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Occupational health services in need of emergency care
A gender perspective on older workers’ employment and working conditions
Patricia Vendramin and Gérard Valenduc

This Working Paper aims to give a structured gender analysis of the working and employment conditions of older workers (aged 50 and over). While working and employment conditions are increasingly recognised as key issues in ageing at work, gender disparities do still not get enough attention.

Individualisation of the work relationship: a challenge for trade unions
Philippe Davezies

This Policy Brief looks at changes in work organisation, the ways in which these lead to an individualisation of the work relationship and the negative consequences arising from the contradictions between how workers see their job and how management perceives it. The brief also presents some practical measures (in the form of ‘research-action’) for trade unions to deal with these new work-relationship-based contradictions and risks.

Climate change: implications for employment
Key findings from the Intergovernmental Panel on Climate Change Fifth Assessment Report
Mike Scott

The Fifth Assessment Report (AR5) from the Intergovernmental Panel on Climate Change is the most comprehensive and relevant analysis of our changing climate. It provides the scientific fact base that will be used around the world to formulate climate policies in the coming years. This guide is one of a series of summaries of the AR report for stakeholders synthesising the most pertinent findings of AR5 for workers and employment. It was born of the belief that trade unions could make more use of AR5, which is long and highly technical, if it were distilled into an accurate, accessible, timely, relevant and readable summary.

Conference
"Women and health at work"
Sharing knowledge and experiences to enhance women’s working conditions and gender equality

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Increased risk of lung cancer among bricklayers

Bricklayers are at increased risk of developing lung cancer, according to the findings of an epidemiological study recently published in the *International Journal of Cancer*. The risk of contracting lung cancer increases in proportion to the length of time spent working in the occupation. The authors see the probable cause as being building workers’ regular exposure to a cocktail of carcinogens that provokes synergistic effects – the situation where the combined effect of two chemicals is much greater than the sum of the effects of each agent given alone.

They point, in particular, to the role played by crystalline silica, found in sand, gravel, clay, stone, etc. and hence present in the course of numerous building operations such as the cutting of materials including ceramic products. Almost 20% of the workforce in the construction industry is regularly exposed to crystalline silica dust.

The study was based on data gathered in 13 European countries, Canada, Hong Kong and New Zealand. Currently, crystalline silica is not covered by the EU directive on carcinogens. The revision of this directive to extend its scope to a larger number of carcinogens has been progressing at a snail’s pace since 2004.

In December 2012, the European Advisory Committee for Safety and Health at Work (ACSH) – on which unions, employers and governments are represented – adopted an opinion in favour of defining a binding occupational exposure limit value for silica which is not so far covered by this legislation.

Belgium: strengthening the legislation on psychosocial risks at work

On 1 September, new rules were brought in to govern the prevention of psychosocial risks in the workplace in Belgium. The new legislation extends the very notion of psychosocial risks (PSR) and sets out new procedures to facilitate the reporting of problems.

The potential impact of the way in which work is organised on the incidence of mental damage among workers must now be taken into account during risk analyses. In that respect, the new legislation imposes compulsory participation by workers in the analysis of psychosocial risks, which should lead to preventive measures which will need to be revised at least once a year.

In addition to this general analysis, an analysis may be conducted with regard to a specific work situation, for example where a single department has experienced several cases of burnout. This ‘specific’ analysis needs to be conducted where a member of the hierarchical chain or at least one third of the workers’ delegation to the CPPT – the Belgian equivalent of the workplace health and safety committee – so requests.

European report on the costs of work-related psychosocial risks

The European Agency for Safety and Health at Work (EU-OSHA) released a report in late June on the costs to the economy of work-related stress, violence, harassment and other psychosocial risks (lack of support at work, overwork, etc.) as revealed by a review of the last twenty years’ literature on the matter, mainly in Western Europe. "Direct monetary costs are mostly paid by societies through the public health care systems", argues the report. It stresses the link between work-related psychosocial risks and mental health problems like depression, cardiovascular diseases, musculoskeletal disorders and diabetes.

The most recent EU figures are for work-related depression. In 2013, the Matrix consultancy firm estimated these costs in a report ordered by the European Commission at 617 billion euros a year in Europe.

The report also presents estimates from national reports, emphasizing the difficulty of inter-country comparisons due to widely-differing methodologies. EU-OSHA is therefore calling for simple methodologies to be developed to help employers estimate the costs of work-induced stress and psychosocial risks.
Experts recommend investigating the potential carcinogenicity of carbon nanotubes

Advisers to the International Agency for Research on Cancer (IARC), a branch of the World Health Organization, have recommended the agency to evaluate – with high priority – multi-walled carbon nanotubes in order to determine if these components might provoke cancer in humans.

Multi-walled carbon nanotubes are hollow, rolled fullerene sheets, with diameters of 2 to 100 nanometers. They have many applications in fields as diverse as electronics, transportation, sports goods, energy, and medicine.

The use and manufacture of multi-walled carbon nanotubes are increasing, as are the numbers of workers with potential exposure to these components.

“Like asbestos, several studies in mice and rats given multi-walled carbon nanotubes by intraperitoneal injection have shown that this agent induces peritoneal mesothelioma”, state the experts in their document.

Long-term studies in rodents treated by inhalation were due to be completed in 2014 in Japan, and others were planned or have started in the European Union and the USA. The results of these studies were expected to become available within the next 5 years.

Workplace chemicals: ETUI puts RISCTOX database online

The risks from chemicals in the workplace are still poorly known. Yet a third of occupational disease claims recognized in Europe each year are due to exposure to hazardous substances. Workers mostly have no quick and easy way to access detailed information on the chemicals they use.

To help them, the European Trade Union Institute (ETUI) has joined with the Spanish Trade Union Institute Istaw to develop the RISCTOX chemicals database. Workers can now access data cards through the ETUI website on 100 000-odd chemicals, many thousands of which can cause cancer, allergies, disrupt the hormonal system or put the reproductive system at risk.

Each card specifies the chemicals classification and labelling under the regulations, its main work uses (solvent, cleaner, paint stripper, etc.), how it affects health, and the occupational diseases it causes.

The information can be called up simply by entering either the chemical’s name or its identification number in the main international chemical inventories into a search box.

Of the 100 000 or so chemicals listed, the trade unions have identified nearly 570 as substances of very high concern (SVHC) for putting on their list of priority substances. These are chemicals commonly used in many workplaces that need priority treatment under REACH, the regulation governing the marketing and use of chemicals in the European Union.

See www.etui.org > Topics > Health-Safety > Chemicals and REACH

45% of EU citizens aged over 50 would like to reduce their working time

On 15 June, the European Foundation for the Improvement of Living and Working Conditions (Eurofound) released a Policy Brief on ageing workers and their expectations in relation to working time organization. The findings reveal considerable variation according to country and workers’ qualifications.

In spite of the crisis, overall employment rates for people aged above 50 have increased over the past few years. “The increase (...) may partly reflect a need on their part for additional income to make ends meet”, states the Eurofound document. This situation also varies considerably according to level of education: “While the average employment rate for men aged 50+ has increased by 1 percentage point, the employment rate of men who have achieved no higher than a lower secondary level of education has fallen by 2.6 percentage points”. It is worth noting also that in Greece and Ireland, two countries severely affected by the crisis, the employment rate among this age group has dropped.

As regards working time, 45% of EU28 workers aged over 50 would prefer to work less, compared with 11% who would like to work more. The remaining respondents are satisfied with the volume of weekly hours currently worked. The highest percentages of people who would like to work more are found in eastern European countries (Romania, Latvia, Lithuania), in contrast to western countries such as Spain, Italy, Sweden and Germany where a majority of 50+ workers would prefer to work fewer hours.

Eurofound also investigated the preferences of retirees, a small majority of whom (53%) would like to work at least some hours per week. People reporting poor health are less likely than average to state a preference for working (48%), while those with the highest level of education are more likely to do so (58%).
UK: TUC report on four-year government assault on workers’ health and safety rights

British trade union confederation, the TUC, released a report in early April on the UK government’s hostile policy towards health and safety at work. Titled “Toxic, corrosive and hazardous. The government’s record on health and safety”, it reviews the measures undertaken by Mr Cameron’s government since May 2010 to undermine labour legislation and inspection. The report shows that state funding of the Health and Safety Executive (HSE), the public body in charge of health and safety regulation enforcement, has been cut by 40%. As a result, HSE staffing has fallen in three years from 3,702 to 2,769. The HSE has also been asked to halt proactive inspections—carried out at sites considered to be at high risk—in a wide range of industries including transport, electricity, health and social care.

Local authorities, who are joint regulators of workplace health and safety along with the HSE, have also been severely hit by government cuts. They have slashed their inspections by a massive 93% since 2009-10, and the number of inspectors employed by local authorities is down by a fifth.

The TUC also criticizes the Conservative government for trying to change the law to put large numbers of self-employed workers outside the Health and Safety at Work Act. The union believes this could have drastic consequences because independent contractors are currently more than twice as likely to be killed at work as other workers.

The TUC believes that the government’s health and safety crackdown forms part of a wider strategy to undermine workers’ employment, maternity, compensation and other rights.

REFIT: Commission red tape-cutting expert group at odds

A group of experts advising the European Commission on its programme to reduce administrative burdens on business published its final report on 14 October. It makes twelve recommendations, including exempting SMEs and micro-enterprises from obligations under EU law. The report is anything but unanimous, though—four members of the fifteen-strong group have released a “dissenting opinion”.

The group of experts known as the “High Level Group of Independent Stakeholders on Administrative Burdens” set up in 2007 is headed by Edmund Stoiber, the conservative former premier of Bavaria. The ETUI argued at the time that the group was lopsided and dominated by business. So the turmoil in which the Stoiber Group, whose term runs out on 31 October, released its final report comes as no surprise. Along with the official unveiling of the group’s recommendations, four “dissenters” have released an opinion that takes a very different view to their colleagues’ conclusions, opposing seven of the Stoiber team’s twelve recommendations and qualifying four others.

“The report seems to us to take an unrelievably negative and therefore unbalanced view of regulation and associated administrative burdens”, the opinion’s signatories.

The “dissenters” are not the only ones to point to the report’s ideological agenda.

“It makes no sense. It sounds good, but it’s pure populism” Luc Hendrickx, an official of the European Association of Craft, Small and Medium-Sized Enterprises, the employers’ organization representing SMEs at EU level, told The Guardian newspaper.

The European Trade Union Confederation argued that Mr Stoiber was “prescribing the wrong medicine”, and that this so-called remedy would undermine the health and safety at work of European workers.

Working conditions in the Eastern Europe textile sector not better than in Asia

In early June, the Clean Clothes Campaign (CCC) demonstrated in a report that working and pay conditions in the textile industry from four countries belonging to the European Union, and six other on its boarders, are similar to those experienced by their colleagues in Asia.

Researchers found that legal minimum wage levels in Bulgaria, Ukraine and Macedonia were just 14% of what is needed as a living wage. Most workers in the sector have no choice but to take second jobs and rely on excessive overtime just to make ends meet.

A female worker, who has worked for 18 years in a factory that today produces for the Spanish brand Zara, told the CCC that she earns 179 Euros per month, which includes an average of 5 hours of overtime every day. This wage does not even cover her food expenses for the family.

Women working for Hugo Boss sub-contractors in Croatia and Turkey unveiled that they were sexually harassed and victims of intimidation and shouting. At the Turkish atelier, they claimed that they had to sign a contract that included a clause to not get pregnant for the next five years.

The number of formal or informal workers affected in the 10 investigated countries is estimated by CCC at three millions, mostly women.

The CCC researchers have interviewed some 300 garments workers from 39 factories producing clothes for brands including H&M, Adidas, Levi’s, Benetton, Dolce & Gabbana.

The Clean Clothes Campaign is an alliance of organisations in 16 European countries, including trade unions, dedicated to improving working conditions in the global garment industries.
The old Workers’ Hall in central Copenhagen has been turned into a museum. It traces the history of the Danish labour movement through the changing daily lives of workers in a journey of the senses through reconstructed apartments chronicling the way many generations of workers have lived since the late 19th century. Visitors can, for instance, buy a cup of the kind of coffee that Danish working class families drank in the aftermath of World War Two. "Coffee" is a misnomer. It is a synthetic, somewhat oily black, bittersweet and slightly acidic surrogate. Its only resemblance to coffee is in being hot. Few visitors fail to make a face at the distasteful experience.

On 6 June 2014, EU Social Affairs Commissioner László Andor put forward a “Strategic Framework on Health and Safety at Work” – a Communication deemed to make up for the absence of a Community policy on the matter. The last strategy ran out in 2012 and the Commission cast around for any reason not to adopt a new one. As early as December 2011 it had a set of concrete proposals from the European Parliament and the Luxembourg Advisory Committee, the body that brings together representatives from governments, trade unions and employers in the EU countries. Issues of workplace health and safety aside, there is a serious problem of democratic legitimacy in the Commission’s cavalier treatment of the only institution elected by universal suffrage and the forum for three-sided deliberations. The Communication contains almost none of the European Parliament and Luxembourg Committee’s concrete proposals but foregrounds its own initiative of an online consultation based on a shambolic questionnaire that just over 500 individuals and organizations apparently answered.

This document is meant to give a steer to the Community institutions up to 2020. Given how President Barroso’s two terms turned out, the question arises: is it programmed action, or really a pronouncement of inaction? The latter looks more like it. So what we have is not a strategy but an unpalatable inferior surrogate likely to leave a very bitter taste in workers’ mouths. Officially, it claims to be focusing on three major areas of occupational health.

The Commission’s first chosen area is to prioritise small and medium-sized enterprises through a clear deregulatory push that treats occupational health as an administrative burden. It is not about improving working conditions in these firms, but cosy-up to their bosses, giving them a competitive edge by cutting their obligations. When you bring subcontracting chains into the picture, it is a policy that will drive all working conditions spiralling downwards.

While the Commission admits the importance of preventing work-related diseases that kill up to 160,000 people each year, it glosses over its own responsibilities, not least the hold-up in the two proposals for directives stuck in the works for more than a decade: the revision of the Directive to improve prevention of work-related cancers and the Directive on the musculoskeletal disorders that affect one in four workers in Europe.

Finally, the Commission refers to the demographic challenge of an ageing population. The problem may be a real one, but the policy unveiled is flimsy. Working conditions as they stand will not allow many workers to work up to retirement. The Commission’s only plan is to set up a network of experts, promote exchanges of good practice and support the spread of information. There is no major policy initiative on the agenda.

Leaving aside its policy steers, this Communication stands out as a poor piece of drafting. It reads like a set of cobbled together extracts from various documents randomly cut-and-pasted together. For example, guidance on preventing work accidents in SMEs is presented as an industrial policy issue. The one reference to equality policies is limited to maternity protection. The information sources are a jumble of proper, validated data like the European Working Conditions Survey and sloppy opinion polls.

The Community Treaty aims for a levelling-up of working conditions. But the policy pursued for ten years by the two Commissions headed by Mr Barroso has taken the opposite tack. The only way to make a breakthrough is for the new European Parliament, the new Commission and the Member States to give a fresh impetus to health and safety at work. The trade unions will be sure to mark their card on that. They will not be satisfied with these watery dregs.

Is it programmed action, or really a pronouncement of inaction?
Women and men – growing old working in an unequal world

European policies have steadily whittled down the idea of active aging to an aim of working longer. But exhortations to delay retirement disregard the unequal abilities of older workers. Specifically, they obscure the inequalities between women and men derived not only from segregation in employment but also the unequal division of daily tasks.

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Employees aged 50-64 made up 26% of the entire employed workforce in the European Union (EU) in 2013. In that age group, women are more concentrated in a handful of occupations: 15% in clerical support jobs, 12% in domestic cleaning and home helpers, 11% in teaching and 11% non-health associate professionals – four occupational categories between them accounting for half of all older women workers. The picture differs for same-aged men: 21% in the manual industry, craft and building trades, 10% vehicle or mobile plant drivers, 9% executives or managers (versus 4% of women). These few figures exemplify the segregation between female and male jobs which is a key factor in the gender differentiation of working conditions.

Part-time working is on average more common among the over-50s than among younger age groups, accounting in 2013 for 9% of male and 34% of female older workers in the European Union. Female part-time is most widespread and most widely differentiated between countries. Seven countries – the Netherlands, Germany, Belgium, Austria, Luxembourg, the United Kingdom and Ireland in decreasing order – have more than 45% of women aged 50 and over working part-time. Only France, Sweden and Denmark are close to the European average, all others are well below. In some countries, the proportion of both men and women part-time workers rises sharply among the over-50s, suggesting that part-time work is a way of reducing working time in the countdown to retirement.

Since the guidelines laid down by the European Commission at the 2001 Stockholm Summit, the employment rate of the 55-64 population has become the flagship policy indicator for older worker retention. The goal was to raise it to 50% by 2010, but despite a significant increase in the male (from 47% to 56%) and especially female (from 28% to 42%) employment rates from 2001 to 2012, it has been delivered only by seven countries. The rise in the employment rate of 55-64 year olds is not due to older worker retention policies alone, but also results from two other factors related to how the labour market works: the general increase in the female participation rate and gradual raising of women’s pension age to equal that of men, and rising educational levels: better educational attainments equate to a higher employment rate.

However, the employment rate tells us nothing about the causes of non-employment, of which there may be many among older workers: registered unemployment, work incapacity or sickness, retirement, being out of the labour market for family or caring responsibilities, and many other reasons besides. On average, the wage employment rate among the population aged 50-59 in the EU in 2012 was 59% for men and 55% for women, and the self-employment rate 18% for men versus 9% for women. Self-employment is therefore widening the gender gap in employment rates.

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There is relatively little gender difference in the share of unemployed, work incapacitated or retired persons – 6%, 7% and 6% of 50-59 year-olds respectively. By contrast, the share of non-work due to family or caring responsibilities is much higher among women than men (8% against 1%); likewise the “other reasons” (9% versus 3%). An examination of the same data at national level reveals significant between-country differences. Many countries with a low proportion of retirees in the 50-59 age group may be seen to combine a proportionately high work incapacitated population with a proportionately high unemployed population, and vice-versa, as if the two were interconnected. The wide range of national institutional arrangements enabling an early labour market exit is the key explanatory factor of these differences.

One logical consequence of the rising older worker employment rate is a lengthening average duration of working life, measured by an indicator devised by Eurostat. In 2012, the average length of men’s working life (37.6 years) was significantly longer than women’s (32.2 years) in all European Union countries. The goal was to raise it to 50% by 2010, but despite a significant increase in the male (from 47% to 56%) and especially female (from 28% to 42%) employment rates from 2001 to 2012, it has been delivered only by seven countries.

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countries apart from the Baltic countries, but with wide between-country variations: for example, women’s average working-life length is longest in Sweden (39.3 years) and shortest in Italy (25.4 years). From 2001 to 2012, the average duration of working life increased for both sexes but much more for women than for men: 2.9 years for women against 1.3 years for men on an EU-wide basis. The between-country variations are not explained by gender parity or differences in the legal retirement age, but by other factors related to men and women’s differential careers and life courses.

A lack of financial security

Job insecurity and money concerns are big shapers of career pathways into retirement. According to the European Working Conditions Survey (EWCS) 2010, 16% of men and 15% of women aged 50 and over fear losing their jobs in the short term and nearly two-thirds of women and men (64%) think it would be difficult to find another similar job were they to lose their current one. Job insecurity is compounded by income insecurity. Here, women and men’s situations differ as they age. As women get older, they are more likely to become the main breadwinner: 57% of working women aged 60-plus are the main household income contributor versus 31% of 40-year-olds. The profiles of men and women wage-earner households diverge after the age of 50. So, most over-50 males have working spouses or partners: from 72% for the 50–54 age group to 60% for the 60–64 age group. The proportion of male one-person households is stable at around 9% in the 50–64 age group. The share of over-50-year-olds with an employed spouse falls more sharply among employed women than men: from 83% in the 50–54 age group to 45% between 60 and 64 years of age. Once into their 60s, 47% of working women have a retired spouse or partner compared to 16% of similarly-situated men. Additionally, more than one in four working women aged 60 to 64 (28%) is in a one-person household. The financial circumstances of unattached working women aged 50 and over appear more critical than that of unattached men: 41% report difficulties in making ends meet compared to 31% of men. This at-a-glance view of the profiles of households nearing retirement reveals gender-differential situations which may necessitate working longer.

Other surveys bring evidence that financial pressures may influence the rise in older women’s employment. Sociologists Magdalena Rosende and Céline Schoeni show from the Swiss example how variability in the second half of careers and “pathways” into retirement originates in the gender division of labour that shapes life courses. The measures mooted to raise the older worker employment rate often disadvantage women; ostensibly egalitarian, they take no account of past gender inequalities in the first halves of careers.

Additionally, second and third pillar pension schemes disadvantage women who have had discontinuous careers and/or worked mainly part-time. This results in a wide gender gap between those (often women) who have to work into old age to make up for a fragmented or late-starting career and those (usually men) who can make an early and relatively well-off exit. This narrows down many of women’s choices.

EU’s “anti-ageing” policy: a foreseeable failure

The EU has not had a health and safety at work strategy since 2012. A grandly titled “strategic framework” document adopted in June 2014 by the European Commission (see editorial p. 5) had three priorities, one specifically being ageing at work.

It offers a bankruptcy analysis, treats ageing as a purely demographic fact, glossing over the issue of social inequalities and how working conditions play into the worsening health that leaves people old before their time and unable to keep working up to legal pension age. It is silent on the obvious differences between men and women, manual and non-manual workers, or the rung on which workers stand on the job ladder. It casts aside the fact that ageing is a cumulative process in that workers end up “paying” for the build-up of stresses and strains throughout working life. This calls for vital improvements to the working and employment conditions of all workers from the very start of working life, without which specific adjustments for older workers or rehabilitation for sick workers will be next to useless.

The policy pointers read like unadulterated management-speak. Not one concrete policy objective is cited; it is all about setting up a network of experts, spreading information around and promoting good practices. Not only is it a far cry from the aim of improving working conditions mainly through binding legislation as required by the Treaty on the Functioning of the European Union, but the Barroso Commission has actually gone the other way to call for a “simplification” of the existing rules.

The question now is whether the new Commission and Parliament will steer clear of a policy that aims so low.

Laurent Vogel, ETUI

**Arduous work has different impacts**

Some health problems grow more common with age. Backache and upper limb musculoskeletal disorders affect more than one in two workers of both sexes from age 50 onwards. With age, a feeling of overall fatigue affects a steadily rising proportion of women, peaking between 45 and 49 years of age (45%), while for men, the peak is reached between ages 50 and 54 (42%). There is a slightly higher frequency of sleep disorders among women than men, increasing as they get older. The gender gap widens from the 40s until the early 60s. More than one in four women in their 50s complains of sleep disorders. Women’s double workload (paid work and housework) is a key explanatory factor in feelings of fatigue and sleep disorders.

While the ability to handle stress declines with age, 25% of male and 28% of female employees aged 50 and over report being stressed through their work. The differences between sexes can vary widely with occupational category. More women than men professionals, managers and supervisors, and to a degree, associate professionals, for instance, are exposed to stress.

Like stress, high emotional demands can also make work arduous. Such “emotional work” is typical of person-facing activities (patients, students, users, etc.) or specific situations that engage the employee’s emotions (dealing with annoyed customers, putting on a polite face, dealing with pain, etc.). This kind of “emotional work” is more common in female jobs, which is a logical consequence of gender segregation in the caring occupations.

The 2010 European Working Conditions Survey found that 25% of female and 30% of male employees aged 50 to 59 feel that their work affects their health negatively, with line of work being a key explanatory factor. In men, among men, semi-skilled manual workers and technicians see themselves as at highest risk, whereas more surprisingly, perceived negative effects on women’s health are higher among professionals (intellectual professions, managers, executives). The worst work situations for both sexes are painful or tiring positions, followed by inconvenient working hours.

These findings need to be set against other research findings which emphasise that men and women are never exposed in the same way to the hazards of work. Men...
are more often concerned by particular more readily identifiable, measurable and "recognized" (through bonuses or early retirement opportunities, for example) working conditions like vibration, noise, heat, cold, exposure to toxins, radiation, heavy loads and night work, while women are more often exposed to repetitive gestures, inability to break off work, dependence on other people's work and lack of job discretion. Also, the physical demands of women's work are not always characterised in the same terms as men's. The similarity of some types of arduous work to domestic labour makes it harder for older women workers to call what they do "physically demanding work".

The impact of unpaid work

The combined burden of paid and unpaid work impacts differently on men's and women's life courses and health. Staying working longer is not a feasible prospect unless the short and long term effects of this double workload are factored in.

Housework and caring remain largely women's responsibilities at all ages. The burden lightens from age 50 but still concerns 22% of women versus 17% of men. Caring for elderly parents and/or disabled relatives falls to rising proportions in this age group, and is the lot of 9% of working women and 3% of working men.

Work/life balance is one of various factors that will influence the decision to keep working or retire. The EWCS 2010 found a high correlation between the proportion of employees aged 50 and over who do not think they will be able to still do their current job when they reach 60 and how well their working time "fits" with their private life. Where working hours are least well-suited, 58% of women and 48% of men aged 50-59 reported that they did not think they would be able to keep doing their current job at the age of 60. Also according to the European Quality of Life Survey (EQLS, 2011), 26% of women and 20% of men aged 50 and over reported that work-related fatigue stops them doing household chores.

The combined and reciprocal effects of work and working conditions and the stresses of juggling work and private life undermine women's health and, notwithstanding their still greater longevity, reduce their healthy life expectancy over the long term.

Our Western societies continue to regard only male-dominated occupations as hard work.

Image: © Isopix

The issue of working conditions cannot be divorced from the institutional conditions of organized career wind-down.

Gender should be seen as central to the analysis of working conditions and policy-making to improve them. The issue of working conditions cannot be divorced from the institutional conditions for organized career wind-downs, which are often specific to national contexts that are strongly influenced by European guidelines. Allowance must be made for gender-differential career and non-career paths, and the inequalities and injustices in this area redressed.
Testimony

‘Damaged beyond repair’

In Europe, increasing life expectancy and the future pappy-boom are everyone’s worst fears. How will we pay all the pensions in coming decades? According to employers, if workers live longer, they will naturally work longer. This apparent good sense fails to take account of the demanding nature of certain trades in which workers, worn out by their labours, cannot even reach retirement. This can be illustrated by the case of a foundry worker.

Statement taken by
Denis Grégoire, ETUI

He’s 60 years old but sometimes feels like he’s 20 years older. ‘I can’t lift a bottle of water with my left arm’, he confides as we are discussing the past, sat at a kitchen table in a house in Rocroi, in the French Ardennes. For Guy Durbecq, a foundry worker who started work at the age of 14 and who for 30 years got up at midnight to start his shift at 1.30 a.m., finding himself in this weakened state is hard to take.

‘After the operation, my arm was in a cast for three months. I couldn’t do anything on my own and I wasn’t allowed to drive. The surgeon said to me: “Your body is worn out – it’s damaged beyond repair.” That was hard to take. But I had to accept it.’

His health problems are in fact long-standing – he has lived with a herniated disc for 20 years – but, up to the end of the 2000s, he refused to follow his doctor’s recommendation ‘to take it easy’ because he was riddled with tendonitis. ‘I was not the type of guy to just stop, so I kept going and kept going, but I was getting increasingly worse,’ he recalls. Injections – up to eight a month – helped at the start, but quickly lost their effectiveness. His body then literally failed. ‘The surgeon told me that, in my left arm, my tendon had basically disappeared, but that he could save what was left in my right arm if I had an operation. Since then I have suffered less and the pain no longer stops me sleeping, but I have to take 17 different drugs every day’, he says, brandishing a small, transparent, yellow plastic box full of tablets.

Foundries were a big part of his life: his father spent all his working life at Le Croissant foundry – aged 82, silicosis is eating away his lungs – and made his son start work there when he was barely into his teens. ‘At the time, in Rocroi, if school wasn’t for you, you were sent to the foundry.’ In the 1960s, this town, well-known for its star-shaped fortifications designed by Vauban, had seven foundries, each employing around 100 workers.

‘I started at the age of 14 as a hand moulder, which involved making the moulds into which molten metal was poured to make parts. At the time, there were no overhead cranes and I had to carry the moulds myself’, he remembers. He stayed in that job for 10 years.

It was hard work, which was also badly paid. So he decided to cross the Belgian border to Couvin, some 10 kilometres away, where wages were higher than in Rocroi. There he was employed as a ladle pourer in the foundry of a manufacturer of wood and coal burning stoves. The ladle was in fact a kind of saucepan filled with 50 kg of hot metal which had to be poured into moulds to make the parts. ‘Four of us could pour between 50 and 60 tonnes per eight-hour shift with those ladles. As we were paid by the casting, the less in each casting, the more you earned. The worst part was the summer when the heat smacked you in the face.’

He ‘ladled’ for 15 years, after which he was put in charge of maintaining the cupola furnace, a vertical oven in the shape of a cylinder around 10 metres high, in which the materials to be melted came into direct contact with the coke used as fuel.

This was also hard work: ‘Once a week, we had to clean the cupola furnace. We had to remove all the red coke, firstly using hooks, and then with a pick hammer. The bottom and walls of the cupola then had to be scrubbed clean. After that, we had to recoat the cupola: two of us would empty 50 kg bags of rammed earth into a machine, which was connected to a pipe operated by a colleague inside the cupola, who had to recoat the walls with refractory material. The operation took three to four hours and was done at night because the cupola had to be operational by the following morning at 5 a.m.’

When he was not maintaining the cupola furnace, Guy Durbecq operated a bulldozer and loaded 25 tonnes of coke and limestone per day into the caster. ‘I was constantly making the same movements and so I started to develop tendonitis.’

As in Rocroi, where there are only two remaining foundries, the number of foundries in Couvin is also shrinking. The stove manufacturer, renowned for the quality, and the price, of its products, was declared bankrupt last February. Guy Durbecq received his redundancy letter, together with around a hundred of his colleagues, but without any severance pay for the time being, despite his 30 years of labour. He remains in contact with Gilles Woirin, the trade union representative – ‘a guy who has always defended us – who is currently fighting through the courts to get them something. It is some consolation for Guy, unlike many workers, that his health problems have been recognised as an occupational disease. How could it have been otherwise?'
Occupational health services in need of emergency care

Special report coordinated by Viktor Kempa, ETUI

Occupational doctors play a key role in preventive workplace health in most European countries. They are there to help the workers by seeing that their work does not harm their health. Their knowledge of the environment they work in also lets them press employers to improve it. Years of worsening conditions in which they provide their services pose a real threat to health and safety.

In this special report, the European Trade Union Institute looks to identify the main factors that are undermining occupational health services in Europe. First among them is the shortage of specialists. The average age of occupational doctors is already high, and little new blood is coming in. This is fraught with consequences: overwork that undermines the quality of services, loss of direct contact with actual working conditions, loss of interest and a feeling of being forsaken.

Some countries have sought to ensure health surveillance for workers by letting doctors who have not done the full training course provide occupational health services. Nurses and other specialists who also operate in the workplace do not always enjoy the protected tenure that occupational doctors have, rendering them more vulnerable to pressure from employers. The organization of external occupational health services has been inappropriately commercialized in many countries.

These developments can drive a hole through the requirement of collective prevention that must guide the occupational doctor’s work. Some occupational doctors carry out individual-oriented public health tasks that should be done by other doctors. This is a trend encouraged by employers generally, who increasingly see the occupational doctor more as a means for controlling absences, and even in some cases workforce selection, and less as a key player in improving their firm’s work environment.
Occupational health in the face of the commercialisation of preventive services

While the 1989 Framework Directive on safety and health at work provides that all EU workers should have access to workplace protective and preventive services, EU law gives Member States wide discretion in how they organize their occupational health system. This makes the EU map of occupational health services very much a patchwork quilt.

Wim van Veelen
Spokesperson of the workers’ group of the Advisory Committee on Safety and Health at Work, Luxembourg

On average, occupational doctors are ageing rapidly. The successor generation is desperately needed.

Image © Belga
Europe, 2014. A great many workers have lost their jobs and are desperately looking for work. To achieve this, they are willing to accept short, temporary contracts or to become self-employed. The entire European labour market is fragmenting. In addition, workers in Europe are having to work, and therefore ensure that they stay in good health, for longer. New risks are emerging, such as exposure to nanoparticles and the use of a new generation of digital devices (tablets and smartphones), making employees contactable 24 hours a day, while legislation to give them better protection from those new risks is delayed. Rather than strengthening worker protection, the European Commission is trying to water down social legislation, on the pretext that Europe has to cope with competition from emerging countries. Inspection services are also losing ground, which is further eroding workers’ health protection at work. It is increasingly difficult to answer the question: ‘To whom can workers turn for advice on health protection and prevention?’.

Riding on the wave of the free-market economy, many Member States have failed to resist the siren songs and have embarked on programmes to privatise their health systems. Occupational healthcare has also become a commercial product. The pursuit of profit and the market-based system, on the one hand, and healthcare, on the other, are difficult to reconcile, and the result is crumbling preventive services and a decline in the quality of the care provided to workers. Faced with these threats, the unions have a duty to demand quality from the providers of occupational healthcare.

The International Labour Organisation’s conventions, the 1989 European Framework Directive on Safety and Health at Work, and the WHO Declaration on Occupational Health for All, have led to the adoption of legislation on occupational health services in many Member States. As a result, multidisciplinarity has become a key concept in protective and preventive services and, as provided for in the legislation, workers are playing an active role in their companies with the objective of promoting better working conditions and, in so doing, improving health protection for workers.

In addition, the provisions of Article 7 of the 1989 Framework Directive, according to which all workers shall have access to protective and preventive services, leave the Member States a great deal of latitude to organise occupational healthcare as they see fit. As a result, significant disparities have arisen among the Member States in terms of both the quality and the nature of the services provided. In the Netherlands, for example, the protective and preventive services (Arbodiensten) do virtually nothing to promote prevention, while occupational physicians spend most of their time cutting work absenteeism and checking that workers who are off sick are ‘genuinely’ ill. In Austria, on the other hand, every worker is required to devote a minimum number of hours to prevention and there are detailed provisions to describe the records that occupational physicians must file. Some Member States are therefore far worse off than others when it comes to prevention. We therefore need to see the definition of common rules at European level.

**Threat to quality**

SME employees who experience health problems or who have concerns about risks in their workplace find it much more difficult to obtain independent advice than an employee of a large company. There are many companies in which it is complicated to gain access to an occupational physician because the company does not have a contract with a preventive service provider or because workers are denied access to occupational healthcare by their employer. There are large groups of workers in Europe who often have no access at all. For self-employed sole traders, but also for workers employed by temporary employment agencies and unemployed workers wishing to return to the labour market, it is quite simply impossible to access occupational healthcare.

Virtually all of the Member States have problems with the quality of outsourced protective and preventive services. Companies want occupational healthcare to cost as little as possible. Consequently, they agree minimum contracts with service providers or, worse still, contracts based on the number of times the services are used. If the services are never used, the companies pay nothing. Moreover, the preventive service providers are in competition with one other, which almost always leads to a decline in quality. It is therefore not impossible for workers to believe that they are consulting a fully qualified doctor, when in fact the ‘doctor’ is not registered or certified as an occupational physician. Furthermore, it is important for occupational healthcare to be entirely independent. There are many cases of employers pressurising occupational physicians to comply with their wishes. A physician’s refusal to do so may have consequences for the contract concluded with the preventive service provider. In several Member States that leads to occupational healthcare failing to report serious risks. It is vital for these physicians to be independent if they are to build a relationship of trust with the workers. Unfortunately, commercial interests gravely damage that independence, as employees testify.

Another major problem is emerging in many Member States: there is a risk of the profession of occupational physician disappearing. Many young students are opting to specialise in alternative disciplines or to become general practitioners. It remains to be seen whether Europe will still have enough occupational physicians in the near future. It is time for policy-makers to address the issue.

Many Member States are already experiencing a shortage of occupational physicians (see article p. 18).

As long ago as 2004, the Commission warned that a significant proportion of the workforce was not benefiting from preventive services and that there were problems with the quality of occupational healthcare, particularly in SMEs, at a time when workers were being expected to work for longer. The unions are therefore right to be concerned. Although the Framework Directive requires occupational healthcare to adopt a multidisciplinary approach, it is the Member States that have to guarantee that the professionals working in preventive services have the necessary skills and capacity. Their efforts to do so are piecemeal and far from transparent.●

Companies want occupational healthcare to cost as little as possible.

**Occupational health services in the EU: mapping the provision**

**Viktor Kempa**
ETUI

Representatives of trade unions and associations of occupational physician from various EU countries met at gatherings organized by the European Trade Union Institute (ETUI) between 2011 and 2013 to compare national occupational health service set-ups. EU law (the 1989 Framework Directive on safety and health at work) refers to workplace protective and preventive services only in very general terms, leaving the practical organization of occupational health services as a national jurisdiction.

With no EU statistics available, the ETUI set about collecting data from trade unionists specialized in occupational health and/or associations of occupational physician in a bid to gauge how many doctors (whether specialist occupational physician or not) are providing health surveillance of workers per 100,000 workers and the percentage of workers covered by occupational health services.

Where provision is concerned, the replies vary between 2 and 55 doctors per 100,000 workers—a huge range that speaks volumes about the variations in different countries’ prevention policies. In some countries, for instance, the providers are not necessarily occupational physician capable of analyzing how work has affected health; they will simply diagnose ill-health or certify fitness for work but play no preventive role. Coverage of workers varies between 20 and almost 100%.

A number of countries were unable to supply exact numbers, or the trade unions and occupational physician sent in estimates which were significantly different. Prudence dictates that these data not be included, though arguably the lack of data is in itself a significant fact. A further caveat is that the occupational physician totals provided by some countries are not for “full-time equivalents”. This is particularly so with Italy, which has a fairly high proportion of doctors providing part-time occupational health services.

Sources: associations of occupational physician, European Trade Union Confederation member organizations
Finally, no data can be offered for the United Kingdom, where occupational health services are not necessarily provided by a specialized doctor but rather by general practitioners (who may have no occupational health training) or specialized occupational health nurses (see article, p. 36).

A comparison of the two parameters shows significant between-country variations in the quantity and quality of occupational health services. In some cases, there is a discrepancy between the number of doctors per 100,000 employees and the share of workers covered by occupational health services. Bulgaria, for example, has only nine occupational physicians per 100,000 employees and yet a coverage rate of 97%, while Finland needs 55 per 100,000 to cover 85% of workers.

What this shows is that nowhere near all employees are getting access to occupational health services. Workers in SMEs and micro-entreprises as well as agency and self-employed workers are in a particularly sorry pass—worsened by having to put up with harsher working conditions, longer or irregular hours of work and non-standard work contracts.

These distortions point up the need for EU regulation in the form of minimum requirements for the expertise areas, functions and role of workplace health protection services, occupational physicians and other such service providers. This is obviously not just about determining the expertise, training and time required to carry out prevention activities or even the measures to be adopted, but also about defining the social function that occupational health services must play. The trade unions argue that occupational physicians must be completely independent specialists who offer consultations, guidance and recommendations to employers and employees and work with other links in the prevention chain, including workers’ reps, both in and out of the workplace. Their mission must be to help preserve workers’ health, not carry out health-based recruitment.
Occupational health doctors in France – an endangered species

Wearied by never-ending reforms, swamped by a soaring workload and ever-expanding duties, undermined by lack of recognition of their speciality by society, the state and the wider medical community, occupational doctors, especially younger medics, may start looking for a change of career.

Denis Grégoire
ETUI
"Some colleagues I’ve talked to, The reform is a worry; if it doesn’t suit, we’ll change professions. I sometimes think I could do with a change of career, but I’m not yet ready to just drop occupational health", vouchsafed one occupational doctor in a professional publication1. France’s occupational doctors have latterly been taking to blogs, reports issued to the press, and attention-grabbingly titled books to voice the disquiet besetting their profession (see: More information p. 22).

According to official figures at 1 January this year, France had 5 694 occupational doctors comprised of 4 011 women and 1 683 men2. At 54.8 years, occupational doctors have the highest average age of all of medical specialities. The average age of occupational doctors in the Centre and Poitou Charentes regions even tops 57 years. As things stand, nearly 75% of occupational doctors are aged fifty and over.

And the projections are sobering. A Ministry of Health study predicts that the numbers could shrink by 62% between 2006 and 20303 with mass outflows to retirement in coming years not being offset by new inflows as fewer medical students find their calling in the profession.

These figures show the scale of the demographic challenge for the secure future occupational health surveillance of workers in general. It is partly in a bid to address this looming shortage that the Ministry of Labour has for almost two decades been working on a major reform of the occupational health system. Why is it still not yet done? In France, occupational health services remain a highly political issue and an arena of contention which broadly pits two diametrically opposed approaches – a health service that serves workers and one that serves the economy – against one another.

It all started in Vichy...

To understand these tensions, we must go back to legislation passed by the collaborationist Vichy government in 1942, when medical services were first imposed on businesses with the intent of identifying French workers fit to perform the infamous “compulsory work service”, i.e., being shipped off in their hundreds of thousands to Germany to replace the German workers sent to fight on the Eastern front.

After the Liberation, the newly-appointed Minister of Labour, Communist MP and former metalworker Ambroise Croizat, sought to make the occupational health services tainted by Vichyism palatable to workers. In 1946, he steered through parliament a new law on occupational health services based on Republican principles like universality (“occupational health services are for all employees”). This Act spells out the remit of the occupational doctor: “The occupational doctor has a purely preventive role. It is to avoid any deterioration in workers’ health by reason of their work, in particular by superintending their hygiene at work, the risks of contagion and their health”.

In short, a system meant purely to serve workers, but in which the idea of medical selection of labour persisted, especially through the provision for checking workers’ fitness. The imperative post-War need for reconstruction, a prerequisite for which was the preservation of “industrial harmony”, and a new government minus the Communists, worked against the law being implemented in line with its initial ideals.

Almost seventy years on, the 1946 Act remains the cornerstone of the Republican, “French-style” approach to occupational health services. “The French system is based on the principles of the Constitution of the Republic which make protection of workers’ health a basic function of the state, and tasks occupational doctors with carrying out that public policy remit”, argues Alain Carré, one of the organizers of “Santé et médecine du travail” a coalition formed to oppose the marketization of occupational health services.

In some professionals’ view, the grindingly slow reforms started in the 1990s to meet the requirements of the EU’s 1989 Framework Directive on health and safety at work are throwing this model into question.

Multidisciplinarity: hopes and mix-ups

Under pressure from the European Union4, France made changes in 2000 to give a more multidisciplinary steer to its occupational health system, rebranding occupational health services as “health and safety at work” services. The idea is to deliver real primary risk prevention by buttressing occupational doctors with other professionals like specialized occupational health nurses, occupational health assistants and specialists in other fields (ergonomists, toxicologists, metrologists, psychologists, etc.) known by the acronym “IPRP” (intervenants en prévention des risques professionnels – occupational risk prevention operators). “Multidisciplinarity”, which is the main focus of occupational health service reforms in France, has been beset by numerous difficulties in practice. Dissatisfied with how it was being implemented, the government sought to bolster it by passing new legislation in 2011.

“We believe the whole thing stems from a misconception. The government saw multidisciplinarity mainly as a way of addressing the shortage of occupational doctors. But we think the opposite – that multidisciplinary working cannot be seen as a response to the shortage of occupational doctors. Our organization has always favoured the multidisciplinary approach but as a means of improving prevention purely for the benefit of employees. In services with an acute shortage of doctors, the introduction of multidisciplinarity has been disastrous”, says Mireille Chevalier, Acting General Secretary of occupational health professionals’ union Syndicat national des professionnels de la santé au travail (SNPST).

4. Initially, only on firms with more than 50 employees.
5. In fact, the 1946 Act makes occupational health services compulsory only in private sector firms. They were not extended to public service employees until 1982. See Buzzi S., Devinck J-C. and Rosental P-A. (2006) La santé au travail. 1880-2006, La Découverte.

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Sociologist Pascal Marichalar, who wrote his doctoral thesis on occupational health services in France, argues that multidisciplinarity is a revisited technocratic approach to workplace health issues that reflects the employer’s agenda. "The way in which multidisciplinarity has been implemented is often little more than the technicization of prevention and a shift from a medical practice-based approach and relationship to the employee, with the idea that getting workers to talk about their work is the quickest way into the reality of work, to a technical approach disconnected from workers themselves where the sole focus is on the work environment," he told HesaMag.

The gradual introduction of multidisciplinary working also raises questions about the independence of IPRPs. Alain Carré believes that IPRPs are ambiguously situated: "Looking at the European legislation, their job is to support the employer. I have found that industrial psychologists in particular were unsure whether they should be siding with the employer or the workers. Also, unlike occupational doctors, they are not classed as employees with protection from dismissal which leaves them more exposed to pressure from employers".

Working on his thesis, Pascal Marichalar came to realize what limited discretion these new operators in prevention had: "to get to see an occupational doctor, I just contacted them directly, and they readily gave interviews in work time. Every time I contacted an IPRP, they asked me to wait because they had to get management approval. I had to submit the questions I was going to ask to a senior manager. In some services, I noted that the IPRPs’ offices were directly facing the managers’ offices, so there was a de facto check on what they were up to".

**Parity for show**

As well as widening the range of players involved in occupational health through multidisciplinarity, the 2011 Act also seeks to bring parity to the boards of directors of intercompany occupational health services, which have long been the sole preserve of employers. They must now have equal numbers of employer and trade union directors. Many observers, however, see this as parity for show because the chairman of the board, who is always chosen from among the employers, has a casting vote in the event of a tie.

"The trade unions were deposited in a management system and can’t get to the point of having quality demands. Where health and safety at work are concerned, it perpetuates a system of trade unions in a negotiation mindset with health on one side and jobs on the other side of the scales," observes Mireille Chevalier. "Occupational health should never be up for negotiation", protests SNFST representative and current General Secretary Jean-Michel Sterdyniak.

The 2011 Act also requires all intercompany services to draw up a “multi-year service plan” that sets the service priorities and is meant to be the link between government health and safety at work policy and the daily work of occupational health services. Jean-Michel Domergue has put a lot into drafting this document for his intercompany service based in Créteil (south of Paris). "We started from scratch and painstakingly worked up a plan that has ended up not much short of 200 pages", he enthuses. The document assigns each (full-time) occupational doctor a maximum 2 800 employees and sets out the multidisciplinary team’s consensus view on how consultations should be organized and even ways of improving the traceability of work-related exposures.

While writing the document was an opportunity for Dr Domergue and his colleagues to re-examine their practice, discuss the profession, in a word, look with fresh eyes at the meaning of their calling, most turn out to be just tick-box exercises. "Most often, the plans have been written by the manager or chairman of the board of directors," admits Dr Domergue.

**Commercial pressure**

Commercial pressure is the biggest threat of all to good occupational health service practice. "We are pulled by conflicting requirements: doctors are asked to do increasingly more things, especially in terms of exposure traceability, at the same time as dealing with a limited number of private companies, usually very large groups, have their own health service, known as “in-house services”.


#8. The very great majority of employers discharge their health and safety at work obligations by joining an intercompany occupational health service (SSTI). These services are responsible for health surveillance of 94% of the non-agricultural private sector working population.
A late but committed calling

For twenty-odd years, Dr Nicole Vigneron was a GP in private practice. Fifteen years ago she decided to stop being a general practitioner and retrain as an occupational doctor. “An occupational doctor friend said, ‘Why not go into occupational health? I think it would suit you’. The problem was, I had a very negative perception of it. But she managed to talk me round”.

Nicole Vigneron sat the special medical residency exam in occupational health – the so-called “European competition” – which allows a qualified doctor to recycle into that speciality after two years’ training.

“I absolutely loved occupational health from the word ‘go’ because it added so much to what I had done in general practice. I found it very complementary in that it made me recall diagnoses that I hadn’t made”, she says enthusiastically.

It was hard going to start with, however. She was taken on as a fixed-term contract worker in the state civil service. It was not long before she observed major health problems with civil servants in one department. Her attempts to bring the situation to her employer’s notice were not well-received. “I was quickly given to understand that it was none of my business. When you tell an employer about the health risks going on in his business – whether public or private – they take it as an accusation and tend not to listen”, says Dr Vigneron.

Relations with her public sector employer went rapidly downhill and she was let go. “They padlocked my door. I never imagined it could get that extreme”, she recalls, still visibly scarred by the ordeal. “Half the employees signed a petition to keep me, so that was nice at least”.

After her dismissal, she was immediately taken on by a Paris-based intercompany service for its medical centre on the Champs Elysees – a high-end district where she attended to employees of ready-to-wear clothing, cleaning and hairdressing businesses and a big finance industry concern.

The fact of working and being able to discuss with colleagues strengthened her commitment to defending to the hilt her view of her chosen profession.

“Independence – you have to claim it, then keep it”, she says, referring to an initial face-off with the management of a company affiliated to her health and safety at work service. “In my annual report, I flagged up a number of problems, including impossible work schedules, health problems developing due to extreme employee fatigue, cases of high blood pressure in a workforce with an average age of 25. The employer said I couldn’t justify this because I hadn’t seen enough people. You only have to announce something that the firm doesn’t like for it to hide behind the rules, saying, ‘that’s not on – you don’t make enough visits, you spend too much time with the employees when you do’”, says the occupational doctor.

“The health and safety at work service is still an employer’s service. They say: ‘Doctor, the fact is that you aren’t getting enough done. You just need to get a lot more done. Simply put, they want us to shoot through it, and I won’t do that. I want to take some time with each employee because even if I don’t see them all, it gives me a better understanding of the business so I can help it identify and then reduce the risks’.

Having learned lessons from her time in the public sector, Nicole Vigneron challenged the company’s decision to change their occupational doctor. She demanded that the company’s works council (EC) should take a decision as the regulations provide. Despite support from one union rep who had herself suffered from problems related to her working hours, the works council took the employer’s side. Dr Vigneron referred the matter to her intercompany service’s supervisory committee – a body of employer and employee representatives drawn from member companies and occupational doctors elected by their peers, and chaired by the chairman of the intercompany service’s board of directors. The first vote upheld the company’s decision. “That first meeting was not held as per the rules. So I decided to challenge the decision” says Dr Vigneron. A second vote went in her favour, but she keeps the company only “on paper” since the head of the intercompany service stood by his decision to hand it to one of her fellow doctors.

The dogged resolve shown by Dr Vigneron is very rare. Most occupational doctors would rather “lose” a firm than embark on a protracted battle that will set them at odds with their employer. “Looking back, I understand them, because it is immensely wearing and tiring to stand up for your rights. You would not credit the pressures I have come under, summonses to meetings and remarks like: ‘Doctor, it’s just you in this situation’”.

Never particularly militant, Nicole Vigneron joined a union in order to stand at the workplace elections. She is now a staff representative and member of the works council for her service. She is also the doctors’ nominee on the board of directors and the supervisory committee. “I was elected by my peers. So that counts as some recognition of what I did”, she emphasizes. “I’m trying to urge the others to stand up a bit, to stop being afraid.”

*In workplaces with more than 300 employees, the occupational doctor writes a company-specific annual activity report which is submitted to the works council and health and safety committee.

"Independence – you have to claim it, then keep it."
"Employers can easily run tactical rings around trade unionists."
Alain Carré

a growing number of people. We have to select just a number of employees to follow-up. Companies that have paid a fee feel aggrieved if not all medical consultations are held. And as my service continues to sell medical consultations...", complains Serge Opatowski, an occupational doctor in a Paris intercompany service.

"Intercompany services make an informal division of work between the medical part of the business which employers recognize they have no right to interfere with, and the service organization and administration part, in particular occupational doctors' work schedules which they feel they have the right to set themselves. But setting these work pac-es has an impact on the content of work, especially workplace visits which are the poor relation of occupational health services", argues Pascal Marichalar.

In a minority of one

The Labour Code may afford occupational doctors some protection against dismissal or re-assignment, but in reality it is exceptionally hard for a doctor to withstand pressure from a disgruntled employer (see Box A late but committed calling) – particular so when support from employees and union reps is not forthcoming. The employee-occupational doctor relationship is underpinned by probably more complex mechanisms than those that determine that with the employer.

Various of the seven occupational doctors interviewed for this investigation pointed to a lack of training or occupational health culture and a more general lack of strategic vision among employee reps on CHSCTs. "There is a high degree of naivety among the trade unionists. Employers can easily run tactical rings around workers reps with the old pals act", observes Alain Carré. Doctors have also reported getting no support from worker reps on CHSCTs after initiating a notification procedure following serious deteriorations in workers' health. Without guaranteed support from workers' reps, many occupational doctors give up the solitary fight.

The unions have always harboured suspicions about occupational doctors, often seeing them as closer to the employer. Jean-Michel Domergue explains this in sociological terms: "Not many occupational doctors come from working class communities, so they naturally feel closer to management than workers".

Alain Carré also sees a sense of class identification, but believes the problem in building a relationship of trust with workers lies with the fitness notice. Like most occupational doctors' associations, he wants it scrapped as a hangover of the medical selection of workers practiced in the early days of company health services. Figures from a study done in the Vaucluse département showed that issuing a notice of unfitness results in almost every case in the worker losing his job, which is clearly not calculated to endear a worker to his occupational doctor.

More information


For the past twenty years, a group of occupational doctors in Bourg-en-Bresse (eastern France) has published an annual report of anecdotal evidence from doctors about the difficulties encountered in daily practice. These alarmingly-titled documents ("Le désastre", "Apocalypse Now", etc.) are available on: http://collectif-medecins-bourg-en-bresse.overblog.com

Carnet d'un médecin du travail is a sporadically-updated blog of personal thoughts from an occupational doctor http://medecindutravail.canalblog.com. See also Box Blogging to cope.
9. Since 1979, occupational doctors have had a statutory requirement to spend a third of their working time on workplace visits (for job analysis, observing work done for risk assessment, etc.). It is a requirement very rarely fulfilled for want of time.

10. Health and Safety Committees (CHSCT) are the main bodies responsible for protecting workers’ health and safety in firms for which they are asked to help improve workplace working conditions. They are called upon almost every year to make a written statement of the reasons for which no action can be taken on them.

11. The July 2011 health and safety at work reform introduced a new provision requiring an occupational doctor who establishes that a risk to workers’ health is present to make a written and substantiated proposal for measures to preserve it. The employer must take the proposals into consideration and if he rejects them, must give a written statement of the reasons for which no action can be taken on them.

12. After a medical examination, the occupational doctor issues a notice of the employee’s fitness or unfitness for his work.


14. The study by doctors working in intercompany services showed that 90% of employees declared unfit were eventually dismissed. Only 23% found employment again. Coll (2008) Devenir des salariés licenciés suite à une inaptitude au poste de 2002 à 2004 en Vaucluse, 53 p.

Blogging to cope

Since 2005, an occupational doctor posting under the handle Sentinelle (sentinel) has been blogging, often humorously and always empathically, about the problems of workers she meets on her medical visits. She tells us about Tania, a 50-year-old building caretaker fired after a work accident (in fact, an assault by one of the building occupants) and Patrick, a maintenance worker at breaking point after yet another humiliation. Or the working conditions of manual workers in the ready meals industry and those – basically little more enviable – of managers on the brink. “Consultations are increasingly becoming somewhere to talk about the violence of the work world in confidence”, she wrote in May 2013.

Above all, Sentinelle tells it like it is. Scrolling through the “Archives” section of the blog gives a clear picture of the idealistic young practitioner.

“The dictionary definition of a sentinel is a soldier or guard whose job is to stand and keep watch for the enemy, prevent surprises, and stop those seeking entry without permission and without identifying themselves. The sentinel must remain at his post whatever happens unless relieved by his officer”, she wrote in September 2005, explaining her choice of pseudonym.

Her initial enthusiasm soon gave way to questions and increasingly severe doubts. She queries where the profession is heading, its contradictions and before long, on the point of her own practice.

“Occupational doctors are still forever begging for the unique risk assessment documents that haven’t been written or stuffed away in cupboards and not updated; they are forever being told that they are not doing their job of making periodic visits when no-one in a number of firms asks them to help improve workplace prevention. Their job is to tick boxes like the new fitness sheet”, she wrote in her last blog, which dates back to October 2013.

“I started this blog with a vision of a shop where you put a number of things in the window to showcase the profession. Today, I see more dead ends than ways forward. It gets you down. It’s unpleasant to think there’s nothing you can do”, she said on the phone last July.

Asked about what led her into occupational health, Sentinelle, as in her blog, tells it straight: “I really wanted to be an A&E doctor. I had to give it up because the job didn’t fit with children and a family life”. Working in occupational health guarantees set hours, a 35-hour week and job security. “When I started out, I imagined a routine, same old-same old job. I found something else entirely – a fascinating and enthralling job. There aren’t many places where you talk about work. You don’t talk about it with friends or your partner – after a while, they get fed up with it – with your GP, who sees around 45 patients a day, you might as well forget it”, she says.

“My office is a place where you can untangle work stories. I try to see how working conditions can make them suffer. I get them talking, try to see where the rub is. The person opposite me might fumble for words, break down in tears, sometimes”, she reflects. “But I’m not there to act as a psychologist. I have to make decisions so as to fulfill our mission of preserving health”, she cautions.

To ensure that she does a proper job, Sentinelle, who works 4/5th time for her children, decided to do no more than 1 500 visits a year, whereas intercompany services often push their occupational doctors to see at least 3 000 workers each year. “The Code of Medical Ethics says that occupational doctors cannot work to dictates of profitability. If some day they force quotas on me, I will pack it all in. Happily, medical independence is fairly well respected in France”.

After nearly ten years in the profession, Sentinelle is wondering what direction to give her career. She often feels powerless, such as when the employer she is seeing is himself deeply upset at having to implement decisions taken thousands of miles away. Such situations, which she describes as “blind alleys”, have increased with the globalization of the economy. Asked about her personal future and that of her profession, she dodges the bullet: “The important thing is why we stay”. Despite the difficulties, Sentinelle is not ready to abandon her guard post.

“My office is a place where you can untangle work stories.”
Occupational health nurses – stopgap or architects of prevention?

The occupational health services reform of the early 2000s opened up the field of occupational health to other professionals than occupational doctors alone. One group – nurse specialists in occupational health – were destined, in a shortage of occupational doctors, to play an important role in the field of prevention at the workplace.

The post of works nurse is a long-established one in French workplaces, but only in big companies, having been a statutory requirement only in industrial firms with more than 200 workers and service businesses with more than 500 employees.

With French occupational health services turning more towards primary prevention entrusted to the multidisciplinary team (see main article), intercompany services now have to take on nurses trained in occupational health. Training has since 1995 been provided in ten French universities, but has only been a legal requirement since 2012 for nurses wanting to work for an occupational health service.

In Lille, Véronique Bacle heads the nursing centre in a social service that provides its members with occupational health nurses and social workers. The service now has 45 occupational health nurses.

“To start with, we met with a lot of resistance from occupational doctors. Gradually, cooperation developed and some fears were allayed. Occupational health was the only speciality where collaboration with nurses was not the natural order of things. Occupational doctors were used to working with their secretaries. They had to relearn to work with another profession in near-identical areas of work”, says Ms Bacle. She stresses the positive contribution of properly trained occupational health nurses to relations with employees because “they are more in touch with work-face experiences and have less of a medical approach than doctors”.

That said, Véronique Bacle admits the validity of some concerns, in particular the inclination of some heads of intercompany services to make up the lack of occupational doctors by recruiting nurses. A concern further heightened by the fact that since July 2012, occupational health services have been legally allowed to task nurses with duties related to the follow-up of employees’ health through the “nursing interview”. The nurse quizzes the employee about his health and occupational hazards following a protocol drawn up with the occupational doctor. If the interview turns up no problems, the nurse issues a “nurse follow-up certificate” which the employer can use to prove that he has fulfilled his obligations as regards employee health surveillance.

“The heads of intercompany services may see it as a stopgap for the shortage of occupational doctors, thinking that it will satisfy their members who are continuing to pay their fees when their employees may not have been seen by an occupational doctor for four years. Some think, ‘we’ll keep firms happy by offering them nursing interviews’. And suddenly, you’re getting back-to-back nursing interviews that may not even last half an hour”, laments Véronique Bacle.

Independence is another issue of concern. Occupational health nurses lack the protection against dismissal enjoyed by occupational doctors.

Véronique Bacle plays down this risk for nurses in intercompany services, however: “Organizationally, their line superior may be the director of the occupational health service; they are part of a team and share a number of ethical concerns with the occupational doctor”. “Where they are directly employed by the company, things are much more complicated. Then, they may come under tremendous pressure with regard to medical confidentiality and reporting of work accidents. That is why we are demanding protected status”, she claims on behalf of the SNPST occupational health professionals’ union of which she is an active member.

*Nurses more in touch with work-face experiences.*

* Not to be confused with the fitness-unfitness notice which remains the sole prerogative of occupational doctors.
“The independence of workplace health services is on the line”

“We need to look after our workers more”, opines work and health expert Frank Van Dijk. The commercialism of health and safety at work services has undermined occupational medicine thinks this ardent believer in a more humane work environment.

Pien Heuts
Journalist

Frank Van Dijk has made it his vocation as an occupational doctor to try and help sick workers return to their jobs.

Image: © Arenda Oomen
He is freshly back from Peru, where he was sent by the University of Munich to train researchers surveying the working conditions of domestic helpers in Buenos Aires and noise trauma in the Peruvian oil industry. The transfer and sharing of knowledge are a vocation for Frank Van Dijk, professor emeritus and member of the International Commission on Occupational Health (ICOH), especially in training for countries where there was no qualified support at the time.


1984: defends his doctoral thesis on “non-auditory effects of noise on health and well-being in industry”

Until 2013: university professor of health education, specializing in work and the environment, with the Coronel Institute which falls under the Amsterdam University Medical Centre.

September 2013: awarded an emeritus professorship. He continues to be concerned with post-academic training and remains active in the Netherlands Centre for Occupational Diseases.

Bio-express

1977-1986: occupational doctor specializing in toxicology. Internationally, he is active in the World Health Organization (WHO) and the International Commission on Occupational Health (ICOH), especially in training for countries where there was no qualified support at the time.

Frank Van Dijk developed his interest in occupational health very early on in his career. His GP practice was seeing patients with what could be work-induced symptoms. Apart from hearing disorders, very little was known about the effects of noise at that time – something on which he would later write his doctoral thesis. In 1977, he moved from general practice into work as an occupational health doctor. “Metal manufacturing and construction were obviously safety-conscious industries”, he says, “but little was yet known about the consequences of exposure to all sorts of chemicals and solvents. In the early 1970s, workers in some factories worked in a fog of asbestos fibres. Exposure to heavy metals was common and there were all manner of work accidents”.

In the 1980s, occupational doctors began to look more carefully at preventing illnesses that onset long after exposure. Although given short shrift by management when pressed on the suspicious number of bladder polyps and cancers found in rubber factory workers, this “awkward squad” doctor was backed by the Ministry of Social Affairs’ Health and Safety Inspectorate and preventive measures were taken. Chemical risk assessment is particularly complex in the rubber industry, not least because of the highly toxic fumes that could be given off in the vulcanization process. Frank Van Dijk collects scientific articles, earns information from suppliers, enlists help from safety and health professionals and specialised laboratories. Four years of painstaking work has enabled him to develop no less than 150 data sheets on the risks associated with manufacturing processes. “The British Industry Code of Practice drawn up in 1987 was immensely instructive here. Later on, new control banding standards were designed so that firms that couldn’t afford to take costly measures could still minimise workplace risks”, he adds.

Frank Van Dijk enthuses about his work. He is currently working on an opinion for sending to the Dutch Government for a new directive on health and safety at work services. The Dutch unions have lost confidence in the privatized workplace health services system (see article p. 14). Even though emeritus since last year and nearing 70, he is not ready for the pipe and slippers. He is still associated with Amsterdam University Medical Centre’s Coronel Institute for Work and Health where for the past 25 years he has been involved in countless studies on the health impacts of working conditions in his chosen fields of chronic diseases and psychological problems.

A member of the awkward squad

Frank Van Dijk

Mass layoffs

As an occupational health doctor, researcher and university professor, Frank Van Dijk has seen a trend that runs counter to the growing awareness of work-related diseases since the 1990s: a rising sickness rate among Dutch workers. The relatively high sickness absenteeism – 9% in the 1980s and ‘90s – had much to do with deep-reaching changes in the labour market. Industry relocated to low-wage countries, giving way to a service economy. Coalmining died in the 1970s, the shipyards and many industries were ailing, and aircraft manufacturer Fokker was in difficulties. “There were waves of mass layoffs. Employers and employees sat in works councils that were applying the work incapacity rules. Many employees with a health condition were declared permanently unfit for work and put on lifetime benefit, and so did not have to become registered unemployed. Occupational doctors did their bit to protect these vulnerable workers”, recalls Frank Van Dijk.

He also vividly recalls the tidal wave of those affected by the “scandalous” abolition of the work incapacity rules in the late 1990s. Close to one million people – one in seven workers – had been declared unfit for work. The Netherlands was the “sick man of Europe”. The Prime Minister made the problem his personal business. The 1996 reform of the Health Insurance Act (“Ziektewet”) would bring in privatization of the system and make employers responsible for absenteeism, reinstating sick workers and the continued payment of wages for a period steadily increased to the first two years. Frank Van Dijk, then a researcher at the Netherlands Institute for Working Conditions’ and

1. In which sulphur is commonly added to rubber to improve its strength with no loss of elasticity. Hot air vulcanisation gives off large volumes of fumes containing volatile components. The composition of the fumes varies widely with the mixtures used.
2. Nederlands Instituut voor Arbeidsomstandigheden.

1. It is now mainly all about controlling and reducing absenteeism.
"As an occupational health doctor, you have to take the lead and do your own research."

Frank Van Dijk. Why? In the late 1990s, reforms to sickness and work incapacity rules put workplace health services out to the private sector. From 1998, companies had to contract with a certified multidisciplinary service (health and safety at work service or ‘arbodienst’). From 2004, occupational doctors provided two years’ after-care for workers who were off sick, and the employer had to keep the worker on the payroll during that period. In 2005, the requirement to contract with an ‘arbodienst’ was scrapped.

Whereas workplace health services used to focus on keeping workers safe and healthy, it is now mainly all about controlling and reducing absenteeism. The big thing for employers and their insurers is to minimise the cost of absenteeism. Health and safety at work services, absence control firms and private professionals have been quick to exploit the opportunities offered to them by the situation.

Frank Van Dijk sees this as a bad thing. ”Company doctors now have hardly any contact with workers. They are the ones who have to get workers permanently back to work. As workers have to stay working for longer, it is clearly important to keep them healthy so they can cross the finish line in good order. The situation with regard to prevention is deplorable, apart from a few big firms. The number of work accidents has not gone down since 2005 and most occupational diseases are not detected or recognized. In small and medium-sized firms, the job of health and safety at work services is clearly to get workers back to work as soon as possible. Firms are advertising with the slogan ‘We bring absenteeism down’.

Loss of confidence

Confidence in the Dutch workplace health system is badly shaken. Many workers see the occupational doctor as an extension of the employer. A satisfaction survey done by the GfK market research consultancy in late 2013 found that 17% of workers are (very) dissatisfied with the occupational doctor’s independence. The absence follow-up contact service established by the FNV trade union in October 2013 reported that 41% of workers do not think the occupational doctor is impartial.

Frank Van Dijk says, “Workers should have more say in the contract that the employer signs with health and safety at work services. There should also be mandatory minimum measures for prevention. And there should be agreement on a minimum price so there is no possibility of dumping. And if the health and safety at work service had a multidisciplinary staff which included at least one professional at the top, you would be getting close to a perfect workplace health service”.

“We need to look after our workers more. They are an invaluable asset”, he says. He is not talking just about permanent employees, but all workers whatever their status, including sole traders with no employees. “We have to see that all workers have access to independent, quality health care. And why can’t that include walk-in health centre services?”

Whatever else, promoting employees’ health and detecting work-related disorders earlier means mainstream health services and occupational doctors working more closely together, argues Van Dijk. If GPs and specialists were to report work-related disorders earlier, the damage and absenteeism could be limited.

Because occupational doctors have little contact with employees’ work environments, they miss identifying many work-related diseases.

This is a big obstacle to a truly preventive management of the hazards of work; as a result, work-related health problems lead to increased absenteeism and even permanent incapacity for work.

The many studies done in association with the Coronel Institute in different sectors (construction, bus drivers, nurses and hairdressers) have left him convinced that prevention is a key means for promoting health in the workplace. He stresses the need for good information to be passed on to workers, preferably during training, and for cooperation at European level. “It is extremely important to share knowledge and experience, because the European labour market comprises 220 million workers. Think of the ‘new’ occupational diseases, the directives on prevention. There is virtually no innovation and coordination at present. There is a need to focus on setting up a European Institute for Work and Health with a network of professionals and scientists working to better support workers and businesses. That is where the investment needs to be.”

a university professor of health education, said: "With privatization, employers found themselves being made more responsible for their workers’ health. They suddenly saw a big financial interest in it. We strenuously objected to pre-employment medical examinations. I still see it as no mean achievement that the Netherlands was the only EU country to hold out against it. The only exceptions were pilots and bus drivers. Employers wanted to screen employees before taking them on so as to turn down any with even the slightest ailment. Blatant discrimination".

Returning workers to employability

Privatization and reform of the work incapacity system have made benefits much harder to claim. The upside, Van Dijk thinks, is the increasing focus on getting sick workers employable again. "We have taken a different approach to the relationship that people with a medical condition had with their work. Employees with a health problem no longer just get written off as unfit for work. All instructions on medical disorders that go out to doctors have to include a paragraph on ‘work’. It’s a much more human-centred approach”.

This gets Frank Van Dijk onto his hobbyhorse “It used to be that after a heart attack, you would stay bedridden for six weeks with all the grimness that entails. Now, two days and you’re back on your bike. In the Netherlands, we have done a lot of studies on the link between chronic illnesses and work, like diabetes and work; cancer and work; heart attacks and work; children, cancer and work; kidney transplants and work; hearing loss and work; vision disorders and work; rheumatism and work; depression and work, and the list goes on”. These scientific studies were done with the involvement of those affected. “We looked with patient groups at what they could still do and what support they needed to stay working in good conditions. Currently, the focus is on participation in the process of work, active employability measures and learning independence. Most people would rather work than be classed as unfit for work”.

Getting absenteeism in grip

Frank Van Dijk regards it as more people-friendly to help workers with an illness or disability return to being employable, to get them to participate in the labour market. It’s a process where occupational health services could play an important role. But occupational medicine has lost the status it once had. Its independence is on the line, complains Van Dijk. Why? From the late 1990s, reforms to sickness and work incapacity rules put workplace health services out to the private sector. From 1998, companies had to contract with a certified multidisciplinary service (health and safety at work service or ‘arbodienst”). From 2004, occupational doctors provided two years’ after-care for workers who were off sick, and the employer had to keep the worker on the payroll during that period. In 2005, the requirement to contract with an ‘arbodienst” was scrapped.

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“Isolation is killing people”
One day in the life of an occupational doctor

The scion of a family of doctors, and with an industrial hygienist for a father, Roberto Calisti’s choice of occupational medicine was almost an act of bravado. Family history aside, his hopes for society were what mostly drove him to his calling and nurtured an unflagging passion for his work. HesaMag joined him for a day, going from his understated office into the blacked-out workshops of the global economy.

Angelo Ferracuti
Journalist and writer
A smiling Roberto Calisti rolls up to the door of the health and safety at work department where he greets me with a handshake. This dandified and fine-featured fifty-something has a boyish air for his age – lightly greying hair and an easy-going but determined look, dressed in sports gear and carrying a dark blue canvas holdall. We are in Civitanova Marche, a town of 40,000 inhabitants on the Adriatic coast in the Marches region of central Italy. The parking lot where I left my car is half empty; the bar opposite stands closed as yet; opposite it is a primary school where a well-built woman waits looking uncertainly at the locked gate.

And so begins his day: we go up to the first floor and enter a spacious office where he greets a few colleagues – mostly women – and opens the door to his fairly cramped office, dropping his bag in the middle of a paper- and folder-strewn desk. To one side, near the entrance, is a smaller Formica-topped desk with a computer: this is where he writes reports and replies to emails, calls individuals or business managers, and pores over documents.

He is an occupational doctor handling “both pre factum and post factum” he specifies at the outset somewhat eruditely as our interview gets under way, “I mean the risk of work accidents and diseases, situations of maladaptive organization”; he is precise and passionate in talking about his work.

I break in to ask, “what does ‘maladaptive organization’ mean?” Frowning, he explains that this is precisely the most dangerous and complex area: “it is where health, safety and protection proper meet. People get sick because in their work setting they experience situations of harassment, or because insecurity is such that it produces stress. In other cases, it is the result of poorly-designed shift rotations, or generally events connected with work organisation”, he says confidently.

In past times, conflict was fuelled by the historic clash of capital and labour, I thought. Now, with the Berlin Wall gone and the class struggle ended, the situation often becomes insidious in post-modern societies, like that experienced by Albino Saluggia, the paranoid central character of Paolo Volponi’s novel Memoriale who for years dealt with wellbeing at work in Olivetti; the whole point is that the body revolts against violence by falling sick.

In Volponi’s novel, Albino believes the opposite – that the works doctors had falsified the reports to get him the sack. The book was published in 1963, before the era of the big industry set-up”, he recalls.

After graduating, Calisti went to work at the sharp end in the north of Italy, mostly in Orbassano, an outer suburb of Turin. This was an industrial centre based on metal manufacturing, dominated by Fiat Rivalta, the recently-shuttered historic firm established in 1968, but also comprising all the sub-contracting firms that made the seats and thefoundries that produced the wings and doors. “It was very much a traditional view of the firm with a boss who started at the bottom of the ladder, sometimes a former department head, but with an industrial-type mindset and a much more authoritarian attitude with a consciousness of being part of a wider industry set-up”, he recalls.

Calisti tells how things were more confrontational, when opposing interests were clearer in a time of contained crisis, and in an era of Japanese-style “total quality” (this is the late 1990s) where work paces were very fast because the need was to produce more and a wider range, while in the Marches region, dominated by textiles and footwear, the reality has always been that of small-, even very small-scale outfits. This was especially so in footwear manufacture where a closed, craft-worker mentality still prevailed, seeing themselves as self-sufficient in production terms and independent of all marketing networks.

“This kind of business owner has an abiding belief that they are on top of everything and don’t need help. A smiling Roberto Calisti rolls up to the door of the health and safety at work department where he greets me with a handshake. This dandified and fine-featured fifty-something has a boyish air for his age – lightly greying hair and an easy-going but determined look, dressed in sports gear and carrying a dark blue canvas holdall. We are in Civitanova Marche, a town of 40,000 inhabitants on the Adriatic coast in the Marches region of central Italy. The parking lot where I left my car is half empty; the bar opposite stands closed as yet; opposite it is a primary school where a well-built woman waits looking uncertainly at the locked gate.

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Coming back to the present and the Marches region, Calisti believes that working conditions in companies like Tod’s are good, disputes minor, stress-related illnesses less common; the trend is towards relations between the company and the individual. The owner sees regulatory agencies as a hindrance, populated by overpaid time-servers who go out into factories only to check piles of useless paperwork. "It’s the view taken by paternalistic, generous businessmen who say, ‘I don’t need help. But the reality tells us that nobody ever has everything under control: ‘Nemo solus satis supit, know-it-alls never know it all’, he proclaims, quoting something his father always used to say when he was young.

**An obsessive researcher**

He shows me his collection of asbestos fibres kept in a small cupboard at the rear of the office near the French windows giving onto the balcony. He is an obsessive researcher, but the material is also useful for teaching purposes. The killer mineral – asbestos – is wrapped in small packages of transparent plastic. There is even Eternit asbestos-cement removed from part of the exhaust of a Fiat 639 bus, Montedison Novara’s dark blue asbestos ribbon, and the asbestos-containing aggregate he collected from the Balangero mine where writer Primo Levi worked. In a collection of short stories, The Periodic Table, published in 1975, the author of *If This Is a Man* describes the environment in which nickel was mined in 1941: "There was asbestos everywhere, like a blizzard of ash: If you left a book for a few hours on the table and then picked it up you found the outline in negative".

We move to the surgery, which is tinier still than the office. A narrow bed is squeezed in up against the right-hand wall; there is also a desk and a small locker. "I think it works best when workers have to tell their own story," he says; in insider-speak, this is known as narrative medicine, a procedure not far off that used by sociologists.

Calisti’s work also used to include site checks on apprentices, but no longer – the works doctors paid by employers now do this, meaning that what once was a medical obligation is now often turned to other ends. "Very often it is about employee selection by stealth, i.e., ruling a worker as unfit for work, or a disabled person not up to it, which at a time of deep crisis like ours is a huge obstacle to getting a job and works to exclude people from the labour market for years at a time". This, he emphasizes, is not a problem unique to Italy because the rule he quotes, "the occupational doctor’s visits cannot be used as a means of personnel selection" is derived from the International Code of Medical Ethics. In Italy, however, the problem had become so acutely urgent that the ethical rule was implemented into legislation in 2008. Often, though, a worker will not accept the private doctor’s verdict and will appeal. "Then the public doctor makes a visit, will see the individual, may perform additional examinations and uphold, reverse or modify the judgment. It’s an important power". Generally, appeals show exponential peaks corresponding to events that are not health- but employment-related, like the pressures of work, and especially the risk of unemployment.

Calisti cites the case of people with disabilities who the medical board passed as fit for work subject to specific precautions being taken, but who were ruled as unfit by the works doctor when applying for a job. "The hardest people to get into work at the moment are those with a learning disability," he says. "Sometimes we have found a solution with the firm. Some paternalistic-style firms may take the attitude that this person is having it rough, we’ll take care of them. Good on them!"

Here in the doctor’s surgery is where patients come to identify occupational diseases. "We get people who are sick or afraid of falling ill, like those who have been exposed to asbestos; then, there is also the epidemiological aspect of it: that’s about figures, where we periodically check changes with different..."
4. Some of Italy’s occupational doctors are state employees attached to the public health system which guarantees their complete independence from employers. Along with their prevention duties, they also have powers to inspect workplaces and impose penalties on employers who breach health and safety laws.

5. This Tuscan town, the historic capital of the Italian textile industry, has in recent years seen many workshops bought up by Chinese businessmen who run them with sweated labour from China, including many underaged workers.

operation with illegal or off-the-books workers in an unofficial firm that is not registered with the Chamber of Commerce.

“These situations are less common now; they form pockets of poverty – people who have no way out, partly because they have no roots; they live in poverty with very little work. From a health point of view, we usually act on the hygiene conditions. Not far away, there is an entire building where I don't know how many live; all they have is a camp bed and skinny mattress each and a box with their personal belongings. They are like those southern Italians who went to Turin with no money to pay for shelter and slept in sleeping bags in the train station”.

Arriving at the gate, Calisti rings the doorbell, which is immediately answered by a young, tall, pale, very thin and frightened-looking Chinese man, who invites us in. “I am the occupational doctor, remember?” asks Calisti scouring his wallet for his ID. At this our host nods his head vigorously with a smile that seems to say, “Sure, I remember”. He was fined for covering the windows with black nylon curtains. Inside the workshop, knitted out in an old garage, we find work stations with sewing/stitching machines and an electric fan in the centre. The young Chinese man tries to explain in laborious Italian that they have few orders at present and there are only two of them to keep the workshop going. Times are tough. “Why have you blacked out the windows again?” Calisti asks sternly. The man looks flabbergasted and extremely embarrassed. He makes an elaborate gesture with his hands to shade his eyes and says it is to keep the sun off him. But the doctor is adamant: they have to go if he does not want to be fined again.

We get back in the car and head off to the old industrial zone which dates from the 1970s and still houses some small outfits, although many have closed or relocated to other countries, especially in Eastern Europe. Just down the street we come to another Chinese-owned workshop which Calisti says represents “the future”. The firm’s original owner went under; now an old-age pensioner, he still oversees production for the new Chinese owners after the company was taken over; it now employs 14 workers also from China. All are registered, the company complies fully with standards in all respects, and its products are fully “Made in Italy”. As we enter, a change comes over the young workers’ faces – their worry and concern are visible, and one anxiously phones through to the owner.

Calisti smiles and tries to put them at ease. “They have taken over a proper workshop and run it very well. Here again, we were called by the labour inspectors to check hygiene conditions, but in practice we have given an absolute clean bill of health on that front; the paperwork, on the other hand, was a disaster. We had to fine them because there was no risk assessment document. That’s why they are scared”. When the owner, a very polite elderly gentleman, arrives the doctor reassures him straight away that “everything’s fine” raising his arm and the young Chinese workers resume work with a smile.

By the time we get back to the workplace health and safety department offices it is already almost one o’clock, and the parking lot is now full of cars: today is report card day for the primary school, Calisti tells me. While he looks for a parking space, I ask him, what is the weakest link in the world of work today? His reply is immediate and unhesitating: the isolated worker. “The loss of relations and the resulting isolation are the worst aspects of our modern times for workers today and it’s something that sociology and especially medicine have not looked into much”, he says. He repeats something he said to me earlier about the fundamental principles of the French Revolution: “Liberty, freedoms – i.e., rights – are all very well; equality is fundamental; but there is no fraternity and Isolation is killing people”.

Calisti then tells me that for him the ideal company does not exist. Even Olivetti – a real Italian icon, especially for the left – the responsible company described by sociologist Luciano Gallino where sophisticated artists and intellectuals worked: “today, it has two problems: asbestos and aromatic amines; the cancer risk for the respiratory tract and bladder has been underestimated. Attacking Adriano Olivetti would be to show mean-mindedness and stupidity, but it shows that self-reliance does not exist even in the places where the culture of vigilance is at its highest”.

Leaving his office this morning, I notice two small frames hanging side by side on a corridor wall. Two black and white photos, with the kinds of populist wisdom that I generally loathe or find trite. But this time, one of them surprised me and I thought that by pure happenstance it had a lot to do with the work of Roberto Calisti and courageous doctors like him who have put themselves very much on the side of the weak. The picture shows a cityscape from the sky, with a quote from William Burroughs saying simply: “The most dangerous thing to do is to stand still”.

This article was written with the valuable assistance of Francesco Carnevale, historian of occupational medicine.

"I think it works best when workers have to tell their own story."
Support for occupational medicine in the Czech Republic is six times lower than in Germany

The Czech Republic has the longest-established tradition of occupational health in Eastern Europe. The beginnings of health care for workers can be traced to the development of the ore-mining industry. Occupational medicine as a special branch began to develop in the 1930s and flourished in the communist era. With the transition to capitalism, occupational medicine has been privatized and the country faces now an acute shortage of occupational doctors. HesaMag asked Milan Tucek, professor of occupational medicine at Prague’s Charles University, to take stock of the current situation.

Interview by
Břetislav Olšer
Journalist

Occupational health training in the Czech Republic has been undermined by the government’s austerity programme.
Image: © Břetislav Olšer
The number of occupational doctors in a country reflects the importance that society places on the profession.

Tell us a bit about how occupational medicine developed in the Czech Republic. What are its traditions and the specific laws governing it?

Milan Tucek — It is a very long tradition going back to the 1930s. The first occupational hygiene textbook was published in 1929. My own view is that occupational medicine was highly developed pre-1989 compared to other countries, albeit partly shaped by old socialist ideas. I feel there has been no significant targeted support for the field – which should be a key component of public health, along with hygiene and epidemiology – over the period that has seen capitalism restored to its current form in the Czech Republic. Globalisation and pressure towards specific ideas of competitiveness mean that social aspects of the field are being noticeably suppressed by business practices. This trend is, unfortunately, governed by the incentives applied to business and employee behaviour. A typical problem is reform of the accident insurance system, which has been consistently put off and now contains no incentives for employers to improve health and safety at the workplace but rather passive compensation for injuries and illnesses already incurred.

As a professor of occupational medicine at Charles University you have to compete with the supposed greater appeal of other medical specialities like surgery or oncology. Can individual fields of medicine be compared like that?

I don’t think they can, each field is different and specific. I think it’s less about competition than appropriate understanding of individual fields. It depends what you mean by the appeal of a field. Almost no medical students start out wanting to specialise in prevention; it takes experience and detachment. Where getting people to enter the field is concerned, the lack of support and understanding of its importance to society and business means that we only have about 16% as many specialists as Germany in comparable relative numbers. We have about 120 occupational physicians for five million production workers, though only 80 of them actually in practice. That comes to almost six times fewer than in Germany.

Is the simple number of occupational doctors a relevant criterion?

It is, because the number of occupational doctors in a country reflects the importance that society places on the profession. In the Czech Republic, austerity measures from 2004 to 2014 meant that occupational health was no longer supported as a core subject of medical training while others were. Vocational training for young occupational doctors has also been severely hit by these measures. At the same time, such public policies were a response to pressure from family doctors’ claims to be able to provide workers with the same level of occupational health services as occupational physicians. Current practice has proven otherwise, because the approach to occupational medicine...
Why has occupational medicine been marginalised in the Czech Republic compared to other EU countries?

The Occupational Medicine Society of the Czech Republic contends that through no fault of the professional community, the situation of occupational medical service provision in the Czech Republic has become quite unique as a result of well-developed legislation and a long tradition of risk assessment. But practice here isn’t the same as in other EU countries, including all our neighbours, Slovakia, Poland, Austria and Germany.

How is it unique and not the same as in neighbouring countries? What consequences does that have for workers’ health?

It is not the same because occupational hygiene, which deals with exposures, is not seen here as an independent technical domain but as a building block of medical doctors’ education. The faculty of occupational medicine was turned into a general medical faculty. I firmly believe that what is needed is not just a medical and clinical background but also knowledge about risk assessment based on evaluation of exposures. Of course, cooperation with non-medical staff in preventive services is compliant with EU law which has been fully taken over.

In 2014, occupational medicine returned to being a core subject of medical doctors’ education. But it is completely unmoved and unsupported by the state. When something has been missing for years, you cannot change things overnight. Hopefully, change will come. The key lies in a professional approach towards major hazards for occupational health. General practitioners are not interested in that. They are concerned with the health of individuals, not workforces. Workplace visits are extremely rare. They have no practical training in how to go about it. Freedom of enterprise is unchecked here.

This would not be possible in Germany, Slovakia, Poland or Croatia.

The result is that the causes of some work-induced problems are not an objective for some who deal with occupational health. Workers may fall ill. Workplaces suffer from a lack of prevention. Sick and injured workers are sent back to work too soon. They can suffer pressure of work while still sick. In such cases there is often no communication with the employer over improvements to the workplace. And the problems are even greater where physically-demanding work or older workers are concerned. As yet, only a minority of employers are sensitive to these problems in the Czech Republic.

European countries differ in wealth; is this reflected in local healthcare and the incidence of occupational disease?

Examination standards and practices in occupational medicine are very similar. The incidence of occupational diseases is not comparable between countries, since schedules of occupational diseases are regulated by different national laws, notwithstanding the existence of a European schedule. Also, occupational diseases cannot be seen as the primary concern of occupational medicine; the main issue tends to be the relationship between work, health and prevention, i.e. prevention of those diseases. Our principal focus is on providing high-quality professional advice, including at company level.

Is it fair to say that workplace prevention, including prevention services, is of a higher standard in wealthy countries?

Personally, I do not think so. It depends on what resources are allocated to health care, how the available resources are distributed, and finally how much goes to prevention. I am not talking about care for individuals, such as screening for colon cancer, which are funded by the insurance companies. Another key role in prevention must be played by the accident insurance system with a high share of prevention which, when accepted by society, can help deliver longer life expectancy and a better quality of life.

How would you characterise preventive health care in the Czech Republic?

Historically, we are an industrial manufacturing country, but one which has undergone major changes since the reintroduction of capitalism because new advanced technology has not been introduced and maintained everywhere and manual labour with overloading of the musculoskeletal system is still widespread. Many industries have disappeared or been transferred to other countries, but I think that we are still close to classical central Europe and significantly influenced by industry in neighbouring countries, especially Germany. We must not forget the hazards of agricultural work. The trade and services sector is expanding steadily, and has a very specific profile in terms of occupational medicine.

Where preventive health care is concerned, there has in recent years been a renewed focus on individual risks (tumours, etc.) for those insured by health insurers.

“We cannot look to save on labour costs by reducing health protection at work.”
"Occupational doctors try to determine suitable jobs for each individual. Unfortunately, this does not suit many employers who want 'one size fits all' workers."

That is a good thing. Interest in primary prevention of diseases is heavily influenced by media interest and people's motivation in general. With some exceptions, this is not too impressive or effective in terms of occupational health protection. The position of the social partners has been weakened in many companies, and accident insurance is ineffective. The results of prevention will not be seen immediately, but in the years and decades to come. Prevention is still a peripheral concern.

What are the priorities in regard to prevention and why?

Financial resources need to be used to motivate employers. A no-claims bonus system is a keystone of that. Then we need support for SMEs through reasonable programmes or specifically targeted measures for improvements in working environments. There is a clear need to tackle stress at work, night work, MSDs, work-related fatigue through monotonous work in difficult positions, vibrations and carcinogens including the manufacturing and application of nanoparticles.

We lack data on the economic benefits of investment in prevention because such investment may go against certain interests in health care. Also general public opinion is not favourable to prevention. Politicians tend to publicize bad examples in order to avoid addressing matters that are unlikely to have visible effects during their term of office. Evidence that prevention works can be validated only on the basis of sufficient data, preferably collected from insurance companies and disease registration, by epidemiological studies including biostatistics. The current data from the United States or Taiwan are unambiguous.

By contrast, the biggest source of workplace exposure is noise, but prevention is relatively effective so noise-related occupational diseases are rare. The hazards of allergic diseases – for example due to exposure to isocyanides, asthma, eczema and asbestosis – are underestimated. Eyestrain is a typical current work-related fatigue, especially for workers who work on VDUs. It requires a proper work regime and sufficient breaks.

Historically, miners, for example, retired earlier than other workers. How does an occupational doctor assess the issue of a miner inhaling dust underground yet smoking once back above ground? Is there a scale that takes this into account when assessing health problems?

It is wholly unreasonable for people in physically demanding jobs to keep on working into old age – the age of 70 is frequently mentioned. Occupational doctors try to determine suitable jobs for each individual and match medical fitness to individual options; unfortunately, this does not suit many employers who want "one size fits all" workers. This is pretty inconceivable for people with allergies or musculoskeletal problems, for instance. Personally, it concerns me that not enough is being done to take account of non-occupational influences on the development of some diseases. If someone is under excessive strain both at work and outside of work, it follows that they will fall ill more easily. Besides, a number of problems have not been resolved, such as the impact of work on allergies or the effect of passive smoking in certain occupations.

Employers have a duty to take care of their workers' health, but don't you believe that workers should also be the "architect of their own health"?

I don't know how employees or workers themselves could be the "architects of their own occupational health". Occupational medicine is a medical discipline that looks for a connection between work and health, and with occupational diseases, the root of the problem lies in the work itself. These days, people are afraid to admit to having these diseases; often they fear losing their jobs. The EU has stated that a healthy and motivated workforce is the source of its socioeconomic development, so a socially-oriented market economy is necessary. In my view, we cannot back away from this standard and look to save on labour costs by reducing health protection at work.●
Occupational nursing in the UK: preventing illness, promoting health and reducing absence

The first occupational health nurse was recruited in 1878 to work at the Coleman’s mustard factory in Norwich. Part of her job was to visit sick workers in their homes in the afternoons. There are today some 3 000 occupational nurses in the United Kingdom. While the nature of their duties has evolved considerably over the years, the profession’s image continues to be marked by its history. It is not always easy, accordingly, for practitioners to know exactly where they stand between their role in offering support to workers and that of preserving employer interests.

Rob Edwards
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One key task of Britain’s occupational health nurses is to provide sick workers with moral support.

Image © Belga
At the age of 45 Dipti feels her life is starting to fall apart. She is finding her job as a secretary increasingly difficult because her eyesight is deteriorating. She has type 2 diabetes, high blood pressure and is overweight.

John (25) is having trouble coping with his work in a call centre. He is under pressure to meet performance targets, works long hours and gets stressed. He suffers from obsessive-compulsive disorder, and is worried that he is going to have to take sick leave while he waits for an appointment for therapy.

Tracy (32) is worried that her job is disabling her. She has worked in a small bakery for five years and has become allergic to flour dust, which has turned her into an asthmatic, wheezing and short of breath. She is trying to live with her symptoms.

Three workers who face debilitating occupational health problems: three workers who – given the right experience, expertise, and resources – can be helped. In different ways, they all illustrate the vital role that can be played by a UK profession that seems unmatched in most other European countries: occupational health nursing.

Dipti’s kind of diabetes, for example, is suffered by nearly three million people in the UK and is often linked to being overweight. Occupational health (OH) nurses can help companies provide incentives for staff to walk or cycle to work, and to make sure there are healthy, attractive options for lunch in the works canteen. At the same time, Dipti can be given access to regular eye tests.

As many as one in six workers are, like John, reckoned at any one time to be suffering from anxiety, depression or stress. But OH nurses can help employers learn how to reduce mental health problems by improving work practices. They can also help John to better understand his needs and, if necessary, help him to find another job.

Tracy, as one of 450,000 new cases of occupational ill health in the UK every year, can be given access to expert advice on her condition. OH nurses can help her managers understand how to reduce exposure to dust in the workplace and try to ensure that no more bakers are made sick like Tracy.

Dipti, John and Tracy are just three of the typical cases highlighted in a 2014 report by the UK Council for Work and Health, which brings together OH nurses with a wide range of other medical professionals. The council is working on a project to envision how occupational health in the UK might develop over the next 20 years.

The project’s leader, Professor John Harrison from Imperial College Healthcare NHS Trust in London, has summarised what OH nurses do. “Occupational health professionals improve the health of the UK’s working population, increase the productivity of UK businesses and enable our public services to become more efficient and cost-effective,” he said.

“It is a unique multidisciplinary approach that prevents work-related illnesses, provides early interventions for those who develop a health condition, reduces sickness absence and uses the workplace to promote health and wellbeing. We are distinctive because we offer a holistic approach that focuses on the person, their work and the business rather than just the disease.”


Need to gain trust

Janet Patterson (43) is occupational health coordinator for the baking company, Greggs, in Newcastle-upon-Tyne. The company employs over 20,000 people in making food and selling it in High Street shops across Britain.

“Occupational health (OH) nurses need to gain trust of all dimensions by demonstrating credibility, honesty and no personal self-interest – it’s all about the people,” she said. The job, she explained, has evolved from being mostly reactive in dealing with sickness and accidents to being 80 per cent preventative.

“OH nurses empower individuals to take care of themselves in both mental and physical wellbeing,” she said. Employers often bring in occupational health expertise to meet legal requirements for health surveillance of workers, but it could provide a great deal more than this.

Patterson was concerned that in times of austerity, occupational health could be chosen for cutbacks. “Businesses are wanting more for less,” she maintained. “More are opting for a tick-box service where they just get what is legally required.”

She also feared there were problems ahead. “The future of OH nursing is in a state of uncertainty due to questions about the qualifications and changing direction of OH nursing,” she said.

“Some OH nurses don’t feel like nurses and some don’t want to lose their nursing identity.”
For Susan Everton, vice-president of the UK Association of Occupational Health Nurses, the primary role of OH nurses was to identify hazards at work, assess the risks and prevent ill health. This can involve dealing with senior management at a strategic level, as well as with individual workers at a personal level.

The most important tasks that OH nurses do are “assessing the health needs of the employee and trying to match those to the resources available,” she said. “The OH nurse should be in a position to influence the decision-makers, and increase their awareness of their responsibilities toward the health and wellbeing of their employees. The OH nurse should also offer appropriate support to the individual to enable them to perform to their optimum level.”

Barbara Wilson, a manager with the occupational health company Clarity Healthcare, argued that OH nurses have to understand the needs of employer and employee, and the specifics of the jobs they do. "In short, we know the difference between a multispindle centrifugal lathe operator and a sagger maker’s bottom knocker,” she said. (One operates a high-tech lathe, the other makes pottery boxes.)

The first occupational health nurse

The first OH nurse in the UK was Phillipa Flowerday, who was 32 when she was appointed on 28 October 1878 to work at the Coleman’s Mustard factory in Norwich. To help better the health of workers, she worked as an “industrial nurse” alongside the company doctor every morning, and visited people in their homes in the afternoons.

Her historic role is recounted in a new textbook, Contemporary Occupational Health Nursing. The book explains that OH nursing was first formally identified as a special field within the UK nursing profession in 1934, when the Royal College of Nursing launched an industrial nursing course. Since then it has mushroomed.

By May 2014, according to the Nursing and Midwifery Council, there were 3,461 registered OH nurses in the UK, slightly more than in 2011 when there were 3,447. There is no detailed breakdown of where they all work, but they are roughly divided between the public sector, including the National Health Service, and the private sector.

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Preventing ill health

Sue Plant (55) has worked most of her professional life as an OH nurse for the government of the Isle of Man, situated in the Irish Sea between northern England and Northern Ireland. “I dealt with guys who dig holes in the roads, bus and tram drivers, teachers, and airport firemen among others,” she said.

“The most important thing an OH nurse does is to prevent ill health. This can be achieved by education of the workforce through presentations and health advice and education, but also via vaccinations, health surveillance where a risk assessment has identified a need for it, and being accessible.”

Plant stressed the importance of not being tied to a desk. “I was more interested in getting out there, meeting the workforce, solving problems and listening to what was going on. That was far more satisfying than being stuck in an office pouring over policies and paperwork.”

Like colleagues, she was worried about the impact of the economic downturn. “I think that the most difficult challenge OH nurses face is that they constantly feel that they have to justify their usefulness at a time when the recession has led to cutbacks, especially in the private sector,” she said.

“In the harsh world of the private sector you have to convince clients of how using OH services can benefit their business. There was a campaign some years ago with the slogan ‘good health means good business’ and this still holds true. But when finances are tight, occupational health can often be the icing on the cake that never gets applied.”

Providing evidence-based fitness to work advice

Karen Coomer (47) is director of KC Business Health in Yorkshire, a company that provides occupational health services to small and medium-sized firms. “I could be working for as many as five different organisations in one week providing services such as case management, health surveillance and training,” she said.

She said that, in her view, the most vital things that OH nurses do are “to understand the culture, risks and nature of the work environment in order to provide evidence-based fitness to work advice and prevent ill health.” This not only included knowledge of traditional occupational health diseases and the causes, but also psychosocial aspects of work.

According to Coomer, one of the main challenges was the lack of understanding of the role of OH nurses by other health professions, including doctors. There were also problems “persuading organisations to invest in supporting long-term prevention of ill-health at work, not just trendy fashionable quick fixes such as some wellness initiatives,” she said.

OH nursing will need to adapt as more people carry on working in old age, she warned. “It is crucial that we look towards the changes necessary to sustain ageing workforces. New health issues such as dementia are now being managed in the workplace and musculoskeletal problems are still an issue with older manual workers.”

2. http://www.aohnp.co.uk/
Health Service, private companies and commercial occupational health providers.

This means that OH nurses work for many different employers in many different environments: for multinational corporations, small businesses, local authorities and other public agencies; at offices, factories, power stations, oil rigs, construction sites, railways, shipyards, airports and numerous other places. Their tasks can include medical screening; hearing and skin testing; pollution surveys; vaccinations; virus analysis; first aid; rehabilitation and managing those off work because of sickness.

There is no doubt that they are addressing a serious problem. According to the Council for Work and Health report, about 12 000 people are killed annually in the UK by diseases caused by their jobs. Every year 400 000 people report that stress at work is making them ill, and a massive 175 million working days are lost to ill health (see box).

These problems are replicated in other countries, with the United Nations’ World Health Organisation estimating that there were 300 000 work-related deaths across Europe every year. Yet less than one in ten of the working population had access to occupational health services in many European countries, it said.

Getting people back into the workplace

The UK’s historic commitment to occupational health was highlighted by Kira Duckworth, a lecturer in OH nursing at Robert Gordon University in Aberdeen. “OH practitioners are seen as a specialised workforce who should be highly trained not just in medical knowledge but also in health, safety, management and who should also have a good understanding of how business works,” she said.

“The government has focused on OH services and recognised the role they can play to help ensure a healthy workforce, with the emphasis on getting people back into the workplace. OH professionals recognise that many people with disabilities can lead long and productive working lives, but often just require a few adjustments to do so.”

Duckworth pointed out, though, that OH nurses still face important challenges. Many work remotely and feel isolated from others in their profession. Some employers fail to understand the importance of hiring properly educated and trained professionals. Sometimes employees see OH nurses as part of management, and being referred to them as a reprimand.

But there are great opportunities too. “I think we are on the cusp of a big explosion of OH services,” she said. “With government focus we hopefully will see the role develop further with more recognition on how an OH service can help keep the working population healthy and safe whilst at work.”

Susan Everton, who has been an OH nurse in London for nearly thirty years with the BBC, the police and the engineering services company, Lloyd’s Register, stressed how important it was to have good interactions with other professionals. “There needs to be trust between the OH nurse and the patient but also a clear understanding of what the OH nurse can do to support the employer in their business strategy,” she said.

“This cannot be done in isolation and often requires good communications with human resources, safety professionals other health professionals – physical and psychological and the employee’s primary health care support. The OH nurse needs to promote, protect and prevent.”

Everton is worried that some employers are cutting back on resources for occupational health, and that there is sometimes not enough support from senior management. “There is always a big debate about the cost of in-house provision or contracted services,” she said. “Many organisations look at the short term and do not always see occupational health as the investment in their people and their business that those of us in the profession do.”

Nevertheless, she was upbeat about the job. “I think it can be a really rewarding branch of nursing, because there is so much variety and opportunity to extend the role of care of a person who in most cases is not ill,” she said. “Often the OH nurse is the only one doing that job in an organisation.”

There was great job satisfaction when things worked well, Everton concluded. “There is quite a buzz to be felt when you know that some programme you have introduced, or some intervention you have organised, or some examination you have performed, has made a real difference to an organisation or an individual, particularly in difficult environments.”

Helping the employee return to work

Jeremy Smith (47) is a self-employed occupational health consultant in Kent. “I have worked in the National Health Service, the ports industry, the gas industry, local government, manufacturing and retail – to name a few,” he said.

“Occupational health is not about finding a cure; it is about advising both the employer and the employee on what they should consider in helping the employee return to or remain in work.” He reckoned that at the moment about 40 per cent of his work was prevention and 60 per cent reactive. In previous jobs, though, he said he had been more preventative and worked strategically with management to improve worker health.

“In my opinion the most important thing any OH nurse can do is make sure any advice they provide is evidence-based and as current as possible,” he said. There could be problems, he added, when employees are reluctant to hear that they are fit for work, or when employers refuse to act on advice and fail to manage their workforce.

Occupational health in the UK – the facts

- 175 million working days are lost due to ill health every year.
- After six weeks off ill, nearly one in five people will eventually leave paid employment.
- Every year about 400 000 people report work-related stress at a level they believe is making them ill.
- 80 per cent of the adult population will suffer with back pain at some time in their working lives.
- 12 000 people die every year from occupational diseases – brought down by lung diseases, poisoned by asbestos or eaten away by cancers.

Nantes/Saint-Nazaire dockers battle for health

Up to 200 of them spend their days unloading the thousands of tonnes of cargo shipped into the French port of Nantes/Saint-Nazaire. It’s a hard job, and while they now run fewer physical risks, dockers are today exposed to the “soup” of chemicals that impregnate cargoes. Wearied of seeing friends struck down by cancers, they have set going a research programme that retraces their toxin-exposed working lives.

Nolwenn Weiler
Journalist
The port of Nantes/Saint-Nazaire stretches for over 60 kilometres of Atlantic coastline along the Loire estuary. At Montoir-de-Bretagne, one of the port’s component sites, towering cranes loom over the waterfront, while miles of conveyor belts like hanging treadmills slice across the eye line. "They carry the bulk cargo (from ships’ holds – ed) to the warehouses at the back", says Karl Montagne, 30 years a stevedore.

He hails a colleague overseeing the winding-up of discharging from the deck of a cement carrier. At the bottom of the 30-foot deep holds, dockworkers bulldoze the cement around. Clad in white coveralls, they work in clouds of dust and exhaust fumes, wearing basic "pig snout" respirators. It’s little enough protection against the silica contained in the cement, which can cause silicosis, chronic bronchitis and cancer. "They’re not much help against engine exhausts, either", grimaces Karl Montagne, "seeing as all the handling equipment lowered into the hold is diesel-engined!" In June 2012, diesel exhaust gas was classified as definitely cancer-causing by the World Health Organization (WHO).

Dock work has always been a risky business. But regular exposure to carcinogenic chemicals poses a particular threat. Chemicals “are an invisible enemy, everywhere but unseen”. “Before, to discharge logs, you had to climb up the pile. There was almost always a risk of them collapsing with you underneath”, mulls Christian Zimmer, a docker like his grandfather. "Now it’s mechanized. There are many fewer physical work accidents, but the wood is riddled with chemicals! Like everything else”.

The soya landed at Montoir-de-Bretagne has been sprayed with pesticides before shipping to prevent fungi, rodent and insect contamination. And when the ship docks on this side of the Atlantic, the atmosphere is sometimes so unfit to breathe that the stevedores have to leave the holds open for hours before starting work. "When the hatch cover is lifted, this chemical fug hits you in the face so you have to turn away. When you’re in the hold, it makes you feel sick (...). They say no rat or insect could live after being sprayed with it!” testify some longshoremen. “Petroleum coke is the worst”, says Karl Montagne. “That is really disgusting. It’s so bad that you can’t prep (discharge and give a full wash down – ed) more than one coke hold a day”. Coke is a black, solid by-product of oil refining. Composed mostly of carbon, it contains large amounts of pollutants like sulphur and heavy metals.

**Toxic careers**

Never having bothered about these dangerous compounds, the Nantes/Saint-Nazaire dockers realised some years back that they might be making them sick or even killing them. “That’s down to Jean-Luc Chagnolleau”, says Karl Montagne. “He’d been a docker for 30 years, and felt there must be a link between his kidney cancer and his job, especially since he had always had a very healthy lifestyle. So, shortly after he was diagnosed in late 2007, he decided to quiz his co-workers about their health. He found out that he was far from alone. Of the 243 dockworkers contacted, 85 said they were suffering from a serious disease, predominantly cancer of some kind, while 43 had died, most from cancer-related complications – lung, prostate, kidney, colon, throat, larynx, bladder, oesophagus, pancreas, liver, rectum, stomach, etc.”

Cancers seem to home in on dockers. Their life expectancy has shortened by 10 years. “Jean-Luc was flabbergasted”, recalls Serge Doussin. "Us, too". Encouraged by onco-logists, Jean-Luc Chagnolleau and his union colleagues set up an association for workplace health protection for Loire-Atlantique port workers (APPSTMP44). "The aim was to support further research and publicize the tragedy of work-related diseases", says Serge Doussin. Well-used to fighting for labour rights, all or nearly all the close-knit group of Nantes/Saint-Nazaire dockers signed up to the association. “There is real unity and active solidarity between them”, estimates Serge Doussin, president of the association since Jean-Luc passed away.

Their active engagement supported by various doctors and stakeholders in prevention resulted in a research action project – “Escales” – being set up in October 2012. Funded by the Loire-Atlantique Regional Council and supported by the regional department for business, competition, consumer affairs, work and employment (Directect), Escales aims to retrace the toxin-exposed working lives of dockers with serious illnesses.

“We did thirty three-hour interviews over 18 months”, says project leader Christophe Coutanceau. “Dockers with a cancer gave very detailed descriptions of their working conditions: what kinds of tools were used? Was the atmosphere dusty? What equipment did they have? etc. We then deduced

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**Combined exposures do not fall within the current criteria for recognition of occupational diseases in France.**
combined exposures ignored

"The study is showing up the main carcinogens that blight workplaces", notes sociologist and Escales’ Scientific Director Véronique Daubas-Letourneux – "asbestos, diesel exhaust gas and PAHs. We are also finding pollutants specific to dock work: arsenic-laden or –free wood dust, pesticides, hexavalent chromium". Is the daily exposure to this toxic mix behind the high number of cancers found from 2008 by Jean-Luc Chagnolleau? Retracing an individual’s combined exposures to multiple carcinogens does not identify the single cause of that cancer.

"It is most likely that each of the different carcinogens the individual was exposed to has played a role in the overall process that gave rise to the cancer", suggests the Escales study. Data is lacking on the health effects of synergy between chemical molecules. But those that are available show that, at best, the risks are cumulative: where there is exposure to two products, the individual effects of each are combined. But often – especially where carcinogenic molecules are concerned – the effects are multiplicative. That means the risk is not doubled but multiplied 50-fold!

Combined exposures do not fall within the current criteria for recognition of occupational diseases in France, with one exception: a former employee at the Givors glassworks, on the southern outskirts of Lyon, who died in 2012 and has just been recognized as having suffered from occupational cancers resulting from combined exposures to multiple carcinogens. "What generally applies is the asbestos schedule", says Véronique Daubas-Letourneux.

But that is the tree that you can’t see the wood for. The specific provision made for it means that asbestos (which remains a real danger) has in practice overshadowed other occupational toxins. "The social security schedules that provide guidance for the identification of work-related cancers need to move with the times", insists Gilles Rialland, a port worker and secretary of APPSTMF44.

"We want them to include combined exposures as the cause of diseases among workers". In order to get combined exposures to multiple chemicals into the scope of social security, the association’s members plan to step up the claims for recognition of occupational diseases in the hope that successes will establish precedents. "The next step is Jean-Luc’s case" says Gilles Rialland. "We managed to get judgment stayed so that the lawyer could include the inventory of toxins drawn up by Escales in his oral arguments".

Half-hearted prevention

Normally, employers have a duty to retrace workers’ past exposures to toxins. But they never do. "The certificate listing exposures to carcinogens, mutagens or reprotoxins that every employee is meant to have just doesn’t exist", says Christophe Coutanceau. Almost no-one has it. The occupational doctors who are meant to issue it don’t necessarily know about it. And anyone trying to get information on the chemical molecules used can come up against an employer’s brick wall.

"Another problem we have is the worldwide movement of goods", adds Véronique Daubas-Letourneux. "Steedoring companies that hire dockers don’t necessarily know what chemicals are used on goods loaded on the other side of the world". "We have to deal with the researchers and lawyers who investigated the claim. See: http://www.verriers-givors.com

French labour law requires employers to declare products and processes leading to an occupational disease and the occupational doctor to certify exposure in all cases where an employee has been exposed to carcinogens, mutagens or reprotoxins.
Collective knowledge production gets official recognition

Cross-fertilisation of workers’ pragmatic knowledge and experts’ learned knowledge has been held to be a valid methodology for showcasing combined exposures to multiple chemicals by prevention professionals and Labour Ministry representatives. “This recognition is a result in and of itself”, says Véronique Daubas-Letourneux, Scientific Director of the Escales survey. “It has to be said that we have strong ongoing regional support for research relating to occupational diseases”. Another singular local feature is the energies of the group of workers who initiated the project. “That won us the unprompted confidence of workers that a researcher could have taken months to gain”, says Véronique Daubas-Letourneux. It will also facilitate the downstream work of informing port workers – dockers and others – at first hand and helping sick workers trying to get their illness recognized as an occupational disease.

In France, two other groups are working to similar methodologies: the Association pour la prise en charge des maladies éliminables (AP-CME – eliminable diseases support group) near the port of Fos-sur-Mer (Marseille region), and the Groupement d’intérêt scientifique sur les cancers d’origine professionnelle (Giscop – scientific interest group on occupational cancers) in Seine-Saint-Denis (northern suburb of Paris).

More on these projects at: http://www.etui.org/en/Topics/Health-Safety/Occupational-cancers/Union-campaigning

From the unions 4/4

7. Mini-bulldozers (calf dozers) equipped with a grab bucket used in holds or on the wharves.
8. Quote from the exhibition “Dockers, corps à l’épreuve” staged as part of the “Escales” study.

(raw materials like coal – ed) which helps to bind dust”, acknowledges Christophe Coutanceau. “But not in every case, far from it!” laments the researcher who believes that “the port industry generally is lagging way behind in protective provision”. Another possibility would be to have pressurized cabins on the minibulks7 used by holdmen that would protect drivers from dust and exhaust fumes. But these don’t seem to be in the spending plans. Even the respirators that are sometimes used are rarely satisfactory. “You can’t breathe with these on when you have to strain”, recounts one docker. “They need to invest in more sophisticated equipment”. “They don’t listen to us”, protests another. “You ask for a vented mask and they say it costs too much!” However that may be, protecting workers against the chemicals in cargo ships is a real conundrum. The Le Havre customs officers who protested in 2010 against the high levels of pesticides in the shipping containers they had to inspect have studied the problem closely and concluded that “the only certain sure equipment is that worn by firefighters in emergency interventions. But it is not suitable for everyday use because it is much too cumbersome”.

Transform work

Effectively protecting employees is not just about equipment, but also looking again at work organization. “Men can’t work for eight hours straight wearing individual respirators”, says Christophe Coutanceau. “They need a break every couple of hours”. “If there are too many constraints, traffic may be diverted to other ports”, argues Dr Philippe Breuille. “Not least because of the various European and international instruments saying that there must be no barriers to free trade”. The Transatlantic Partnership Agreement being negotiated since July 2013 by the United States and the European Union is even mooting the idea that special courts could levy massive fines on states if laws (e.g. protecting employees’ health) were to diminish a firm’s "expected future profits"!

Dockers are split over the issue. Some argue that prevention is vital and do not want to yield ground. Others fear seeing the work go elsewhere. “Asking too much could easily cost us our jobs”, sighs one. “But for us, health at work and the long-term future of the port are not an either-or thing”, stresses Serge Doussin. “Anything but! If the job is to keep going, you have to preserve the skills and see that they are passed on”. Committed to their work, and proud of their know-how, the dockers want to pass on their knowledge to the next generation. “But we want to do it without risking our lives. We’re fed up with seeing mates go so young. It hits hard”.

"Asking too much could easily cost us our jobs."
Rana Plaza: international community must keep up the pressure

More than a year on from the Rana Plaza tragedy – the textile industry’s worst-ever disaster – most of the top Western clothing brands have pledged to improve workshop safety. But with no real progress in trade union freedoms, Bangladeshi workers will struggle to enforce their right to dignity.

Silvana Cappuccio
CGIL (Italy)
Former head of occupational health with the International Textile Workers Federation. Author of the exposé of the jeans industry, Jeans da Morire.

25 April 2013. Rescuers search the rubble of the collapsed Rana Plaza for survivors.
Image © Belga
Commemorations were held the world over on 24 April this year for one of the worst tragedies in industrial history – the collapse in 2013 of the Rana Plaza building in the Bangladeshi capital Dhaka killing 1,138 people and seriously injuring 2,400 more. All the victims – most of them young women – were toiling in five workshops inside the building making up clothing for export to the West.

For a while, the tragedy made international headlines, when normally exploitation of the weak and their daily woes gets little media coverage. The images from the rubble of the five floors that collapsed in minutes, showing scattered piles of machinery, merchandise, bills and battered bodies, the reports of desperate scrabbling to pull out survivors and the grief of prostrate families beamed around the world, created a furore. It was widely and rightly castigated as industrial mass murder, with claims that such a calamity could have been averted had the will been there and the grim precedents not been ignored. A cast-iron argument, given the 700 workers killed between 2006 and 2013 in Bangladesh’s garment industry alone.

The images and reports sparked pledges of help and solemn undertakings from the international community, institutions and civil society aimed at two main things: ensuring that such tragedies never recur; and applying the full force of the law by prosecuting those responsible and getting “fair” compensation for survivors and victims’ relatives. The UN’s tripartite labour agency, the International Labour Organisation (ILO), expressly called on the Government of Bangladesh – the world’s biggest exporter of clothing second only to China – to hold manufacturers and distributors liable for their omissions and neglect. Clothing brands and their international clients were also called on to shoulder their own responsibilities for improving working, health and safety conditions.

The decisions proclaimed at the time are reviewed here to see if the words have been turned into deeds, or if the outpourings of outrage were just a knee-jerk emotional response that has faded with time.

**Accord and discord**

Among the first international initiatives was the international Clean Clothes Campaign (CCC) launched by trade unions and non-governmental organisations through a petition urging the clothing brands whose garments are made in the disaster-struck workshops to take practical steps to see that such tragedies never happen again. Their lobbying prompted some 160 big Western clothing brands who source from more than 1,000 factories in Bangladesh to join with the international federations of textile workers IndustriALL Global Union, and service workers UNI Global Union in signing up to a five-year agreement on fire prevention and building safety on 15 May 2013. The companies include Sweden’s H&M, the biggest buyer of Bangladeshi-made apparel, Holland’s C&A, Spanish brands Inditex (Zara), El Corte Inglés and Mango, British retailers Primark, Tesco, and Marks & Spencer, Germany’s Tchibo, Hess Natur, Adidas and Puma brands, and America’s Abercrombie & Fitch and American Eagle. US group PVH Corporation – parent company to Calvin Klein, Tommy Hilfiger and Izod – has agreed to update a similar agreement already signed in 2012. Gap originally intended to sign but finally pulled out citing concerns about possible legal liability (sic!). Italian brand Benetton joined the Accord under strong international
pressure after evidence was found in the rubble of its relations with suppliers who sourced their production here through middlemen.

The brands pledged to put money into improving textile workshop safety in Bangladesh, allow independent inspections of workplaces and fund the commitments arising from it, starting with improving building safety. The Accord re-enacts the provisions of ILO Convention No. 155 by which workers have the right to refuse to do unsafe work, and requires signatory companies to terminate business relationships with suppliers that refuse to carry out checks and improve safety. To date, only 500 out of an estimated 5,000 garment factories have been inspected. Irregularities – some serious – were found in most, but production was halted in only eight cases.

The agreement also provides for workplace health and safety committees to be set up, with at least half the seats going to elected workers’ reps. The clear question arises, though, how such provisions can be implemented in a country where freedom of association and the right to bargain collectively are denied, and where after strong union pressure the minimum monthly wage in the textile industry was set in December 2013 at $68 – less than what is decent enough to live off.

Just a fortnight after the collapse of the Rana Plaza, the Bangladesh government yielded to international pressure and announced plans to give 3.6 million textile workers a statutory right to join a union, when previously they had to get the factory owner’s permission. The pronouncements were reported in the international press as marking a turning point in people’s lives and work. Sadly, they were just empty words, and people are still living and working in conditions that are anything but those of a free life worth living. The hollow joke is that Bangladesh’s biggest textile industry bosses are embedded in the political establishment, Parliament and in any event the ruling parties, and have no plans to tighten up laws that could hit their own pockets.

More: within mere months of these wage increases, garment manufacturers began bemoaning that brands that sourced from them had allegedly threatened to move their orders to Cambodia, Ethiopia, India or Vietnam if higher pay was passed on into the cost of the goods.

The Accord is certainly positive and innovative of its kind, but to get it enforced, workers need to have the freedom to join the union that will protect their rights, in which they are democratically represented and have the means to bargain collectively for their pay and work conditions. That requirement is still nowhere near being met. Universal human rights therefore demand that trade unions, governments, institutions and the various actors of the international community keep up the pressure.

“Due diligence”, anyone?

At the end of 2013, representatives of the Bangladesh government, the local and international clothing industry, trade unions and non-governmental organizations set up the Rana Plaza Coordination Committee with the ILO acting as a neutral chair to set going a process to provide financial and other support to victims and their families through an agreement known as “the Arrangement”. Under this, financial awards are calculated in line with the requirements of ILO Employment Injury Benefits Convention No. 121, and the whole procedure is to be coordinated by a multi-stakeholder committee to ensure that all victims receive an advance of 50,000 taka (about 470 euros).

For this, the Rana Plaza Donors Trust Fund was set up, open to companies, organizations and individuals wishing to provide financial and medical assistance to Rana Plaza families. Sadly, no consensus proved reachable on the criteria for setting up the fund due to a point-blank refusal by the multinationals that had been even briefly customers of the manufacturers concerned and their ongoing mutual buck-passing at the expense of the workers. The fund is neither one thing nor another, and lacks the characteristics of the compensation mechanism it should have been. It was designed as a voluntary means of expressing solidarity, open

2. www.ranaplaza-arrangement.org
3. The list of “donor” businesses can be found on www.ranaplaza-arrangement.org/fund/donors/donors
4. “Due diligence” is the process whereby organizations identify, prevent and mitigate their own potential or actual negative impacts and to realize how they themselves manage relationships with their suppliers and subcontractors.
to not just multinationals but also government, businesses and business federations as well as trade unions.

The results are a let-down in every respect. Morally and legally, the failure to assign liability speaks for itself. The fund-raising procedure started on 24 March 2014 has yielded underwhelming results. Two months on, only a score of companies had contributed, including Primark, C&A and Mango. And their manifest responsibilities notwithstanding, neither the Bangladesh government nor business federations have paid a penny.

A year on from the collapse, the NGOs engaged with this issue joined with Bangladeshi workers and local and international trade unions to launch the “Pay Up Now to the Rana Plaza Trust Fund” campaign aimed at the big clothing brands. Many of the workshops’ customers still do not want to pay into the international fund for victims. The garment manufacturers’ association has cold-shouldered it, admitting only the equivalent of the wages owed to the Rana Plaza workers. Of the US$ 40 million deemed necessary, only US$ 16 million has been paid. But just 1% of the annual turnover of the clothing brands that are Rana Plaza’s customers would cover the full amount of awards due. Companies that have not contributed include such names as Auchan, Benetton, Carrefour, Iconix (Lee Cooper) and JC Penney. Spain’s Inditex and Dutch firm C&A, by contrast, as major customers of Bangladesh, have paid into the fund even though they are not supplied by Rana Plaza manufacturers.

The UN Working Group on business and human rights has reminded the big corporate customers of their responsibility to conduct “due diligence” on all their supply chains, according to the principles of prevention and remedying of human rights violations. The governments of countries where corporate customers are located (especially the United States and the European Union) have been reminded that they are required to promote and enforce the Organisation for Economic Cooperation and Development (OECD) Guidelines for multinational enterprises requiring respect for human rights and fundamental labour standards in all countries in which they operate, including their responsibility as regards subcontractors.

In the wake of the Rana Plaza disaster, questions parliamentary and challenges were raised in many countries, as well as in the European Parliament, but – once again – there is a massive policy failure to be seen because the interests of multinationals and the power of capital prevail. Claiming respect for labour rights as universal human rights and not standing helplessly by – these are ethical imperatives for all bodies that make up the trade union movement and for what still professes itself to be a civil society.
Han Dongfang: from Tiananmen hero to modest workers’ champion

Don’t, whatever you do, call him a dissident. Hero of Tiananmen Square he may be, but he won’t be labelled that way – too intellectual, too highbrow. Han Dongfang always remembers that before the spring 1989 protests he was a railway worker. And who with a name like Dongfang – meaning “the East” in reference to The East is Red, China’s anthem during the Cultural Revolution – could set themselves up as a counter-revolutionary?

No, Han Dongfang was never a self-appointed Lech Wałęsa of the Far East. “I never urged the workers on to political action,” he writes in his autobiography published in early 2014 in France. A hard-headed country-boy, he just wants to do his little bit to improve workers’ living and working conditions. An action man, then. Exiled to Hong Kong, he founded the China Labour Bulletin in 1994 with the aim of persuading the poorest workers of the benefits they could reap from organizing collectively. It was printed out and posted to a list of 5,000 firms, a bit like a message in a bottle cast into the sea. As you might guess, the results were disappointing.

Han Dongfang knew that he would get nowhere without practical involvement by the workers themselves. But what could he do, trapped in Hong Kong? It was then he remembered his unsuccessful application to Radio Beijing at his mother’s prompting, who thought he had “a lovely voice”. So he contacted the US Congress-backed Radio Free Asia which had recently set up in Hong Kong, which offered him several hours’ weekly air time. He started out feeling his way along, commenting on working conditions in China from his cramped studio. But he got bored with it not being connected to workface realities. “I was just an editorializing journalist, never getting out of the office and doing nothing but commenting,” he now says.

So he persuaded Radio Free Asia to set up a direct chat line with workers in all regions of China. “These weekly talks helped me understand how Chinese workers live and what they go through every day. They let the China Labour Bulletin build up a country-wide network of workers”. Now, it draws a big audience over the Internet in China, but also elsewhere – the show is a big hit with Chinese communities throughout the world.

The Internet and social networks, especially Weibo, the Chinese Twitter, help reach a younger generation born in the 1990s. “They are a generation of migrant workers who won’t let themselves be ground down (…) They have developed an Internet-based virtual solidarity which can be turned into a huge physical protest movement in a flash”, he enthuses from his belief in their ability to make things happen.

Unlike their parents, they never lived through the “iron rice bowl” period where industry workers had job security, a pension guarantee, medical care, free schooling for their children, and company-provided housing. Privatization in the 1990s “turned local officials into the bosses of private companies”. The bond of trust was broken; the Chinese regime’s Marxist veneer was irreversibly shattered.

But there is still a long and challenging road ahead. Industrial development has put the environment and workers’ health at risk. “Most of the cases we have taken up in the past two years concern work-related accidents and diseases,” he says. Silicosis is wreaking havoc, affecting more than six million workers – miners, naturally, but also workers in the building trades, cement works, jewellery manufacture, etc. To help them claim compensation, the China Labour Bulletin sends lawyers out to even the remotest villages. And it is paying off: the law was overhauled in 2012 so that silicosis sufferers no longer have to prove the causal link between their illness and their job to get compensation.

After twenty years’ activism, Han Dongfang finally seems reconciled to the idea that he may never go back home. China to him is what he now experiences through the personal stories of those who growth has sidelined, urging them to get organised and stand up for their right to dignity but without crossing the red line. Because he has not forgotten Tiananmen Square: “In China, you take political action at the risk of prison or even death.”

—Denis Grégoire

Mon combat pour les ouvriers chinois

autumn-winter 2014/HexaMag #10
A spotlight on the dark holds of the world economy

The sea holds an endless fascination. It has brought humans from different lands into contact for millennia. It is also a dangerous place where imaginary denizens of the deep like sea-monsters and mermaids have long lurked. The global structure of present-day capitalism is heavily underpinned by sea transport. Around 2 500 billion tonnes of goods were carried by sea in 1970, rising to over 8 000 billion tonnes by 2007.

Studies on the health and safety of seafarers are scarce. It is as if this key industry that keeps the global economy running goes as unseen as its cargo holds. This book by David Walters and Nick Bailey shines a penetrating light on this world. The authors take issue with the view that health and safety problems are just caused by natural hazards. Oceans and storms, shipwrecks and typhoons do play a part, but the real problem lies elsewhere. It is one of work organization and the structure of a profit-hungry industry.

The authors work from the scant data available on the health and safety of seafarers. The figures vary, but all converge on a high excess mortality of workers at sea compared to workers on land. A 2005 Norwegian study concluded that the provision for leisure, recreation, religious service and communications facilities are better in UK prisons than ... on many ships.

A handful of multinationals have a stranglehold on the world merchant fleet of more than 100 000 vessels, with complex power structures linking company shareholders, shipmasters and principals, let alone the role of ports and insurers. This fragmentation of power takes advantage of the countless opportunities offered by the absence of rules, weak controls, difficulties of taking collective action in an international context.

The International Maritime Organization has focused its action on developing a code whose main aim is to prevent major accidents and their environmental consequences. The problems of crew welfare and health are ignored and the code provides no mechanism for consultation of seafarers.

The on-board work organization betrays its military origins, with rigid forms of discipline and a system of coercion that seafarers’ unions have rarely taken issue with. And yet history shows that they can form a real balancing force. From the 19th century on, crews have taken collective action through desertion and refusal to work on unseaworthy ships despite harsh crackdowns on the seamen. The International Federation of Transport Workers, created in 1896, has undergone a transformation in recent years from a permanent secretariat between national unions to becoming a global union organizing direct action and negotiating its claims with employers. The federation, which represents 600 000 seafarers, has its own network of trade union inspectors who have no compunction about boycotting ships and companies that violate workers’ rights.

Written for the non-specialist reader, this book explores the countless links between technological developments and employment relations. It ranges across the many aspects of an industry with an approach that combines sociology, the study of legal rules and the specific input of occupational health disciplines. Hopefully it will give an encouraging lead for other similar studies to emerge on other components of the world economy.

—Laurent Vogel

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#11

Nurses’ working conditions

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