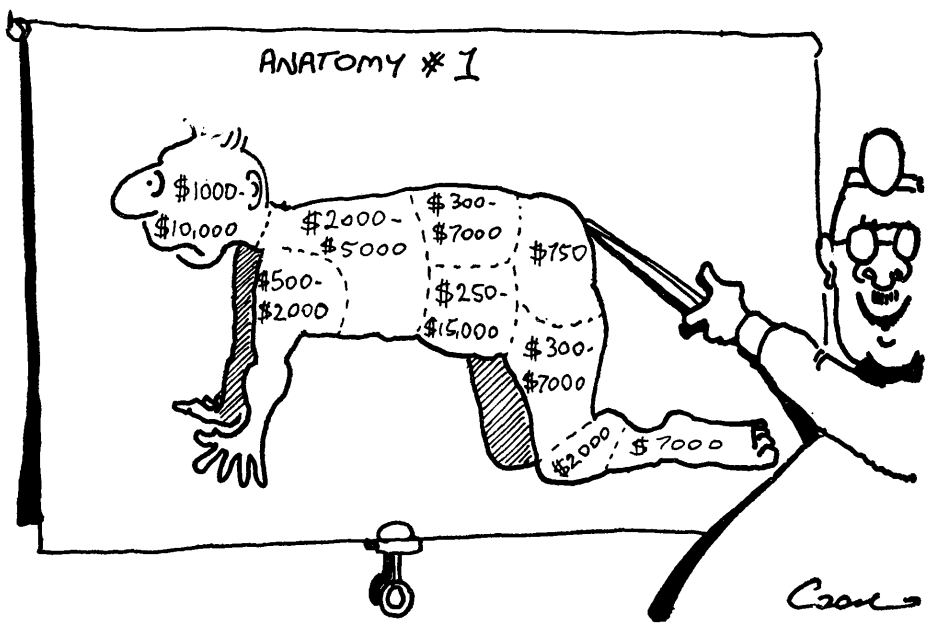
The present climate of unemployment and economic recession has tilted the balance further in favour of employers. In late 1977 the West Australian government announced its intention to slash compensation payments from average weekly earnings to 85% of award wages. This was followed by further restrictions on the payment of compensation if the injured worker was drunk or negligent. In December 1979 the Victorian government amended section 9 of the Workers' Compensation Act. Workers were required to show that employment made a 'substantial' (previously 'material') contribution to their illness before compensation could be granted. The amendments also prevented the families of dead workers obtaining compensation through the Act as well as through civil action - considerably reducing settlement payments in the case of death. It was only following

widespread industrial action by unions that the government agreed to a compromise definition of 'contributed to a reasonable degree'. While similar moves to restrict compensation payments have not been mooted in N.S.W. employers have expressed considerable opposition to any attempt to expand the scope of compensable injury to include, for instance, stress.

The Workers' Compensation Commission limits the range of illness for which work is a recognised cause. As already stated, for injuries involving muscular strain , gradual physical degeneration through stress and/or disease and mental illness a specific causal event may be difficult to identify. Where the extent of injury is in doubt decision is reached on an adversary basis with the insurance company/employer on one side and the worker and union on the other. This procedure has tended to divide the medical and legal profession into those primarily acting for employers and those ostensibly serving the workers' interests. Given what has already been said about the medical profession and definitions of health, it is almost axiomatic to state that the odds are firmly balanced in the employers' favour.

Workers and specific groups of migrants in particular have frequently been accused of malingering or exaggerating their injuries in order to obtain a larger compensation settlement. Available evidence indicates, however, that the bulk of workers suffer severe financial hardship and emotional stress as a result of illness.[32] The heated discussion of compensation rackets, fraud and neuroses has acted as a smokescreen which obscures human suffering, suggests workers gain from sickness and excuses the absence of effective rehabilitation facilities for those workers unable to carry out their previous job.

For the more severely wounded products of industry's struggle for greater output, the Commissions establish a de facto life income. It is in the interests of employers and insurance companies to minimize their liability and legitimate this by accusing workers of malingering, fraud and deviance. Economic considerations are the paramount concern of the compensation system. Payment is contingent on establishing a link between injury and diminished industrial efficiency. The worker's body becomes part of a contractual relationship - so much for the loss of a leg, eye, ear etc. Overall, employers pay a cheap price for the injuries their workplaces inflict. Nor is Australia in any way unique in this respect.[33] Referring to American steel workers, Spencer aptly remarks, "the fingers, arms, legs, balls and carcasses of blue collar workers still come at bargain prices."[34]



In sum, government intervention in the area of work practices and compensation while modifying employer behaviour to some extent has not resolved the conflict of interests which threatens workers' health. Rather, workplace injury has been institutionalized and incorporated within a mythology of social progress and state welfare. The causes and effects of occupational sickness have largely been defined out of the context of collective negotiations between workers and management. Work hazards are infrequently a major issue in labour/management bargaining.

While there is no question that safety is an industrial matter, arbitration commissioners at both the state and federal level have been loath to make rulings on hazards beyond those prescribed by statutory legislation unless there are no laws or those existing are demonstrably inadequate for a particular group of workers (e.g. deep sea divers). This disinclination to make orders that would significantly alter work patterns by prescribing manning levels, shiftwork systems or particular types of machinery is indicative of the recognition that such actions would impinge on managerial prerogatives and impose heavy costs on industry. The myth that health is a complex field requiring professional expertise also inhibits both union officials and commissioners.

Trade unions have often been at the forefront of demands for better safety standards at work. This has been particularly so for those with members in the metal trade, building, construction, abattoirs and mining where hazards are most apparent. The space devoted to safety and health in journals and other literature has, however, not matched in any way the effort reserved for negotiating over wages and hours of work. Further, seldom has expressed concern been translated into effective industrial action. Only exceptional unions like the Boilermakers' Society (now part of the AMWSU) and the Miners' Federation have adopted a committed stance on occupational health, attempted to inform members of work hazards, the nature and impact of various illnesses and supported industrial action over work hazards. Most unions at best supported lobbying for further and more stringent government legislation.

Safety and occupational health have not formed part of the stated policy objectives except as an adjunct to other policies such as opposition to piecework. Nor has health engendered much debate at ACTU congresses and state Labor Council meetings. In 1959 the ACTU interstate executive decided to set up Industrial Safety Committees in each state in an effort to reduce the 'mounting toll in industry'. The impact of these bodies was negligible. Only in the fact of growing public awareness, the disclosures of medical research and a strike at James Hardie, Melbourne was the use of asbestos raised with federal government. In the last 12 months the ACTU has allocated substantial funds to the question of work injury - the first time such a step has been undertaken by it. In the postwar period the activities of the N.S.W. Labor Council in this area have been largely confined to operating a compensation department, making submissions to government inquiries and advocating the introduction of legislation modelled on the British Health and Safety Act.

The direct industrial demands of unions in the area of occupational health have been generally restricted to the provision of make-up pay, sickness benefit claims, less taxing jobs for incapacitated workers, establishing guidelines for early retirment, the presentation of members' cases (through union paid barristers) before the Workers' Compensation Commission and at common law, and the extension of employer liability for specific injuries such as deafness. By and large, these demands are directed at

the consequences of illness rather than its causes. Some unions, such as the Federated Ironworkers' Association, have devoted enormous space in their journals publicising the size of settlements obtained for crippled workers while failing to mention any action over the conditions which gave rise to such horrific injuries.

Occasionally, direct action by shop committees (notably in the railways and power stations), miners lodges and groups of workers has placed effective pressure on employers to eliminate hazardous conditions. In this respect, unions promoting a strong and semi-autonomous delegate system are better fitted to negotiate over local dangers than those unions which seek to circumscribe rank and file independence and adhere strictly to central arbitration tribunals. Even where action has occurred, it has mainly been restricted to strikes and bans over more obvious dangers as evidenced by injuries and fatalities. For instance, the public disclosures in 1977 and 1978 of deaths arising from contact with asbestos resulted in workers taking direct action in the Victorian railways, Garden Island naval dockyard, Chullora railway workshops and the Art Gallery of N.S.W. [35] Notably, workers engaged in the actual mining of asbestos at Barraba and Barylgil have not taken action which might cause the loss of their jobs at a time of high unemployment.

Ultimately, independent action by workers is limited by their awareness of health hazards. The establishment of a Workers' Health Centre in Sydney and the activities of the Workers' Health Action Group, Trade Union Medical Centre and Working Women's Centre in Victoria has induced greater recognition of occupational health. The Workers' Health Centre, for instance, has debated the issue publicly with government officials, employers and doctors; directly involved itself in handling worker's enquiries and providing information for the workplace as well as producing evidence on specific hazards such as tenosynovitis. The efforts of such bodies, however, have been constrained by their meagre resources and the hostility of more conservative union leaderships who see their activities as threatening.

Reasons for the absence of formal union involvement in work related illnesses include a lack of recognition exacerbated by inadequate research resources and the traditional preoccupation with wages and hours of work. This may be related to the bureaucratic structure of unions. The over-riding concern of the labour movement with economic goals reflects pervasive social values as well as a failure by union leaderships. To become more active would require a direct challenge to managerial prerogatives. The instrumental attitude of workers fostered by capitalist ideology represents an additional impediment. A number of unions have in the light of developments in the U.K. attempted to become more active. In 1978, the Victorian branch of the AMWSU adopted a comprehensive policy on occupational health. In the following year the National Conference of the union resolved to appoint two safety officers. The Municipal Officers Association has also formulated a policy on occupational health. Such moves are still uncommon. Many union officials feel reticent about engaging in activities for which they possess no expertise. It also appears there is a widespread acceptance of employers' attitudes to safety.

Employers predominantly view occupational illness as a cost factor. An awareness of safety questions is predicated upon the assumption that remedial policies will not impinge on employer profitability. The Metal Trades Industry Association, for instance, has decried the massive cost of work injuries and called for greater safety awareness, the appointment of

safety officers, committees and company doctors, the placing of safety signs and courses.[36] At the same time, it has stressed the incentive value of maintaining a gap between wages and compensation payments to encourage an early return to work by injured employees. Further, the need to get the 'right' attitude amongst workers, avoid hypochondriacs and malingerers, and make safety the subject of competition by awarding prizes for accident free working days is emphasized.[37] The latter practice has the perverse effect of discouraging the disclosure of injuries.

Little attention has been directed at the safety implications of different production levels, work patterns, machine design and plant layout. Any attempt by workers to negotiate on such matters has been strongly resisted. Where changes have been implemented they have generally represented a cheap solution. For instance, workers supplied with uncomfortable (and potentially dangerous) ear muffs as opposed to the more expensive remedy of reducing factory noise levels. The token measures mentioned do little to alter the overall incidence of illness but camouflage the conscious expropriation of well being. As already pointed out, the notion of accident proneness further serves to justify this approach by stigmatizing the victims as careless or stupid. As a last resort employers have countered more significant attempts to reduce injury by pointing to the economic costs this would entail. Hence, asbestos continues to be used despite medical evidence demonstrating its harmful effects. In other cases, production facilities have simply been shifted to regions, states or countries where standards are less stringent. The latter capacity, and the threat posed to local employment if regulations inhibit the ability of Australian industry to compete with imports, has been used by employers to counter any attempt to significantly expand statutory protection.[38] In the final analysis, the safeguarding of capital and pursuit of profits overrides any question of safety. This situation can only be understood within the ideological framework where profits are more important than the welfare of individuals or groups.

CONCLUSION

In Australia, health, wealth, information and power are unequally distributed as a direct result of the social relations of production under capitalism. The pre-eminence of higher production, pursuit of profit and the consumerist ethic relegate the quality of working life - both spiritually and physically - to one of abject subordination. Workers sell their lives along with their labour power. Historically, intervention by the state has modified some hazards and created the impression that health is not a question of class struggle. Nevertheless, the conflict remains. Ultimately, the state has always collaborated with employers if it appeared legislation might threaten the viability of industry. Union leaderships have largely accepted this situation and sought to negotiate the best deal for injured workers rather than attacking the root causes of illness. This inaction can be partly explained by the capacity of the bourgeoisie (including the medical and legal professions) to mystify the underlying inequalities and priorities of health organization. The most effective challenge to this has occurred when well organized groups of workers have vigorously contested

managerial prerogatives with regard to work organization rather than relying on inadequate laws. Such challenges are rare and have often met fierce resistance from employers. Without complete control of the production process and access to information there is little prospect of establishing a work environment where injury will be uncommon, abnormal and indeed truly accidental.

FOOTNOTES

1 In the interests of brevity, additional references and some sources have been omitted from the footnotes. Those seeking further details should contact the author.

2 Quoted in the National Health and Medical Research Council, Recommended Practice for Occupational Health Services in Australia (extract from the Report of the 75th Session of the NHMRC, AGPS Canberra, 1973), p.1.

3 L. Doyal, The Political Economy of Health, Pluto Press, London, 1979, p.23. Quoting World Health Organization evidence (p.59) Doyal notes that the rate of decline of mortality has slowed since the 1960s and even gone into reverse for males in some instances. One reason for this has been the growing incidence of diseases such as cancer, heart disease, arthritis and diabetes associated with environmental changes including those relating to the workplace, production, consumption and stress.

4 H.P. Dreitzel (Ed.), The Social Organization of Health, Macmillan, New York, 1971, p.xii.

5 See for instance, M.W. Susser and W. Watson, Sociology in Medicine (Oxford University Press, London, 1971) chapter 4; L. Doyal, op. cit. and Ivan Illich, Limits to Medicine: Medical Nemesis: The Expropriation of Health, Penguin, Harmondsworth, 1978.

6 For evidence of this, see L. Doyal, op.cit., p.26; J. Kuprinski "Psychological Maladaptation in Ethnic Concentrations", Mental Health in Australia pp 49-51; D.L. Jayasurlya "Social Mobility and Mental Illness - An overview and assessment of recent studies", Mental Health in Australia pp 80-87; Michael Mann, Consciousness and Action amongst the Western Working Class, Macmillan, London, 1973; R. Hurley "The Health Crisis of the Poor" in H.P. Dreitzel (Ed.) op.cit., pp.83-122; J.M. Najman et al "Patterns of Morbidity, Health Care Utilization and Socio-Economic Status in Brisbane", The Australian and New Zealand Journal of Sociology, Vol.15, No.3, November 1979 pp.55-63 and R. Taylor, "Health and Class in Australia", The New Doctor, Issue No. 13, 1979, pp22-28.

7 H. Waitzkin, "A Marxist View of Medical Care", Science for the People Nov/Dec 1978, Vol.10, No.6, pp.31-42 reviews the development of Marxist literature in the area of health from Engels onwards.

8 J. Kovel, "Therapy in Late Capitalism" Telos, No.30, pp.73-92. A forceful analysis of the historical origins of modern clinical medicine and the ideas of health, sickness, life and death which underpin it can be found in Michel Foucault, The Birth of the Clinic, Tavistock Publications, London, 1976.

9 See, for instance, Alan Klass, There's Gold in Them Thar Pills: An Inquiry into the Medical-Industrial Complex, Penguin, Harmondsworth, 1975 and Richard Taylor, Medicine Out of Control: The Anatomy of a Malignant Technology, Sun Books, Melbourne, 1979.

10 I. Illich, op.cit., p.51. The notion of iatrogenic diseases or those created by modern medicine as a result of the application of diagnostic and therapeutic procedures is also dealt with by R. Taylor, Medicine Out of Control, op.cit. For a discussion of the generation of the medical profession as an instrument of social control see I.K. Zola, "Healthism and Disabling Medicalization" in I. Illich et al, Disabling Professions, Marion Boyars, London, 1977, pp.41-67.

11 Quoted in J.M. Stellman and S.M. Daum, Work is Dangerous to Your Health, Vintage Books, New York, 1973, p.xiii. A study commissioned by the Ford Foundation indicated that 30-40% of all sickness in the U.S. was occupationally induced. Quoted in The Sydney Morning Herald, December 6, 1979, p.6.

12 V. Navarro, Medicine Under Capitalism, Croom Helm, London, 1976. Another set of estimates is provided by Ray Davidson, Peril on the Job, Public Affairs Press, Washington, 1970. Davidson argues that about 40 workers are killed and more than 6,000 injured each day as a direct consequence of their employment.

13 P. Kinnersly, The Hazards of Work: How to Fight Them, Pluto Press, London, 1978, p.13. Like Navarro, Kinnersly argues that offical figures represent only the tip of the iceberg.

14 B. Bartlett, "The Politics of Occupational Health", The New Doctor, Issue No. 13, 1979, pp.12-18 provides a useful analysis of some aspects of this including the structure and priorities of the medical profession.

15 The Workers' Compensation Commission of New South Wales, Annual Report and Workers' Compensation Statistics for the year ended June 30 1977, NSW Government printer, Sydney, 1978. These figures exclude the large number of people disabled or bereaved by work in previous years.

16 T.G. Sweet, "Australian Strike Statistics 1913-1976", The University of Aston Management Centre Working Paper Series, March 1978, Table 8 and Appendix 5.

17 "Management and Accident Prevention", Symposium on Occupational Injuries, Published Proceedings, NSW Division of Occupational Health and Radiation Control, Lidcombe, 1973, chapter 13, pp.193-199.

18 The Workers' Compensation Commission of N.S.W., op.cit. For a study of the incidence of injury amongst Victorian abattoir workers see G. Joslin, "Epidemiological Aspects of Hand Laceration in Abattoir Workers" Symposium on Occupational Injuries, op.cit.

19 For evidence linking hazards and specific injury to particular occupations, see P. Kinnersly, The Hazards of Work, op.cit.; J.M. Stellman and S.M. Daum, Work is Dangerous to Your Health, op.cit.; D. Ferguson, "Occupational Factors in Back Strain" and A.J. Groble, "Heart Disease" both in Symposium on Occupational Injuries, op.cit., pp.175-178;

C.L. Cooper and J. Marshall, "Occupational Sources of Stress: A Review of the Literature relating coronary heart disease and ill health", Journal of Occupational Psychology, 1976, No. 49, pp.11-28; M. Peacock, Asbestos - Work as a Health Hazard, ABC, Sydney, 1978, and Legal Service Bulletin, Health and Safety at Work: A Review of Current Issues, CCH, Sydney, 1980, chapter 1.

20 "Fatigue", Symposium on Occupational Injuries, op.cit., p.48, and J. Walker, "Tenosynovitis: A Crippling New Epidemic in Industry", The New Doctor, Issue No. 13, 1979, pp.19-21.

21 L. McKenzie and S. Shaw, "Occupational Health and Women", The New Doctor, No. 13, 1979, pp.38-43. For further evidence of the hazards facing women and evolving legislative and union responses, see articles by Rosalind Petchesky, A.C. Hill, V.R. Hunt, C. Bell and M.J. Wright in Feminist Studies, Vol.5, No.2, Summer 1979, pp.233-309.

22 A study undertaken by the Department of Labour and Industry in N.S.W. found that non-English speaking workers were no more susceptible to accidents at work than other community groups in the same jobs. See The Sydney Morning Herald, February 21, 1979, p.11.

23 In his study of American auto workers, Kornhauser found that assembly-line production had an adverse affect on their mental well-being. A survey of Australian telegraphists conducted by Ferguson disclosed that one third had suffered a destabilizing neurosis at some stage of their career. He concluded that the jobs many people undertook could be deemed as mental health hazard. See also earlier discussion on the incidence of tenosynovitis amongst female process and assembly workers. A. Kornhauser, The Mental Health of the Industrial Worker, John Wiley, New York, 1965 and D. Ferguson, "A Study of Occupational Stress and Health", Ergonomics, Vol. 16, No.5, 1973, pp.649-63.

24 M. Maurice, Shift Work, I.L.O., Geneva, 1978, and J. Carpentier and P. Cazamian, Night Work, I.L.O. Geneva, 1978. A study by Brown found that there was an appreciably higher accident rate amongst workers on night shift, afternoon shift and overtime than those on normal day work. See J.R. Brown, "Factors involved in the Causation of Weight-Lifting Accidents", Ergonomics, No.2, 1958, p.117.

25 Asbestos Killer Dust, The British Society for Social Responsibility in Science, London, 1979, pp.251-254. See also The Sydney Morning Herald, November 1 and 28, 1977, p.6, December 5 1977, November 3 1978 for further evidence of public debate on the issue.

26 The Sydney Morning Herald, July 8 1978. See also I. Lerch, "Risk and Fear", The New Scientist, Volume 85, No. 1188, January 1980, p.8 who quoted further research on the health risks associated with petroleum.

27 The Sydney Morning Herald, June 25 1979 report.

28 In September 1978, the American Secretary of Health, Education and Welfare announced the results of study which indicated that at least 20% of cancer in the U.S. was work related. Quoted in The Sydney Morning Herald, September 13, 1978, p.1. Other studies have argued a relationship in excess of 40% of cancer cases. For discussion with

regard to this, see Legal Services Bulletin, Health and Safety at Work, op.cit, p.13; P. Kinnersly, The Hazards of Work, op.cit. and A.Bell, Division of Occupational Health, N.S.W., quoted in the National Times, February 6-11, 1978.

29 For a full listing of these statutes, see D.R. Hull, "Occupational Health and Safety and Industrial Democracy: Appendices to R. 14", Unit for Industrial Democracy, Department of Labour and Industry, South Australia.

30 It was estimated that factories in N.S.W. were visited on average only every 3 years. The Sydney Morning Herald, May 26 1978. See also The Sydney Morning Herald, September 24, 1979, April 9 1980. In the U.S., the situation is apparently worse. Since the introduction of the federal Occupational Safety and Health Act in 1970 there have been more than 770,000 violations incurring an average fine of $25. Even such trifling penalties have been bitterly fought by American employers. George Haglan, "The Occupational Safety and Health Act", a paper delivered to a Trade Union Training Authority seminar held on February 15, 1980 in Sydney.

31 The Sydney Morning Herald, April 20 1978. See A. Moller "How Good are Work Noise Standards" and J. Brown " A Note on Industrial Deafness in Australia", The New Doctor, No.13, 1979, pp.44-46 for a discussion on appropriate noise levels.

32 For instance, J.I. Balla and S. Moraitis, "Knights in Armour" The Medical Journal of Australia, pp.355-361; S. Encel and C.E. Johnson, Workers' Compensation Redemption Settlement and Rehabilitation, School of Sociology, University of N.S.W. 1972 and The Ethnic Affairs Commission of N.S.W., Annual Report 1978, N.S.W. government printer, Sydney. For evidence of the media generated controversy surrounding workers' compensation payments and fraudulent rackets see The Sydney Morning Herald, March, April and May of 1978. A more balanced discussion of reactions to injury and compensation neuroses can be found in J.Lloyd and B. Stagoll, "The Accident Victim Syndrome", The New Doctor, Issue No. 13, 1979 pp.29-34.

33 For details of the industrial injury benefit systems operating in Europe see European Industrial Relations Review, No. 71, pp.13-17.

34 Charles Spencer, Blue Collar: An Internal Examination of the Workplace Vanguard Books, Chicago, 1978, p.227.

35 The Sydney Morning Herald, May 31 1979. The latter action by building workers induced the Building Workers' Industrial Union N.S.W. Council to place a state-wide ban on the use of internal lining board containing asbestos. The Sydney Morning Herald, March 4 1980. Storeman at Shell Oil Refinery in Sydney refused to handle high-lead petrol following the publication of research outlining the health risks associated with it. The Newcastle Morning Herald, October 12 1978, p.3.

36 The Metal Trades Journal, July 1 1964, p.335; October 1 1964; Vol. 32, No 13, June 1 1966; Vol. 33 No. 2 February 1967 and July 1970

37 Ibid, September 2 1968.

In November 1979 the N.S.W. Director of the Chamber of Manufactures criticized government regulations on production and marketing which he alleged hindered the ability of industry to compete with countries which enjoyed both lower wage costs and 'less rigid legislative requirements'. The Weekend Australian, November 2-3, 1979, p.4. The significant health problems of third world countries - including those originating in the workplace - are beyond the scope of this paper. For a general discussion of the issues, see L. Doyal, op.cit., and V. Navarro, op.cit.