HesaMag

#11

The nursing world at tipping point
The art of preventive health and safety in Europe
Alfredo Menéndez-Navarro

This book stemming from the exhibition 'The art of preventive health and safety in Europe' presents historical and vintage posters from various European countries showing how graphic design has been used to promote health and safety prevention in more than 20 different cultural environments.

Viewed from an artistic angle, meanwhile, the publication offers a journey through the art of the 20th century and across key national artistic and graphic movements, with the incorporation of photography, photomontage, geometric abstraction and rigorous typographic treatment.

Les risques du travail. Pour ne pas perdre sa vie à la gagner
Annie Thébaud-Mony, Philippe Davezies, Laurent Vogel, Serge Volkoff

Since the 1990s, the quality of working conditions has gradually made its way into the debate on social issues and real progress has been made. Nevertheless, the situation remains critical. This unique work, aimed at a wide audience, uses concrete examples from many different countries to identify the active measures needed for improvement in this area. Through a team of international experts, this work constitutes a political and practical tool for moving the debate about risk prevention forward.

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Newsflash...

Up to 6 000 carcinogens, mutagens and reprotoxins floating around EU

According to figures notified to the European Chemicals Agency (ECHA), 5 675 chemicals that manufacturers/importers consider to be carcinogenic, mutagenic or toxic for reproduction (CMR) can be found on the European market.

ECHA, which is in charge of implementing two sets of EU chemicals rules (REACH and CLP), published the data in a report released on 19 January 2015. The agency compared the data supplied by manufacturers/importers when notifying the classification and labelling of hazardous substances under the CLP Regulation with the registration dossiers submitted under REACH. Of the 5 675 chemicals marketed in the EU that manufacturers/importers regard as CMRs, just 1 169 were registered.

‘Why this is – and what makes NGOs and trade unions deeply unhappy – is that the REACH Regulation only requires CMRs produced in Europe or imported in quantities of one tonne or more a year to be registered,’ says the ETUI’s chemical risks expert Tony Musu.

The ECHA report concludes that by far most notifiers have classified their CLP Regulation Annex VI CMRs correctly in line with that instrument’s mandatory classification. But it also identifies more than 4 000 CMRs on the European market which have been notified as such by the manufacturers who market them but not registered under REACH.

This means a large number of CMRs are floating around the EU market outside the REACH registration procedure whose net benefit is to require manufacturers to supply highly detailed information so as to keep tabs on the risks of these hazardous chemicals to consumers’ and workers’ health.

The ETUC calls for occupational cancer prevention measures

On the occasion of World Day for Safety and Health at Work, commemorated each year on 28 April, the European Trade Union Confederation (ETUC) has criticised the European Commission’s failure to promote occupational cancer prevention measures.

The ETUC has manifestly run out of patience. The carcinogenic agents Directive, the main instrument for protection of workers from the risks related to exposure to carcinogens or mutagens in the workplace, has been under revision for ten years. It is obvious that the Commission’s ‘better regulation’ campaign on which so much emphasis has been placed in recent years, is hardly conducive to progress in this area.

The failure to act has human costs, as the ETUC points out in a communiqué, quoting the figure of 100 000 deaths a year from workplace-linked cancers. The ETUC thus estimates that 150 000 lives have been lost in the European Union since the announcement by the European Commission, in October 2013, of its decision to suspend all ongoing legislation initiatives in the occupational health and safety field.

‘Measures to protect workers from cancer and fertility difficulties, are being treated as “red tape” and a so-called “unnecessary burden” on industry’ said Bernadette Ségol, General Secretary of the European Trade Union Confederation. ‘It is shameful.’

The European trade union confederation has called for the adoption by the Commission of compulsory limit values for exposure to 30 dangerous chemical substances. To date the directive places occupational exposure limits on only three carcinogens: benzene, vinyl ether monomers and hardwood. The ETUC calls also for extension of the directive to substances that are toxic for fertility and reproduction.

The enormous cost of poorly regulated toxic chemicals

On 5 March, researchers from the New York University School of Medicine disclosed a study concluding that endocrine-disrupting chemicals (EDCs) are associated with an increased risk of serious health problems costing at least 157 billion euros per year in Europe alone.

EDCs interfere with the functioning of the body’s hormone system. They have been linked to cancer, diabetes and infertility.

The estimate was limited to chemicals commonly found in human bodies: bisphenol-A (BPA), used in hard plastics, food-can linings, and paper receipts; two phthalates used as plasticizers in vinyl products; DDE, the breakdown product of the banned insecticide DDT; organophosphate pesticides and brominated flame retardants.

The biggest estimated costs, by far, were associated with chemicals’ reported effects on children’s developing brains. Numerous studies have linked widely used pesticides and flame retardants to neurological disorders and altered thyroid hormones, which are essential for proper prenatal brain development. The study attributes at least 5% of European autism cases to EDC exposure.

At European level, the issue is hotly debated. On 29 January 2015, the EU Council of Ministers decided to back Sweden in taking the European Commission to the European Court of Justice for not enacting a regulation on EDCs.
Breast cancer: the workplace aspects are too often forgotten

An important association of public health professionals has issued an online appeal for an increase in the research resources devoted to investigating the occupational causes of breast cancer. The appeal is launched in a context of scientific controversy unleashed by the publication, at the beginning of January, of an article that might be interpreted as shifting the weighting of environmental and genetic factors in the increased level of cases of cancer observed in recent decades.

The American Public Health Association (APHA), which has some 30 000 members throughout the world, placed online at the beginning of January an appeal for recognition of the occupational nature of some breast cancers. The association denounces the lack of attention accorded to some alarming research findings that indicate a link between exposure to chemical agents in the workplace and the increase in rates of breast cancer. In the view of APHA, research on the occupational and environmental causes of breast cancer must become a priority: ‘Until recently, women’s occupational health hazards continued to be mostly invisible, studied inadequately and infrequently despite women’s long-time participation in the workforce. This lack of gender perspective comes at a price: working women’s health’.

The document draws attention to the presence in the workplace of a category of toxic agents that affect the hormonal system and are commonly referred to as ‘endocrine disrupters’. Substances subject to particular caution in this respect include bisphenol A – the use of which in the manufacture of food containers has been banned in France since January – and phthalates. The presence of these chemicals in the workplace could, even in small quantities, prove harmful for the health of women workers.

APHA points also to the risk factors associated with work organisation, reiterating that night work has been recognised as a ‘probable carcinogen’ by the International Agency for Research on Cancer (IARC). APHA considers that research on breast cancer must be redirected towards environmental risk factors, and in particular the workplace, because ‘more than half of breast cancer cases cannot be explained by traditional causes or risk factors (e.g. weight, diet, alcohol abuse, genetics).’

Women’s health and work: the quest for visibility

The conference on women’s health and work, organised by the ETUI from 4 to 6 March in Brussels, showed that a situation of equal rights for men and women in the workplace is very far from having been achieved. A serious obstacle on the road to such equality is the invisibility of the specific risks to which working women are exposed and that stem frequently from work organisation methods.

The main findings of the European Working Conditions Survey – conducted every five years by Eurofound (the European Foundation for the Improvement of Living and Working Conditions) – were presented by Colette Fagan, a sociologist from the University of Manchester.

If the time required for travelling to work plus all the many hours spent on unpaid labour (childcare and housework, etc.) is added on to the number of hours spent in employment, a woman with children puts in a 70-hour week. No category of male worker, whatever his family status (married or cohabitee, single father caring for his children, etc.) works a comparable number of hours.

Katherine Lippel, a lawyer and researcher at Ottawa University, presented a survey showing that female workers are more exposed to workplace harassment than men (17% compared with 13%). Where as a high educational level appears to play a protective role for male workers, no such phenomenon is observed among women.

Elke Schneider, of the European Safety and Health Agency, stressed the invisibility of the exposure of women to biological and chemical risks. ‘Women’s exposure to dangerous substances remains largely unexplored’, she said.

Lucía Artazoç, of the Barcelona public health agency, made a point of emphasising the impact of social class on women’s health. The more a woman is in an economically vulnerable situation, the more she is likely to endure harmful working conditions, excessive or unsocial working hours, and inappropriate demands from her employer.

See: http://www.etui.org/en > Events > Women’s health-and-work

Québec: Gender differences in work-related exposure

Researchers have completed one of the first gender analyses of occupational exposure to chemicals. Using epidemiological data from two studies – one on lung cancer, one on breast cancer – covering 1 677 men and 2 073 women in the Montreal area in the late 1990s, they estimated and compared the proportion and exposure levels to 243 toxic substances for men and women by occupation.

Men are more exposed at work to vehicle exhaust fumes, petroleum fractions (recovered petroleum constituents in a distillation column), polycyclic aromatic hydrocarbons (PAHs), dust from building materials, and abrasive dust, while women are more exposed to fabric dust, textile fibres, ammonia, formaldehyde, and other aliphatic aldehydes.

But most of these relative share exposure differences are eliminated when occupation is factored in. A study of some 4 269 points of comparison for men’s and women’s exposure within the same occupational group revealed that only 3.1% showed marked gender differences for which there was no obvious explanation.

The conclusion is that stratified gender analyses are needed to gain a clearer view of gender differences in exposure and occupational diseases, says France Labrèche, lead author of the study and epidemiologist with the Institut de recherche Robert-Sauvé en santé et en sécurité du travail (IRSSST).
Unions sound the alarm on nanos in food

On 12 March, the IUF, an international federation of trade unions representing workers employed in the preparation and manufacture of food and beverages, published policy recommendations on the increasing use of nanomaterials by food-related industries.

‘Products containing engineered nanoparticles are being rapidly introduced into commercial production at every stage of the food chain, yet there are no specific safety regimes or adequate hazard assessments in place to protect workers, the public and the environment,’ said Ron Oswald, IUF General Secretary.

The union, together with a group of NGOs, is concerned that despite growing evidence that nanomaterials are beginning to be used in common food products, companies are still failing to provide consumers with information about whether their products contain nanomaterials.

This is particularly worrying because a growing number of studies have indicated that a range of health harms may be caused by ingestion of engineered nanomaterials. The organisations notice that nanoparticles of titanium dioxide have been found in products such as peanuts and chewing-gum.

Violence and harassment: a report highlights a north-south divide

The European Foundation for the Improvement of Living and Working Conditions published at the beginning of April a report on violence and harassment in workplaces in 29 European countries (EU-28 and Norway). The document divides the countries into four main groups, depending on the prevalence of the phenomenon, the policies and procedures in place in businesses, and the level of awareness within society. There is a clear delineation between northern Europe on the one hand, and the southern and eastern countries on the other.

The Nordic countries, the British Isles, Belgium and the Netherlands lead the way: their societies and public authorities recognise the phenomenon as a major problem. As a result, the governments, social partners and even businesses have implemented policies to counteract it.

On the other hand we have the countries of southern Europe and Hungary, where the low incidence of the phenomenon, according to public surveys, and sociocultural aspects (e.g. power distance, non-avoidance of conflicts) do not encourage the authorities and the social partners to put in place far-reaching measures.

France, Germany and Luxembourg form a middle group where awareness of the issue is increasing.

Most of the countries of eastern Europe, like those of the Mediterranean, demonstrate very little awareness of the issue despite it being more prevalent than in Europe as a whole.

Firefighting increases cancer mortality risks

Firefighting exposures increase the risk of death from cancer, according to a study carried out by the NIOSH, the U.S. federal agency responsible for conducting research on work-related diseases. Of eight types of cancers examined, researchers found that lung cancer and leukemia mortality risks increased with firefighter exposures.

‘These findings add to evidence of a causal association between firefighter and cancer,’ said the researchers.

They gathered nearly six decades of data on firefighters from Chicago, Philadelphia and San Francisco, comprising almost 20,000 male firefighters with 1,300 cancer deaths and 2,600 cancer incidence cases.

The results are the second phase of the study. In the first phase, published in October 2013, researchers found that firefighters had higher rates of several types of cancer (respiratory, digestive, and urinary systems).

Firefighters can be exposed to contaminants from fires that are known or suspected to cause cancer. These contaminants include combustion by-products such as benzene and formaldehyde, and materials in debris such as asbestos from older structures.
100 000 work cancer deaths: time for action!

Laurent Vogel
ETUI

The former head of the EU’s Safety and Health at Work Agency Jukka Takala has sounded a wake-up call: cancers induced by working conditions kill over 100 000 people in the European Union each year. Cancers account for 53% of work-related deaths compared to just 2% for work accidents. Every one of these deaths can be prevented.

To do away with workplace cancers, there must be a stronger framework of laws, more checks by health and safety inspectors, and no let-up in union action to get human life valued more than company profits.

Mr Barroso’s ten-year stint as the Commission’s top man has brought EU health and safety at work policy grinding to a halt. A majority of Member States now want to stir the Commission from its inaction, pointing not only to the immense suffering these 100 000 deaths represent, but also to the rising costs to public health and social security budgets. Businesses are able to shift the costs onto society because it can take two decades or more between a worker being exposed to carcinogens and the disease starting to manifest. Not many cancers get recognized as occupational diseases. The risk of prosecution is low, as can be seen from the acquittal of Swiss billionaire Stephan Schmidheiny by Italy’s Supreme Appeal Court on 19 November 2014. The judges acknowledged that the multinational Eternit wilfully sacrificed the lives of more than 3 000 people in Italy, but acquitted the company head because the statute of limitations had run out.

On 4 March 2014, the German, Austrian and Dutch Labour Ministers sent a joint letter to the Commission calling for an urgent review of the Directive on exposure to carcinogens and mutagens at work and making specific proposals. The current legislation, based on scientific evidence dating back forty years, has manifestly failed to deliver effective prevention. Its exposure limit values cover less than 20% of real-life situations of exposure to workplace carcinogens. It does not cover crystalline silica, diesel fumes or dozens of other agents that cause cancers in workers. Nor does it cover reprotoxins.

In December 2014, a large majority of Member States demanded Community policy initiatives on endocrine disrupters. In late January 2015, the EU’s Council of Ministers took the unprecedented step of joining Sweden in taking the Commission to court for not keeping to the prescribed deadline for setting criteria to identify endocrine disrupters in pesticides.

Endocrine disrupters are just as concerning as carcinogens, being involved in a sharply rising range of cancers like breast cancer in women and prostate cancer in men. They increase the risk of certain cancers in children whose parents were exposed during their work. A European policy has big added value where both carcinogens and endocrine disrupters are concerned. For prevention to be effective there must be a comprehensive strategy covering the internal market, environmental protection, worker protection, public health, scientific research and technological innovation. It is the very essence of the Community’s purview. For the Commission to yield to the pressures of industry puts public health at risk.

Only the Commission can propose new laws. The EU’s institutional set-up means that MEPs cannot table draft legislation. The Commission is abusing its prerogatives by refusing to put proposals for a directive to Parliament and Council, thereby frustrating any possible policy discussion.

The new Commission President, Jean-Claude Juncker, has made things worse. Policy decisions are snarled up in a paper-chase system. Now, even before being coming up for discussion by the Commission as a body, any proposal for legislation on occupational cancers must get the nod from Vice-President Valdis Dombrovskis, who has the eurozone and social dialogue portfolios, and better regulation tsar Vice-President Frans Timmermans. Every hurdle creates a new opportunity for industrial lobbies to block it.

Political pundits say that the first 100 days of a political team are a crucial litmus test of its credibility. The slow-moving European decision-making process stretches that time-frame out to about twelve months, meaning that legislative initiatives could be expected from the Commission sometime in 2015. What the EU does about work cancers will be the main credibility test for its health and safety at work policies. The unions will not be standing idly by. Throughout the year, they will be organizing action to demand appropriate legislation and to roll out workers’ initiatives in support of prevention that works.
Deregulation continues to kill

We are used to reading warnings on cigarette packets: 'Smoking kills'. This should not distract from other vital health factors. The paralysis in European occupational health policy has become one of these vital factors.

Laurent Vogel
ETUI
More than 160,000 dead every year, including some 100,000 from occupational cancers. One worker in two considers that he will not be able to continue to work until the age of 60 years. This is not a simple subjective perception. In the various countries in Europe, employment rates are falling dramatically for 55-year-old workers even though the doubt surrounding early retirement rights is increasing the risk of toppling into poverty. Occupational health matters are complex. They do not result directly from the state of the art or the science. They also reflect the power relationships between social classes. Immediately and directly, in the life of businesses in which bodies, on a day-to-day basis, constitute operating costs. In a more delayed and diffuse manner, in public policies.

The watershed of the Barroso years

In the late 80s, the desire to implement the single market persuaded European institutions to encourage improvements in working conditions. This was partly a concession to the trade union movement. It was also the expression of an economic project whereby the position of Europe in the global distribution of work was to be consolidated by the quality of work. This was described as a central issue for a knowledge-based economy. Occupational health, lifelong learning, consultation of workers in undertakings, and industrial policies based on innovation were other facets of a European strategy that was supposed to result in a new social compromise and a return to a cycle of growth.

With hindsight, these texts leave the impression of a certain naivety. There was already a significant discrepancy between trumpeted projects and actual developments. Production chains were reorganised in line with a neo-liberal model that left little room for collective compromises between capital and labour. The dominant features of this "modernisation" were summarised well in 2010 by Christine Castejon and Thomas Coutrot: "generalised competition (in theory, the only way to go), job insecurity at every turn, reduction in leisure time, alignment of the public service with a model of profitability, obsession with the short-term".

The collapse of the Soviet bloc played a paradoxical role. In one way, it seemed to confirm the superiority of a capitalism moderated by social reforms. Towards the end of the ‘90s, 12 of the 15 countries that then made up the European Union were governed by socialist democracy but this was breaking, with variable intensity depending on the country, the structural links it had maintained with trade unionism and the labour movement for at least a century. The word ‘reforms’ had a completely new meaning. It no longer meant attempts at the redistribution, on a more egalitarian basis, of wealth, education, power or health. It was now a matter of ‘reforming the labour market’ to make it more flexible and opening up new opportunities by privatising the public services. The general trends in this evolution of capitalism on a worldwide scale were supplemented in Europe by the fact that the dominant classes in the West felt free no longer to make significant concessions to the labour movement. The new elites in the East, born largely out of the privileged bureaucracies of the former Stalinist regimes, were determined to dive into the process of capital accumulation without having to pay an excessive price in terms of the improvement in living and working conditions. The four decades during which most independent forms of the labour movement had been destroyed seemed to them to be an essential step in rapidly achieving a competitive position on the world market. The enlargement of the European Union in 2004 was an opportunity for an alliance between the political heirs of Margaret Thatcher and those of General Jaruzelski.

The political results of the Barroso decade for occupational health were disastrous. We shall not dwell on this. Bear in mind, however, that the essential role of the European Union was to develop a legislative framework for the harmonisation of working conditions and ensure that the Member States were observing the rules put in place. As regards Community legislation, no significant initiative was instigated despite the obvious failings hampering prevention. The revision of the Directive on the protection of workers against carcinogens got bogged down. The adoption of a directive on musculoskeletal problems was halted even though a draft text was ready. Even a second-line initiative like the prohibition of exposure of workers to passive smoking during their work fell through the cracks. The rare projects that were completed concerned initiatives started earlier, which it would have been difficult to block owing to the inertia inherent in large institutions. In parallel, the Commission began a wide-ranging campaign against the "legislative burden" represented by legislation on occupational health.

'Better regulation': locking in the future

Ten lost years is a lot but the key factor undoubtedly lies elsewhere. Every effort has been made to lock in the future, and to establish new bureaucratic mechanisms to make the launch of legislative initiatives more and more arduous. With no substantial revision of the EC Treaty’s provisions on the production of legislation, we have been witnessing a silent constitutional counter-reform. This is intended to slow down the adoption of new texts, whether in the social or environmental field or for consumer protection. It is due to various different blocking factors. It is based on the development of an internal bureaucracy and more and more systematic use of outside consultancies. It tends to relegate tripartite consultation and the role of the European Parliament to the sidelines. Political discussion of legislative choices is giving way to calculations as sophisticated as they are unreal with regard to costs and benefits.

We can trace the main stages of this process that is being rolled out under the Orwellian watchword ‘Better regulation’. This ‘better legislation’ is inspired by a legal concept based on ‘market totalitarianism’ in the happy expression of the French lawyer Alain Supiot. A statutory rule is only good if it generates profits (from the almost exclusive point of view of private enterprises, need it be said?).

The switch from Barroso to Juncker in November 2014 changed the style but not the substance.
An Impact Study Office was set up in late 2006 with the task of evaluating in advance any proposed legislation even before it has been officially drafted by the Commission. The evaluation criteria are vague. They result in arbitrary management of this procedure. The entire process is characterised by a lack of transparency allowing industry lobbies to play a central role. Thus, this Office was able to block the proposed directive on the prevention of musculoskeletal problems with inconsistent arguments. At the legal level, there is nothing to prevent the Commission disregarding a negative opinion issued by that body. In practice, it has tended to grant it blocking powers taking effect downstream, thereby preventing the only Community body elected by universal suffrage, the European Parliament, from expressing a view. Over time, the requirements – defined by the Commission itself – for the content of impact studies have become ever more complex. As a result, greater resources are allocated to the conduct of cost-benefit studies than to the substantial content of legislation. As regards the revision of the Directive on carcinogens, cost-benefit studies of very debateable reliability were subcontracted by the Commission to private consultants. These studies were completed in 2011. Four years later, the impact study has yet to be presented. Embarrassed explanation: in the meantime, the requirements for the impact evaluation had become even more stringent so that the Commission no longer had sufficient elements to present its evaluation.

The Stoiber Group

The establishment in August 2007 of the ‘High Level Group on Administrative Burdens’, called the Stoiber Group after the Bavarian conservative leader who chaired it, can be examined as a textbook case of the techniques of political manipulation in the field of regulation. Originally, this group was to be restricted to examining the ‘administrative costs’ of existing legislation. Employers’ interests were always overrepresented in the group. Of its 15 members at the end of its mandate in 2014, six were employers’ representatives. Four others had been involved in consultative bodies set up by right-wing governments of the United Kingdom, Germany, Sweden and the Netherlands. The Stoiber Group’s mandate was supposed to come to an end in 2010. Edmund Stoiber twice obtained extensions for it. In June 2014, it drew up recommendations running in a clearly deregulationist direction. According to the group, its recommendations would save over 40 billion euros. These estimates were based on a simplistic method. Private consultants carried out a few interviews with enterprise leaders on the supposed costs of different types of regulation. They then extrapolated the stated costs to all enterprises in the European Union. No verification was able to establish whether the data emerging from these interviews corresponded to reality. The only ‘validation’ consisted of the infinite repetition of the same figures from one document to another.

In December 2012, the Barroso Commission initiated ‘REFIT’, an acronym for ‘Regulatory Fitness and Performance Programme’. The objective was to review all of the European legislation already adopted (the Community ‘acquis’) and to submit any new initiative to competitiveness tests. In practice, this involved abandoning any ambitious policies in the social and environmental fields. By October 2013, REFIT was being reflected in the blockage of proposals intended to enhance occupational health legislation. REFIT is not just an obstacle at Community level. The Commission is using it to get Member States to revise their own legislation downwards. In the most indebted countries like Greece, Portugal, Ireland and Cyprus, the Commission used the troika mechanism to impose a brutal challenge to social rights. For Adalberto Perulli of the University of Venice, the picture is clear: ‘A recurrent feature of these reforms and more flexible labour law is the exponential growth of inequality and insecurity. A picture that, in the eyes of an observer today, seems far removed from the picture appointed him special adviser for ‘better regulation’. The press release triumphantly announced that the Commission’s initiatives in the field of ‘better regulation’ would save EUR 31 billion. These figures are based on the same fanciful extrapolations made by firms of private consultants on the claimed cost of directives.

The decision-making process was made even more onerous. It brought to mind the censorship mechanisms used by the Catholic Church for publications. Any proposal originating from a Commissioner can only be submitted for collegiate discussion by the Commission if it has first passed through two filters: an initial level of control (and blockage) involves the compulsory approval of a Vice-President of the Commission. Each of the six Vice-Presidents oversees a disparate set of subjects. After this nihil obstat comes the imprimitur. Vice-President Timmermans still has the power to block any initiative he considers contrary to the sacrosant principles of ‘Better regulation’.

European Parliament technically unemployed

On matters of occupational health, it may be asked whether the European Commission – in its upper circles – has lost all contact with reality. It is no longer just trade union critics who are bemoaning the failure of its policies. Most Member States no longer accept the legislative paralysis. This has come to the fore over the last 12 months through several initiatives.

In March 2014, the Labour Ministers of Germany, Austria, Belgium and the Netherlands sent a very firm letter to the European Commission demanding the revision of the Directive on carcinogens. In December 2014, the Council of Environment Ministers decided to join Sweden in a legal complaint against the European Commission, which was blocking the actual application of an essential part of the 2009 Regulation on pesticides. It was supposed to have defined criteria concerning endocrine disruptors by the end of 2013. Giving way to pressure from pesticide manufacturers, the Commission did not meet the obligation that it had itself proposed. Its reaction following the unprecedented initiative of the Member States was to adopt new delaying measures: a wide-ranging online public consultation to be followed by … an impact study of the possible costs of defining the criteria!

An absurd exercise insofar as a simple definition of criteria gives rise to no costs that can be determined in advance. Finally, on 9 March 2015, meeting at the initiative of the Latvian Presidency, the Council of Social
The evaluations have been ongoing for 20 years. In occupational health, the first exercise dates back to 1995, with the Maltoni Group established in September 1994. It is difficult to find a single original idea emerging from these laborious procedures.

8. The evaluations have been ongoing for 20 years. In occupational health, the first exercise dates back to 1995, with the Maltoni Group established in September 1994. It is difficult to find a single original idea emerging from these laborious procedures.

Even the world of employers is split between its support for the Commission’s deregulationist approach and the fact that legislative paralysis involves unforeseen drawbacks.

**Bureaucracy and its rituals**

On 25 February 2015, a broad coalition of 31 employers’ organisations wrote to the European Commission. While reiterating its ideological support for the principles of ‘Better regulation’, the letter demanded that the revision of the Directive on carcinogens be unblocked. It was signed by associations from very diverse sectors: automobile production, medical technology, iron and steel, mining, aluminium, etc. It was also supported by the powerful American Chamber of Commerce to the European Union, which represents the US multinationals. Of course, the reason for the letter was not workers’ health. The signatories were concerned because the legislative inertia in this field might result in prohibition or restriction measures under REACH, the Regulation on the production and marketing of chemicals. Although we clearly do not share the motivation of the signatories, it is no less comforting to find that the simple defence of their own interests is leading them to break away from the purely deregulationist ideology of the global organisation for European employers, Business Europe.

Up to now, the Commission has responded impassively that there is no need to rush. Its own procedural requirements have to be completed before the substantial questions put to it. The agreed response with regard to the trade unions, Parliament and states or employers’ circles was that it was vital not to do anything with regard to legislation in 2015. The absolute priority was to evaluate the existing legislation. This has been an interminable exercise between different Commission services and private consultants, resulting in voluminous texts in which it is difficult to find any concrete analysis of needs. Mr Juncker tirelessly repeats: ‘Europe must only concern itself with the big picture and leave the small things alone’. The only problem lies in knowing who has the power to define what is ‘big’ and what is ‘small’.

Any institution, public or private, tends to develop a bureaucracy that considers its development and reproduction as ends in themselves. The system ends up by becoming divorced from the functions for which it was conceived. Procedures are no longer directed towards functional efficiency but towards the reproduction of rituals, giving the bureaucracy the illusion that it is dominating reality. This process may become irreversible when the institution is no longer even able to spot the signs of its own crisis. It considers that all is well as long as the formalities and ceremonials are being observed. It is in this context that an evaluation should be made of the proposals currently doing the rounds within the European Commission, whereby negotiations between trade union and employers’ organisations are to be submitted to ... both prior impact studies and possibly public consultation on the internet. Such a proposal would run counter to the basic principles of the EC Treaty, which recognises the independence of parties in collective negotiations. It would put an end to any attempt at social dialogue while, in parallel, the same Commission repeatedly says that it would like to revive this activity.

The crisis in the regulation of occupational health has now become a more essential crisis for EC regulation as a whole. This may give an opportunity to revive more global mobilisations for another Europe. There is no doubt that this is a battlefield on which the trade union organisations need to be involved.

More information


These publications can be consulted at www.etui.org.
The nursing world at tipping point

Special report coordinated by Marianne De Troyer, ETUI, and Caroline Verdoot, FGTB.

Deteriorating working conditions, lack of staff, job burnout: the health sector has been experiencing a serious crisis for a number of years. Across Europe, the trade unions are ringing alarm bells. The health of their members is at serious risk.

In the countries worst affected by the recession, the policies of austerity have made the situation even worse and their knock-on effect has been a reduction in the quality of care.

In Spain, the need to reduce the public debt has been very cleverly exploited to push through plans to privatise institutions. The right to health is now at risk, not only for the most vulnerable. Many Spanish nurses, especially younger ones, are heading for Germany.

Meanwhile, Germany, which can barely meet the extensive care needs of its older generations, is turning into the laboratory for disgusting social dumping practices. Highly qualified workers there are faced with deteriorating employment and working conditions, especially in care homes for the elderly.

Physically and mentally exhausted, fed up watching their private life being whittled away by work, and powerless in the face of the market pressures that are reshaping their sector bit by bit, nurses are planning to leave the profession. There are no signs that the public authorities are aware of the full extent of the malaise.
Hospitals tested by austerity

The austerity policies being followed in most European countries have not spared the health systems. Poor people are not the only ones to suffer. Nursing staff have seen their working conditions deteriorate rapidly over recent years. More and more of them no longer see themselves as part of current developments in the hospital world.

Caroline Verdoot
General Federation of Belgian Labour (FGTB), former hospital nurse

The practice of reporting, adopted from the private sector, has rapidly spread throughout the hospital sector, creating an additional burden for nursing staff.

Image © Belga
The austerity measures applied over recent years in most European countries have of course affected the financing of public health systems. Investment has been constantly reviewed downwards and the share of health expenditure not covered by social security has increased.

The spectre two-speed medicine has raised its head. The most well-off patients gain rapid access to care in private clinics, while the public sector, with less subsidy than before the crisis and therefore with reduced financial and technical resources, is finding it more and more difficult to meet the health needs of the majority of the population.

Preferring to spend their money on other things, many Europeans find themselves having to give up monitoring their health or delay expenditure on health care, which may have the effect of aggravating their condition. They are going into the healthcare circuit too late and the number of patients considered to be serious cases is multiplying in care units. As shown by a study covering Greece, Spain and Portugal, the crisis has given rise to an upsurge in infectious diseases, including AIDS, and suicides.

There were significant variations from country to country. The situation was by far the most worrying in the United Kingdom, where 36% of those who took part in the survey said that they were thinking of leaving their jobs. Some distance behind was Italy, where 20% felt the same way. The countries least affected were Belgium and the Netherlands, with less than 10%. France was right in the middle of 10 countries surveyed, with 15%.

When it came to the reasons for leaving, the participants were primarily concerned about their health and individual factors (burnout, general health, work ability, physical diseases, age), followed by work organisation.

As regards work organisation, the lack of possibilities for development, influence at work and the requirement to carry out tasks not belonging to nursing were the participants’ main complaints.

The largest European study to look at the situation in detail was carried out 10 years ago. Between 2002 and 2005, a team of university academics used a questionnaire to survey 10 European countries. Just over 56 000 nursing professionals took part. They worked in various institutions: hospitals, nursing homes, home care institutions and institutions for outpatient care. A total of 15% said that they frequently considered leaving the nursing profession. This was particularly evident among those between the ages of 25 and 35, and among men. Nursing staff working in hospitals and those with the highest qualifications were most likely to consider leaving the profession.

The 'health and individual factors' indicator highlighted the impact of nurses being overworked. The researchers used a ‘burnout scale’ to assess the situation among nursing staff in hospitals. The worst scores were recorded in France, Belgium, Slovakia and Poland. These last two countries, where the possibility of giving up work before the legal retirement age is very limited, saw the worst scores in terms of the general health of nursing staff. These results indicate that general health and, to an even greater extent, psychological health (burnout) are clearly associated with the intention to leave the nursing profession.

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Twelve months after the first phase of the study, the researchers contacted some of the participants again to find out if they had actually left their jobs. A small majority (54%) had left the institutions they had been in but were still working in the healthcare sector; 13% had taken time out and 9% had left the profession altogether.

Of those who had left the profession, the researchers observed that a key reason for their departure was that the demands on them were too low. These nurses seemed to be seeking greater challenges, wrote the authors. This interpretation was supported by the situation in Sweden, where, unlike the other countries, ‘too low demands’ did not play a major role. However, nurses in Sweden have greater autonomy and responsibility than in many other European countries.

A vocation under threat

Entering the nursing profession is generally seen as taking a vocation as it requires devotion, patience, availability, knowledge, etc. For several years, working conditions have been getting worse and worse. The public health systems have to reduce drastically their spending, while the demand for care is escalating in tandem with the increase in life expectancy. The professionals who work in the sector no longer have any hesitation in taking to the streets to denounce their work overload and the pressure they constantly have to endure. Is this unease widespread?

The 'health and individual factors' indicator highlighted the impact of nurses being overworked. The researchers used a ‘burnout scale’ to assess the situation among nursing staff in hospitals. The worst scores were recorded in France, Belgium, Slovakia and Poland. These last two countries, where the possibility of giving up work before the legal retirement age is very limited, saw the worst scores in terms of the general health of nursing staff. These results indicate that general health and, to an even greater extent, psychological health (burnout) are clearly associated with the intention to leave the nursing profession.
In hospitals, short-term reforms, exacerbated by budgetary restrictions with immediate effect, have led to delayed investment, reductions in administrative costs and falls in workers’ remuneration. Care staff, in particular nurses, are a soft target for the rapid implementation of savings.

Greece and Portugal have had to suffer the most severe and numerous austerity measures (hospital closures, wage falls, re-structuring, privatisation, etc.).

Cuts in health professionals’ remuneration have been applied in Cyprus, Greece, Ireland, the Baltic countries, Romania, Spain and Portugal. Wage freezes have been imposed in the United Kingdom (except for the lowest wages), Portugal and Slovenia while, in Denmark, wage increases have been smaller than originally planned. In Portugal and Catalonia, overtime has been less well paid. Finally, staff reductions, including direct redundancies, non-replacements or non-renewal of contracts, have been recorded in nine Member States6.

In Ireland, public funds allocated to health have been reduced by 17% between 2010 and 2012. These budget cuts have resulted in wage reductions, voluntary redundancies (more and more frequent) and non-replacements. Overall, there has been a staff reduction of 4 000 between 2009 and 2011. According to the WHO’s European office, it is possible that the pressure to lower the remuneration of health staff in countries where wages are low has produced short-term savings to the detriment of gains in efficiency. The WHO is worried that some changes risk threatening access to services or damaging the motivation of health staff.

The economic crisis is also having a tremendous effect on the nursing staff themselves. As for other European citizens, the purchasing power of nurses and care assistants has fallen throughout Europe. It depends more and more on payments associated with unsocial working hours such as working on holidays, in the evening and at night. A lengthy illness might put such workers into very precarious situations, since their wages are no longer supplemented by irregular benefits.

All European countries are facing a shortage of care staff. There is a risk that this will deteriorate even further in view of the changing demographics affecting most European countries. While the ageing of the population means an increase in the need for care, the professional health population is also ageing and becoming scarcer6.

To mitigate these shortages, the existing staff are compelled to increase their overtime hours, often without pay and very difficult to compensate with time off in lieu owing to the staff shortages.

Since units have to operate with a minimum number of staff per occupied bed, the use of temporary staff is frequent. At least, it was, because today, since they have become too expensive, hospitals prefer to turn to standby teams. These are nurses who move from one unit to another as required by units which are temporarily under-staffed. Temporarily staff are still being hired and students require a lot of time and energy on the part of permanent staff, which just adds to their daily workload6.

In order to deal with the shortage of doctors and guarantee satisfactory access to care, some countries have assigned more complex functions to the most qualified nursing staff. Specialised or advanced nursing positions are being established to a greater or lesser degree, depending on the country, but some tasks usually only performed by doctors are now being undertaken informally by nurses. The OECD has also noted that the introduction of ‘advanced nursing practices’ may require changes in legislation and regulation in order to remove the barriers to their development6. How can these tasks actually be justified in administrative documents which do not provide for them? And, in the event of an accident, how can certain current informal practices by justified, which do not legally form part of the lists of tasks assigned to nurses?

In order to confront the shortage and keep the staff remuneration budget as low as possible, hospitals in western Europe are recruiting foreign care staff (read the article on p. 26).

The shortage of general practitioners and families’ and close helpers’ lack of time and resources are making public hospitals, and especially their accident and emergency departments, the easiest point of access to the health system, which is resulting in overcrowding and thus an increase in the risks of aggression towards overworked staff (read the article on p. 34). The increase in activities in public institutions is quicker than the increase in staffing.

In Europe, hospitals consume 20 to 50% of the budgets allocated to the health system8, while the percentage of GDP allocated to health is roundabout 10%.

In some countries, there has been a switch from global, fixed financing of hospitals to financing for service. Previously, most European countries allocated funds to hospitals according to global fixed budgets based on the number of admissions or the number of beds occupied. This system encouraged hospitals to increase the number of admissions or increase the length of stays in hospital. For more than twenty years, financing for service, inspired by the United States, has been based on diagnosis and therapeutic procedures. It is said to be more efficient (since it is based on evidence based medicine/nursing), more objective and more equitable in view of the activities and the difficulty of the tasks, which may vary greatly from one hospital to another. This is actually a statistical tool which is very useful for public health, making it possible to estimate geographic variations in the frequency of certain pathologies or groups of pathologies and medical practises.

However, this system has perverse effects. In Belgium, care units are financed by flat fee based on national average stays in hospital. What is dangerous is that some hospitals reduce their lengths of stay dangerously short to compensate with time off in lieu owing to the staff shortages.

Nurses, a soft target

Shortening times in hospital

The patient-nurse relationship cannot be likened to that of client-trader.
in order to make money. If a patient occupies a bed for less time than the average for such a class of pathology, the hospital is the winner, since it has received a certain sum covering \( x \) number of days in hospital.

Since 2008, the activities of both doctors and care staff have been recorded in a joint report. At certain times of the year, all the activities of nurses, from the simplest (for example, making a bed) to the most complex (tending to a wound), are detailed, listed and recorded there. Records used to be kept in hardcopy. Nowadays, more and more use is being made of computerised versions. Hospital managers can make use of this tool to compare their own results with those of other hospitals. They use the data in the management of staff and deployment to the various units.

Clearly, the results risk being biased since the more activities are recorded, the more resources are allocated to perform them. Reported discrepancies are, for example, fictional patient discharges in order to re-record an admission. However, a unit reporting an abnormally high quantity of work in comparison with another of the same type risks attracting the attention of the public authorities.

This benchmarking within hospitals and between hospitals, these quantified performance indicators and the increasing computerisation give rise to stress and uncertainty with regard to the future of working teams. This competition between hospitals encourages mobility of care staff and a high turnover rate.

However, nursing activities are complex and cannot be summarised in figures and percentages. A hospital cannot be organised in the same way as any company attempting to improve its turnover. The patient-nurse relationship cannot be likened to that of client-trader. The relationship and communication aspects, the missions to inform and educate the patient, who are constantly on the go. A patient discharged too soon from hospital risks their families and to the training of students.

Thus, so as to increase their financing, it is not in hospitals’ interest to keep patients in their beds for too long. The reduction in duration of stays in hospital speeds up patient turnover, which increases staff workloads. In fact, turn-over is considered, after interruptions during the execution of tasks, to be the main factor contributing to the increase in workload. Professor André Grimaldi, diabetologist and former head of department at the Pitié-Salpêtrière in Paris, explains that it is sometimes necessary to wait for a few hours to obtain a bed in medical intensive care. "The enterprise hospital" uses a "just-in-time" management system, he explains. Put more simply, this means that there should be no empty beds, since they do not make any money. And a bed, once occupied, is more profitable with a seriously ill patient than with a patient who is less so. Patients therefore play at musical chairs to the detriment of the staff, who are constantly on the go. A patient discharged too soon from hospital risks complications and aggravation of his state of health with, into the bargain, a possible return to the care circuit.

Public hospitals tend to mimic the methods of the private sector. Reports, meetings and projects proliferate and staff (doctors and nurses) are no longer able to devote their time to the patients. Furthermore, it is the human resources staff who organise schedules from their office, without paying much attention to the reality in the field and without leaving much margin for adaptations between colleagues. The consequence being that superiors are leading staff whose jobs they do not know.

Wellbeing of hospital workers
The contradictions between methods of organisation and a hospital’s missions and values result in degradation of working conditions and absenteeism owing to sickness.

The working conditions in the hospital sector are already very challenging (atypical hours, teamwork, physical work, psychosocial burden, occupational risks associated with exposure to chemical and biological agents, etc.). Over recent decades, the world of work overall, and particularly the public and hospital sector, has been confronted with an intensification of work.

Some nursing staff can no longer see the sense in their work. The French trade unionist Denis Garnier explains that staff are experiencing an ethical conflict between the requirements imposed by the hospital and their wish to perform a job well done.

The psychosocial and emotional burdens are increasing both among the teams, reduced to the status of ‘human resources’, and among the managers who are subject to very great pressure following the implementation of new management systems, systems for comparing units within the same hospital and between hospitals. For some of them, the values which attracted them to healthcare have been shaken by the sometimes abusive use of numerical objectives and the reduction of the complexity of their activities to numerical graphs and tables.

This is supplemented by the requirements for availability and instantaneous information for patients and their families. They demand complete and rapid information, take information from the Internet and can become aggressive or violent.
The values which attracted them to healthcare have been shaken by the reduction of the complexity of their activities to numerical graphs and tables.

situations must also be able to be managed and time has to be devoted to communication, even if such time is not necessarily ‘profitable’ from a finance point of view. Finance managers, doctors, families and patients sometimes tend to consider nurses as they are portrayed in the collective imagination, i.e. a stereotype person blessed with patience, compassion and an ability to put up with countless small interruptions during their work or accept last-minute changes in schedule and overtime. Clearly, without imagining that a nurse also has a private life, a life outside the four walls of the hospital.

The population of health professionals is particularly affected by burn-out. Burn-out appears after a period of prolonged exposure to psychosocial risks. It is characterised by exhaustion, depersonalisation (or cynicism) and a loss of professionalism (or a reduction in professional effectiveness). The quality of relationships between nurses and doctors, especially in care units, affects the three dimensions of burn-out. The support of colleagues and line management and good working relations represent a factor in wellbeing at work. It is also essential for the team manager (line management) to be aware of the realities in the field and to be involved both at the level of overall hospital management and at care unit level.

Furthermore, a low level of communication between colleagues and neglected social relationships are associated with depressive symptoms linked with the perception of an imbalance between the effort made and the return (recompense for the work performed) identified by nursing staff. This imbalance is considered to be a psychosocial burden, a source of stress and consequences for physical (cardio-vascular, dermatological, etc. pathologies) and mental (depression, relational problems, sleeping problems, etc.) health of workers. Workers in an under-staffed team and the arrangement of equipment in the workspace) or even appropriate and on-going training are reckoned to be key elements.

Quality of care and patient satisfaction

According to an international study devoted to staff and patient satisfaction, the proportions of nurses considering that they are providing patients with poor quality care vary greatly from one country to another. The rates are close to 50% in Greece while it is 11% in Ireland, 13% in Finland and 28% in Belgium. The burn-out rates run from about 10% in the Netherlands to some 40% in Poland, Ireland and the United Kingdom and up to 78% in Greece.

Despite a quite generalised shortfall in the quality of care in the 12 European countries covered by the study, an improvement in the quality of the working environment and a reduction in the number of patients per nurse are associated with an improvement in the quality of care and increased patient satisfaction.

The models for human resource planning in health institutions are generally based solely on the volume of staff. They have long ignored their effects on the quality of care lavished on patients and on the quality of working conditions. On the basis of data collected in 2010, the Registered Nurse Forecasting (RNCAST) project investigated, in 30 hospitals in 12 European countries, satisfaction at work and the psychosocial burden. The study showed that an increase in workload per nurse is associated with increased mortality among patients who have undergone surgery, while their level of training is associated with a fall in mortality. The authors concluded that budget cuts for nursing staff could have a negative effect on the health prospects of the patients being treated.

A study published recently in The Lancet identified, after having analysed all the scientific literature from 1996 to 2012, the factors essential for the organisation of effective infection prevention programmes. Every year in Europe, healthcare gives rise to more than 4 500 000 infections, resulting in about 37 000 deaths and 16 million extra days in hospital. The authors identified 10 essential elements making it possible to reduce infections and improve patient safety. Of these, sufficient staff in both day units and night units (and in particular avoiding the standby team system), a bearable workload (in particular avoiding long working days), optimum ergonomics (as regards both materials and the arrangement of equipment in the workspace) or even appropriate and ongoing training are reckoned to be key elements.

In order to protect the health of care staff and provide for the best possible quality of care, it is essential that hospital finance and human resource managers take sufficient account of the human aspect. The same applies for the survival of hospital institutions: as shown by the European Agency for Safety and Health at Work (EU-OSHA), investing in the health (physical and mental) and safety of workers is beneficial for the economy of enterprises and institutions.

It is not solely a matter of the quality of life of health professionals, the quality of their care depends on their working conditions. In the interests of public health for current and future generations, all European citizens should demand in-depth consideration of the way in which the political authorities in European countries are managing public health at present.
Spain: at the bedside of a public health service verging on melt-down

Since 2008 and the consequences of the economic and financial crisis, Spanish hospitals have been hit by budget cuts and creeping privatisation. These austerity measures are being reflected in a deterioration in working conditions and the quality of the care provided. In the face of all this, trade unions, employees and user associations are striving to defend a universal, high-quality health system.

Nathalie Pédestarres
Journalist, correspondent of www.bastamag.net
The panorama is not very flattering for hospital management bodies. Beds are crammed into corridors and single rooms. Emergency exits are blocked and the work of care staff is being hampered. With the increase in winter illnesses, services quickly become saturated. Most patients are elderly and require special attention. The cramped conditions exclude any privacy. While some are having bedpans emptied, others are being served meals. The ambient smell is unpleasant. The tension among care staff is palpable. The accident and emergency department at 12 October Hospital, south of Madrid, seems on the cusp of melt-down.

‘I’ve had enough!’ sighs a nurse while taking a blood sample from an elderly woman. The nurse is hoarse, the patient too, but she cannot take a break. If she did, her workload would immediately fall to one of her colleagues. ‘Absent staff are not replaced’, explains a colleague. ‘And then there are also new economic sanctions.’ In 2012, Mariano Rajoy’s government (People’s Party, right-wing), changed the system of daily allowances paid to civil servants unable to work owing to non-occupational illness and accidents. So a nurse will see her allowances reduced by 75% from the fourth day of absence and up to 100% from the twenty-first. The hoarse nurse is still furious: ‘How can I recover when I am in constant contact with sick people? Not to mention that I have to be careful not to infect anyone myself’.

These worrying scenes are commonplace. In another Madrid public hospital, San Carlos Clinic, saturation of the accident and emergency department has forced the institution to cancel long-scheduled operations so as to free up beds and staff. A few months earlier, the accident and emergency staff at Madrid’s La Paz Hospital were also bemoaning the serious deficiencies in their care unit: ‘22 beds for 45 patients’. The Spanish press has echoed the general warnings of the care staff and the indignation of the population in the light of several deaths. They spent up to four days in the accident and emergency department after nine months on a waiting list!

**Increase in cases of medical negligence**

The Defensora del Pueblo (the Spanish equivalent of the Ombudsman), Soledad Becerril, recently published a highly critical report on the situation of the accident and emergency departments in public hospitals. It pointed out, among other things, that ‘the situation of saturation of accident and emergency has become permanent’ and ‘is resulting in more cases of medical negligence’. Reyes Gallego, a nurse at 12 October Hospital and a member of the Unified Health and Safety Union (Sindicato Único de Sanidad e Higiene, SUSH), confirms these risks: ‘When there are three patients in a cubicle intended for two, corridors full of beds and a patient needing urgent attention, the potential errors rises exponentially’. For their part, hospital management bodies and health authorities invariably refer to ‘isolated situations’.

It is difficult to quantify the extent of medical negligence. There are no published official statistics. In 2005, the Spanish Institute of Statistics stopped publishing indicators for the quality of care in hospitals. Only the Defensor del Paciente (Defender of the Patient) association, established in 1987 to come to the assistance of victims of medical negligence, publishes an annual report based on complaints made against accident and emergency departments. According to their data, the number of cases of presumed medical errors has been increasing relentlessly since 2010, rising from 12,162 complaints (including 554 deaths) to 14,749 (including 835 deaths): a rise of 21% in four years. It is for the medical experts and possibly the courts to determine whether there have been any professional failings and whether such failings are directly responsible for deaths. ‘On average, year on year, 40% of the cases that come to the association are confirmed as medical negligence’, says Carmen Flores, president of the association. What about the remaining 60%? The available data do not distinguish between rejected complaints and those not followed up, patients’ legal fees being a deterrent from pursuing claims.

The users’ association is faced with another phenomenon: complaints concerning the length of waiting lists. ‘These complaints concern delays in obtaining a specific treatment, being referred to a specialist or simply obtaining a diagnosis. Of the total number of complaints we receive, two thirds relate to waiting lists’, explains Carmen Flores. These,

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**Towards the end of universal care for the most vulnerable**

Another measure to reduce costs decided in 2012 provides for the withdrawal of the Health Card from all who do not contribute to Spain’s social security system. This involves immigrants in irregular situations, but also the families of regularised immigrant workers and anyone in a situation of social exclusion – young people with no income, the unemployed whose rights have expired, people in a situation of dependence or pensioners receiving less than EUR 400 a month, etc. According to a Doctors of the World report published in February 2015, 40,000 people have been deprived of the right to free medical care, except for emergency assistance.

For more information


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The number of unemployed nurses has multiplied by five, with 20,000 care staff out of work at the end of 2013.
too, have been increasing for three years. According to National Health System statistics, between June 2012 and December 2013 the average wait for an operation rose from 76 days to 88 days. Almost one patient in six across Spain has been on a waiting list for at least six months. For Carmen Flores, there is no doubt about the cause of these cases of negligence and these delays, it’s the budget cuts imposed by the government.

The Spanish Government uses a euphemism to describe this: ‘urgent measures to guarantee the sustainability of the national health system and improve the security of provision’. These measures are reflected in the abolition of 19,000 jobs throughout the country between January 2012 and January 2014, i.e. 7% of public health staff (272,000 doctors and nursing staff). The budget allocated to the public health system fell by 11% between 2010 and 2014. Apart from the deterioration in working conditions and the quality of the care provided to patients, this austerity policy has given rise to an exodus of care staff out of Spain (see the article on p. 26). ‘In the last three years, 7,376 doctors [out of a total of 232,816 doctors registered with the Medical Association in 2013] have applied for a certification of qualification in order to go and work abroad’, calculates the Medical Collegiate Organisation, which oversees the profession. ‘This figure gives a good illustration of the crisis passing through the medical profession in Spain’. The number of certificates awarded has almost tripled since 2010. In parallel, the number of unemployed nurses has multiplied by five, with 20,000 care staff out of work at the end of 2013.

**We are suffering enormous stress**

‘Public health is clearly being ill-treated in Spain’, protests Reyes Gallego, of the minority trade union SUSH. ‘We are overworked and our efforts are valued by neither the hierarchy nor even society. How can we be motivated under these conditions?’. Very often, staff are the direct target for users’ annoyance, considering them to be responsible for their long wait for care. ‘We are suffering enormous stress. Sometimes, at the peak of activity in accident and emergency, a doctor comes and tells us to stop what we are doing and to examine another patient. These are far from the optimum conditions taught at nursing college for this type of work’, says Mar Coloma, a nurse at the Ramón y Cajal public hospital in Madrid. ‘This pressure means that nurses live in constant fear of making errors, never mind the damage this causes’. She remembers an overworked nurse whose finger had been severed in a lift door a few months previously.

Everywhere, quantitative evaluation, through budget management, takes precedence over evaluation of the quality of care and the treatment of patients. ‘As a departmental manager, if you show the management that you are capable of managing the budget allocated and, better still, if you can make savings on the budget, you are rewarded’, says Luis Fernández of the Paediatric Cardiology Department at Ramón y Cajal hospital. ‘Otherwise, you are penalised with a budget reduction for the following year.’ The situation in the clinics is hardly any better. ‘The organisation of work has deteriorated in recent years. Before, we had an evaluation system, greater participation in decision-making and regular dialogue with our superiors. All that has disappeared with the present government’, says Luis Fernández, who works in the Campo Real clinic, 30 kilometres from the capital. ‘We now have the impression that the hierarchy places more value on our ability to reduce costs and manage the budget rather than improve the living conditions and health of our patients. It’s highly discouraging.’

Rather than guaranteeing the sustainability of the national health system, the Spanish government is accused of undermining it, to the advantage of private clinics. The process of privatisation of the health sector began in 1991 under the term of office of the socialist Prime Minister, Felipe González. At that time, a parliamentary report was already talking about ‘a certain fatigue in the health system’. ‘Since then, successive governments have deliberately allowed the public health system to decline. They have constantly reduced its budgets and staff numbers and outsourced services, so as to push the public towards private operators’, complains Juan Antonio Recio, a former nurse and member of the Anti-Privatisation of Public Health Coordinating Group (CAS), which includes health professionals, users and trade unions opposed to the austerity measures. In 2015, the unionist went on hunger strike for 40 days at Princesa university hospital to protest against privatisation.

**Rampant privatisation**

Requesting to be treated in the public sector and being directed towards the private is what happened to Juan José Martín. He needed an operation for varicose veins. First of all, he had to undergo cardiological examinations and have a consultation with a specialist. However, the Madrid public health system now has a computerised service, managed...
by a private company, which centralises all consultations and redirects them directly towards specialists, depending on the state of their diaries. Initially sent to a private institution, Mr Martín refused on principle, wishing to support public services. Response of the Madrid health service: his consultation requested in January 2015 will not be granted until next October. ‘This is a tactic to discourage patients and direct them towards the private sector, where they will not have to wait months to obtain a consultation’, he explains.

Manuel Rengel, a nephrologist at Princessa university hospital confirms this strategy. The patients he receives have initially been systematically directed towards private clinics, under contract to the state, for the initial examinations, which also causes problems with regard to patient follow-up, since, although the consultations are centralised, the transmission of medical records seems to fall between the cracks. ‘There is no communication with the private doctors conducting the initial examinations’, complains the specialist. ‘Therefore, if there is a problem, I don’t know whom to approach. Even if I do know, I have to request authorisation from the hospital management to make contact with an outside doctor with respect to a patient.’ By-passing the computer system, the nephrologist therefore insists that all examinations take place in his department so that patient follow-up is not fragmented.

A report by the Trade Union Confederation CC.OO. (Comisiones Obreras), published last September, gives a detailed analysis of the changes in the budgets allocated to the public system and to the public-private partners with respect to health². Whereas the cash passed to the public care structures is decreasing, that sent to the public-private partnerships is increasing. In ten years, from 2002 to 2012, it has risen from 3.6 billion euro to 5.7 billion, an increase of 63%. Eight new hospitals managed by the private sector under the terms of a partnership with the state have opened their doors in the Madrid region. Public sector care staff have been transferred to them. Are the working conditions and the quality of the care provided still satisfactory? A study undertaken by the Anti-privatisation Coordinating Group after these hospitals opened tends to indicate the opposite, having gathered dozens of witness statements³.

Operating theatres flooded

‘Transfer to the new hospital was the worst year of my life, with toxic relations between professionals and a deteriorating quality of care. Whenever we started to protest, we had huge problems with the management. Some of our statements found their way into the press and we received direct threats’, says an accident and emergency doctor at the privatised Majadahonda hospital. ‘Although the team is quite young, 30 to 40 years old, absences from work are becoming longer and longer, with obvious depression. I’ve seen doctors snap and go home in tears’, says a nurse at the same hospital. The very design of these new hospitals is questioned by the staff working there. ‘There are leaks everywhere, the pipes drip. When it rains, the water comes under the emergency exit doors into the operating theatres, even though these are meant to be completely watertight! The only thing the management suggests is to use buckets’, says an auxiliary nurse at Infanta Leonor hospital.

The reaction to this degradation of the Spanish health system first came from the anti-austerity movements, born in the wake of the ‘indignant movement’. Following the announcement in April 2012 by the Regional Minister of Health, Javier Fernández Lasquetty (People’s Party) of several measures – fall in the public health budget by 7%, total privatisation of several hospitals and clinics –, many groups of citizens were formed to protest against the budget cuts and privatisation. Then, ‘white tides’, comprising health professionals, patient associations and trade unions (including the two main confederations, CC.OO. and UGT), flooded the streets of Madrid in support of a ‘health system under public, universal and high-quality management’.

In January 2014, the Supreme Court of Justice in Madrid decided to implement a preventative suspension of the process of privatisation of six hospitals. This extensive privatisation could ‘do irreparable damage’ to users and medical staff in Madrid, the judges considered. At the same time, the regional government announced that it wished to abandon these privatisations. This suspension of privatisation does not resolve the upheavals with respect to the organisation of work and the outsourcing of services affecting care staff. At Princesa university hospital, the cleaning services have been sold to a company in the ACS group, which is active in construction and public works and services. Consequence: ‘Our team has lost 45% of its staff’, says one of the employees, who prefers to remain anonymous. ‘They are asking us to provide the same quality of work as before, but it’s impossible! We have written several letters to the management to tell them that we do not accept responsibility for the condition of the hospital with respect to hygiene.’ The anger becomes all the greater since the groups profiting from these privatisations are often implicated in corruption scandals associated with the illegal financing of political parties. The Spanish public health system is really suffering! ’
Occupational health: a starting point for European social dialogue

Since 2006, representatives of the staff and management of private and public hospitals have met regularly as members of the European Sectoral Social Dialogue Committee for the Hospital Sector, a body recognised by the European Commission. Occupational health issues quickly made it onto the agenda, and tangible results were soon achieved, with an agreement on sharps injuries being transposed into a directive. Could this initial success pave the way for further improvements in working conditions in the sector?

Interview by
Denis Grégoire
ETUJ

In 2010 an agreement between social partners resulted in a Directive on prevention from sharp injuries in the healthcare sector.
Image © Belga
The sharps injuries agreement is a good example of how the social partners can get involved in designing and implementing European legislation that meets the needs of workers and reflects the realities in the healthcare facilities. It also helped to strengthen the role of social partners in the field of health and safety in general, especially in countries where they would not otherwise have had a role in codifying the process and in monitoring what is happening and how the legislation is being implemented.

Finally, this involvement in transposing and monitoring the directive on sharps injuries also helped in some countries to expand the coverage of this agreement from the hospital sector into some other sectors where there is a risk of sharps injuries, such as elderly care.

The most important point is that the framework agreement allowed us to set out a range of general principles – on risk assessment, prevention, training, etc. – on which the health and safety initiatives pursued by social partners, together with governments, should focus, and these principles can also be applied to other risks.

Mathias Maucher

Mathias Maucher is responsible for the ‘Health and Social Services’ sector at the European Federation of Public Service Unions (EPSU). EPSU affiliates about 8 million public service workers from over 260 trade unions in more than 45 countries, about 3.5 million of them from the health and social services sector.

Could a similar approach be envisaged to counter problems such as musculoskeletal disorders and psychosocial risks?

Those two points are very important for our current work and we are indeed running a joint project with HOSPEEM to look again into possibilities of social partner-based activities to address these health and safety risks, i.e. to prevent and to reduce them. These initiatives will obviously need to be underpinned by national policies and legislation, by European directives and by a European OSH strategy.

In the case of musculoskeletal disorders, it is easier to start our work because there is already European legislation on manual handling. A legislative initiative was undertaken in around 2009 to broaden the scope of the legislation and the range of risks covered in a directive on ‘ergonomics’, but eventually that could not be pursued due to political resistance from governments and employers’ organisations. In principle, there is a strong interest from EPSU in having a broader scope so that risks related to musculoskeletal disorders are covered, with a stronger focus on risk assessment and also an adaptation of the legislation to changes in working realities and work environments in the sector.

What we have heard from several of our affiliates is that the existing legislative framework seems to work rather well in hospitals. But it is obviously more the case in the Nordic and the Western European countries, where there is more money in the system, a generally functioning social partnership and effective legislation. We have generally observed, however, that outpatient/community-based/home care is not that well covered and that improvements are needed there. There are developments such as ‘hôpital à domicile’ – home hospital care – with medical care provided outside the walls of a hospital and a trend towards smaller organisations providing medical and care services.

For psychosocial risks and stress in the workplace, it’s more complex. They are obviously a very important challenge for the health sector, due to factors such as increased work load and time pressures, the intensification of work, ethical stress (resulting from the fact that you too often cannot do what you have been trained for and what your own work ethics and the ethics of your profession would demand), a lack of worker involvement in decision making, and violence, harassment and bullying. There is also a need to address much more organisational issues leading to psychosocial stress, in addition to support measures for the individual worker. As yet, there is no specific EU legislation on this risk or certain aspects of it.

'It’s far too early to say what we will be able to agree upon together with HOSPEEM.'

Mathias Maucher
and what the appropriate instruments, the final scope and the priorities for action might be. But both social partners want to use the opportunities afforded by the Healthy Workplace Campaign 2014-2015, initiated by the European Agency for Safety and Health at Work, and enrich that campaign with input from the health sector.

Many nurses complain about how hard their work is and do not believe they will be able to keep going until the legal retirement age. What can be done to tackle the challenge of premature ageing among healthcare professionals?

One major focus of our approach to this challenge, on which we were able to agree guidance with HOSPEEM in 2013, was to look into policies or strategies that would start earlier than the age of 50 or 55. Many workers might not even be able to work at that age because they are worn-out, have already been affected by occupational diseases or disabilities, and are no longer physically or psychologically capable of doing their job.

There is a need to develop a comprehensive approach spanning the entirety of the worker’s life and career, based on measures to support effective recruitment and retention. We are very much in favour of developing measures and policies to prolong healthy working careers from the start, but opposed to increases in the retirement age.

We are therefore endeavouring to build up a package of measures that would help reduce the particular physically and psychologically demanding elements of work, such as night shifts and weekend work, or lifting patients. We are also seeking to improve the organisation of work, to provide for continuous professional development, and to allow for time for tutoring and mentoring. We are talking about a mix of arrangements to enable workers, especially nurses, healthcare assistants and paramedics, but many others too, to keep working for longer, but in the healthiest way possible. Another strong focus of our approach to the ageing workforce was on demonstrating the positive effect of investing in measures to achieve these aims. It is also in employers’ interests to promote measures that reduce the costs of sick leave and long-term absences from work due to disability or occupational diseases caused by exhaustion and excessive work-related stress.

Measures to reduce the operating costs of healthcare systems have been imposed in many European countries. Is it possible to gauge the consequences of these measures on the working conditions of nursing staff yet?

First of all, the measures have had an immediate impact, with pay freezes and, in several countries, pay cuts, as well as clear staff shortages. In several countries, the economic crisis has seen many of our colleagues made redundant, as well as an increase in unemployment among qualified health workers. This results in an increased workload for those in employment. In some cases we are also witnessing more precarious employment conditions. When the economic crisis hit, in many countries, there was no systematic investment in equipment or training, and often not enough money for continuous professional development and lifelong learning for all health workers.

What we saw with regard to the health and safety provisions is that where there was no strong European legislative framework giving rise, in turn, to national regulations and other supporting actions – ranging from awareness raising to training, risk assessment, education and investment in equipment, etc. – health and safety policies and provisions came under enormous pressure or were no longer respected, to the detriment of the health and safety of workers and patients.

The European policy and legislative framework has helped to prevent attacks on national regulation, as we have seen in Spain where the legislation on the prevention of sharps injuries provided a safeguard against reducing the level of protection. What we hear from our Spanish colleagues, for example, is that when you have this European legislation and OSH strategies in place, then the national health and safety institutions can better underpin their work, put aside money and keep up a political commitment to preventing and reducing OSH risks.

Where there is a strong European legislative framework that has also been underpinned by social partner-based arrangements, governments, ministries and employers are more inclined, or even obliged, to act. In countries where these pre-conditions are not met, the situation has become more difficult and in some cases disastrous. EPSU and HOSPEEM have agreed to a code of conduct on cross-border recruitment in an effort to prevent social dumping in the sector. Is this kind of measure, which is not legally binding, enough to counter such practices, particularly in the elderly care sector, where staffing needs are considerable?

With regard to the use of and compliance of recruitment agencies and the non-discriminatory treatment of migrant workers by employers who are members of HOSPEEM, it seems that the code is working well. But we at EPSU are also interested in the broader sector encompassing residential and home-based elderly care. In this sector in particular, there are employers that do not work with properly functioning agencies, will not necessarily comply with European and national legislation and, last but not least, will not sign up to collective agreements that would bind them to provide certain employment conditions.

We are seeing improper behaviour at two levels: first of all, especially in the commercial private hospital and elderly care sectors, some employers use recruitment agencies that do not comply with the principles set out in the code of conduct and then also fall back on contractual arrangements with lower pay, longer working hours, professional qualifications that are not properly recognised, and clauses linked to language courses that bind the workers to the employers for a longer period. We have seen this with Spanish nurses in intensive home care.

The other point is that the professional qualifications of nurses are not properly recognised, particularly when employers have not signed up to collective agreements. If you are a general nurse, you need to be recognised as a general nurse in another EU Member State. Language difficulties cannot be a reason not to recognise a professional qualification and not to comply with the existing legislation and collectively bargain pay and working conditions.

We are confronted with often scandalous treatment of thousands of health and social care workers, in particular in the Mediterranean area and from Central and Eastern Europe, and mostly in the elderly care sector. In these countries, not least as a consequence of the crisis, there is a depletion of the workforce. These countries are losing considerable numbers of their highly qualified, motivated, and well-trained workers, in whose general education, professional training and medical studies they have invested. A code of conduct alone cannot help in this context. We would
need other legislative or policy measures to better protect and support workers in the countries with outward migration and more investment in these health systems to provide better pay and working conditions there, too.

Brussels, 13 March 2015

For more information

EPSU devotes part of its website to the European social dialogue in the healthcare sector: www.epsu.org/r/20

In 2009, your organisation signed a framework agreement on sharp injuries with EPSU that has been transposed into an EU directive. What conclusions do you draw from this experience?

Tjitte Alkema — As representatives of an employers’ federation, we are not per se looking for additional regulations at the European level because we think there are already quite a lot of directives that are also influencing the national settings. So we select the instruments that we think are appropriate. In the case of the medical sharps agreement, at first the social partners were not so interested in dealing with this issue because it was seen as very technical. It was only after a seminar was organised, where the impact of this problem, supported by facts and figures, was introduced into the discussion, that the social partners became aware that dealing with this problem was about more than finding a technical solution.

In the context of the agreement, we included key principles, especially risk assessment, prevention of worker injuries with the introduction of safe needles when needed, information, awareness raising and training of medical professionals. We had four regional seminars on the implementation of the directive. During one seminar, a medical doctor from one of the participating hospitals told us a story about entering an operating theatre after the safe needles were introduced there. She was looking around in this operating theatre and she saw a load of plastic capsules lying around. She asked one of the operating nurses what these capsules were. The nurse told her: ‘Well, these are the capsules that we have now on the safe needles and we break them up before we start the procedure, then we can keep on working like we used to.’

This is exactly the point that we wanted to make by reaching this agreement, that it is not just about finding a technical solution, but mostly about awareness raising and also influencing the cultural aspects of workplace safety.

Could the process that led to the transposition of the European social partners’ agreement on sharp injuries into a directive be used to address other risks?

Tjitte Alkema

Tjitte Alkema is Secretary General of the European Hospital and Healthcare Employers’ Association (HOSPEEM).

HOSPEEM was formed in 2005 to represent the interests of European Hospital and Healthcare Employers on workforce and industrial relations issues. It has members across the European Union both in the state- or regionally-controlled hospital sector and in the private health sector.

Occupational safety and health is an area that is very well regulated both at the European and at the national level. I don’t think that additional regulation is particularly necessary. What we do think is that, like what is currently happening in the REFIT programme, all these directives have to be reconsidered in terms of whether they are still fit for purpose. It’s always important to evaluate what you have put in place as regulation to see if it is still an appropriate way of reducing the risk that it was intended for.

In the instruments that we are using with EPSU in the social dialogue we also always include a paragraph on monitoring and evaluation, forcing ourselves to follow-up on our agreements to see if they are still having the effects that they were intended to have.

Your sector is deeply affected by musculoskeletal disorders and psychosocial risks. What plans do you have to tackle these problems?

In 2014, HOSPEEM and EPSU agreed on a work programme in which one of the key elements is dealing with these two topics especially. In two weeks’ time in Paris, on 25 March (the interview was recorded in early March, Ed.), we are going to have a large conference on the issue of musculoskeletal disorders (MSDs) with many stakeholders, including research institutes. It’s important that we start with a conference like this to distinguish between facts and opinions and also to identify effective practices already in place. It’s not an issue that requires new regulation. What it does require is a good exchange of information on the most effective approaches for dealing with it.

With regard to psychosocial risks, I have seen from research that the two issues can even be interrelated. Sometimes MSDs lead to psychosocial risks in the workplace. So there is coherence between the two. I think that the approach of the conference in Helsinki will be mostly the same, namely trying to establish an objective platform where we can discuss facts and research outcomes and exchange good practice examples. But of course, the approach will also be different because within the area of MSDs there is a technical aspect that needs to be taken into consideration, whereas for psychosocial risks and stress at work this will be different. It’s more linked to industrial relations, relations between management and professionals and work organisation issues.

It’s very obvious that there is a prominent reason to tackle these two hazards, for employers too, not just because we want to create the safest possible workplace for staff, but also because there is a very clear economic incentive. The two issues that we are talking about now are the major causes of staff absenteeism.
A mental shift, combined with good work approaches, makes it possible to continue to work until the retirement age.

Concerning the manual lifting of people, new technical approaches have been put in place in many Member States, where lifting patients manually is not part of the protocol at all anymore.

There are quite a number of initiatives that have reduced the physical burdens on nurses as a professional group. These new approaches are available and cost-effective. This can be done without introducing new regulation or new rules.

These approaches can work very well. On top of that, training and continuous training should be put in place. Beyond the age of 45, and also beyond the age of 50, there is not currently a huge training budget available for professionals in these age groups in the sector. We should rethink this approach to investment in training in health professionals because investment in training should, as far as I am concerned, continue until retirement age.

European countries with an ageing population have been trying to respond to the growing medical care demand by recruiting nurses in Eastern Europe or in countries severely affected by the crisis such as Spain. In some cases, they have been hired on less advantageous terms than the national workers. How do you respond to that?

In 2008, EPSU and HOSPEEM adopted a code of conduct on ethical cross-border recruitment and retention that states that if international recruitment is required because there is a temporary shortage of health professionals in the receiving country, then the terms and conditions under which these migrant workers are employed should be the same as the terms and conditions applied to the local workforce.

As a European employers' Federation, I stick very much to the agreement that we have with EPSU, which makes it very clear that the terms and conditions, the availability of training and the relevant ILO conventions should all be maintained.

My Federation has no intention whatsoever of approving a situation where there is social dumping or wage dumping.

I would also like to stress that distinguishing between facts and opinion is very important. The absolute number of nurses working as migrant workers in Western EU countries is really very low. And it is also a result of the fact that due to austerity programmes in many Western European countries, instead of having a shortage of health professionals, we have an abundance of health professionals. In Western European countries, we now have unemployment among well-trained young health professionals who were educated to fill positions that we anticipated would absolutely need filling in the near future.

For a couple of years there has been a trend across Europe of bringing new private-sector-inspired organisation and management methods into care settings. Some professionals consider this as a fundamental transformation of the nature of their job and can no longer see themselves carrying on. Are these new methods inevitable?

Actually, I think that most professionals in the sector should be happy with the fact that new insights in human resource management are being introduced in a sector that has not been influenced that much by outside influences like modern human resources and management theories. I think in many Western European countries, you are already seeing a mix of public health providers and private health providers. I don’t think that the quality of human resource management in a private setting is worse than in a public setting. I know from my own experience working in a university environment that investing in the skills and education of public-service employees is often a much-neglected part of human resources policy.

I don’t think that many health professionals are leaving the sector because human resource strategies from the private sector are being introduced. I think that it is more of a plus than a risk. What you do see is that, as a result of privatisation, the budgetary system sometimes also changes, putting pressure on health providers to provide more services at lower cost. This creates work-related stress among health professionals that cannot always be dealt with within the hospital setting. And if this is happening, it is nothing to do with introducing private organisation methods: it is a result of budgetary restraints.

I think that we should be very clear about one thing: the hospital sector will never be a real private sector. It will always be a sector that provides services of general interest. So we need to align the interests of the health professionals who want to provide these services of general interest and introduce effective human resources strategies to support them.
The invisible workers caring for the German elderly

German hospitals, clinics and retirement homes are desperately short of labour. They are therefore recruiting more and more foreign care staff, mainly women, from eastern and southern Europe. With the low wages, employment contracts with exploitative clauses and onerous tasks, Germany is not the Eldorado hoped for.

Rachel Knaebel
Journalist, correspondent of www.bastamag.net

Beth Wambui Haupt, whose husband is German, comes from Kenya and has lived in Germany for eight years. Since 2009 she has worked as a nursing auxiliary with old people in a retirement home in Berlin.
'What you have to do to work in Germany', says an endorsement to the employment contract to be signed by Bulgarian nurses recruited by a German temping agency. And as regards reaching Eldorado in Germany, the premier European economy: 'We can’t offer you a land of plenty in Germany, because it doesn’t exist!', warns the contract. Then, in bold: 'In Germany, everything is directed towards a high-performance society. This means you have to give 100% every day.' The other clauses of the employment contract are hardly more enticing. Employees have to pay financial penalties of EUR 3,000 to 5,000 if they disclose the employment and training conditions to a third party or if they breach the contract during the first year. This ‘fine’ has to be paid immediately and is collected by a Bulgarian collection firm.

'These clauses are null and void; they have no legal validity,' says Vladimir Bogoeski, a Bulgarian-speaking trade union adviser to the German Trade Union Confederation DGB (Deutscher Gewerkschaftsbund). As part of the European project for assistance to casual workers, Fair Mobility, he has already helped some of these nurses hired by the temping firm. ‘Workers have told me they had to sign 15-page contracts on the spot, with no time to ask for advice.’

The German health system has for years been recruiting care staff from eastern Europe. This phenomenon has taken on a new scale with the ever more striking shortage of labour in the sector. According to German Employment Agency figures, a nursing post remains vacant for 15 weeks on average before being filled. This period increases to more than four months for a job in a retirement home which provides health care. The situation is only going to get worse in view of the changes in German demographics. In this context, some recruitment agencies seem open to any abuses.

**Offices throughout eastern Europe**

It was in his Berlin office that Vladimir Bogoeski received the first appeals for help from a handful of Bulgarian nurses in mid-January 2015. He is now dealing with two groups from Sofia, the capital, and a provincial town, Vratsa. Similar recruitment is said to be underway in Romania. The German temping company has offices throughout eastern Europe, from Tallinn to Budapest. Its website has been translated into six languages: Bulgarian, Romanian, Slovak, Hungarian, Czech and English. It finds qualified nurses, organises three-month German courses for them in their own countries, then sends them to work in Germany on temporary contracts. Care staff are seduced by tempting wage prospects.

In Bulgaria, nurses’ wages are miserable, between EUR 300 and 700 maximum, explains Valeri Bosukov. He used to work as a German teacher for the temping company. He taught the language of Goethe to a group of ten women from Vratsa with a view to their early employment in Germany. In order to have their nursing qualifications accepted, migrant staff must first of all be able to prove an adequate knowledge of German. However, according to the teacher, ‘it is impossible to reach this level in three months without any prior knowledge’. The future employer pays the costs of German lessons, estimated at EUR 1,800 per person for three months. But this advance payment has to be reimbursed by employees once their employment contract has been signed: EUR 150 deducted from their wage each month for a year.

‘Nurses had to leave their jobs in Bulgaria to attend the course, which is full-time’, says Vladimir Bogoeski. ‘They don’t earn anything during this period’, adds Valeri Bosukov. They are supposed to receive EUR 10 compensation per day, but the money doesn’t always arrive. It’s like financial slavery.’ Without the required level of language, these people, even though trained, cannot work as nurses in Germany. They have to either reimburse the EUR 1,800, or go to Germany anyway to work as trainees until they pass the language test, or as care assistants for a 20% lower hourly wage. These temps also have to be highly mobile and flexible: the contract is very vague as regards possible workplace. Employees can be sent anywhere in Germany and to any kind of healthcare institution: ‘hospitals, retirement homes and any healthcare institution’.

Under these conditions, none of the nurses in the group from Sofia being followed by Vladimir Bogoeski eventually boarded the plane for Germany. The trade unionist and three of the nurses sent letters of resignation. The response from the company was unexpected. ‘We request that you pay the costs of language training in the sum of EUR 1,800 by 15 February to the following account’, instructed the temping agency in a letter in late January, threatening them with court proceedings and financial penalties.

Vladimir Bogoeski was unimpressed: ‘We are going to ask for proof of the cost of the course’, says the trade unionist, who contacted the company. The company previcated, arguing that it had never really made a threat of financial penalties. But it continued to worry the care staff. ‘The nurses are really afraid of these fines. They are also afraid of just consulting a trade unionist’, says the
German teacher Valeri Bosukov, who is acting as an intermediary between the German trade union and the nurses from Vratsa.

Without sufficient knowledge of the language and without recognition of their qualifications, those arriving in Germany work for the time being with the status of trainees. 'Without a proper wage, with just a roof over their head provided by the company and pocket money to feed themselves,' says Vladimir Bogoeski. 'They have no idea what's going to happen. But they are qualified nurses, with lots of experience, who have worked in intensive care, accident and emergency and neurology here in Bulgaria. Today, they are almost on the street and have no possibility for continuing to learn German,' their former teacher complains.

Spanish, Portuguese and Greek nurses

Eastern Europe is not the only breeding ground for migrant nurses for German care institutions. More and more Spaniards, Portuguese and Greeks are coming to work in Germany owing to the crisis in southern Europe. Maria (her name has been changed) is Portuguese. Qualified in nursing in her home country, she chose to emigrate to Berlin. Her first German employer first of all paid her the wage of a part-time care assistant. The language course was financed by European funds. She learned German and then started at a retirement home in Berlin. When she realised that her wage was far less than she could earn elsewhere under better conditions, she resigned. Her former employer then claimed reimbursement of the costs incurred when she was learning German: thousands of euro to pay.

These particular practices have appeared in recent times in Germany. They have been implemented by private institutions recruiting staff directly from abroad, without going through temping agencies. 'Since the health sector is facing a labour shortage, wages are generally rather high,' explains Kalle Kunkel, Secretary General at the German Services Trade Union Federation Verdi. So a nurse can earn EUR 13 to 15 gross per hour. But the sector has no collective agreement applying to everyone. Only public institutions have one. So, private clinics, retirement homes and care services can offer far lower wages to nurses from abroad, who are not aware of the normal level of remuneration.

Kalle Kunkel turns to a heavy file and takes out a contract offered to a Spanish nurse by a company providing intensive medical home care. The company employs about a hundred foreign nurses, 5% of its staff. The wage is EUR 9.50 gross per hour. The company has no staff representatives, so we have not managed to find out how much German colleagues are paid on average. But I have seen in German nurses’ contracts offered by this company that wages begin at EUR 11.

The company denied any discrimination and issued a statement to the effect that it pays its employees ‘according to their qualifications and experience’. Remuneration is negotiated individually and depends on candidates’ profile, qualifications and soft skills, added the company, refusing to provide details. 'The employer can always say that foreign nurses do not speak German as well as the others and this justifies a difference in wage. But, for its part, the firm receives the same amount from its clients', Kalle Kunkel points out.

'When Portuguese or Spanish colleagues see that they could earn more elsewhere, they want to change employer and then they notice that this involves a clause in their contract obliging them to remain in post for three years. Otherwise, they have to reimburse the costs incurred during the German course', continues the trade unionist. The sums claimed vary from EUR 6 000 to 10 000, amounts which taper off in line with the number of months worked. According to the Verdi trade union, at least 300 migrant nurses have been in this situation in the last two years just in the Berlin-Brandenburg region.

From operating theatre to cleaning the floor

It's not just the remuneration. Nurses' work is often less qualified and physically harder in Germany than in the home countries of European staff. In Germany, it covers tasks such as hygiene care carried out elsewhere by care assistants. 'Nurses in the rest of Europe often have broader skills than in Germany. But there are areas, such as basic care, where they have little practical experience', says the German Agaplesion group of private clinics, which employs more than 200 migrant nurses in Frankfurt alone who receive up to 200 infirmiers migrants rien qu'à Francfort.

'Spanish colleagues who come to work here are more highly qualified than the Germans. Our working conditions do not meet their expectations', confirms Dietmar Erdmeier, adviser on health policies at the Verdi trade union confederation.

Some companies specialising in home care also require them to carry out tasks which have nothing to do with care. 'For example, an intensive home care company which has recruited dozens of European nurses in recent years needs qualified staff for medical care, but these trained nurses are also treated like home helps. They are asked to do everything: walk the dog, water the plants, clean the floor', says Sylvia Timm, a Polish adviser specialising in the care sector at the DGB trade union confederation. 'One

'We can’t offer you a land of plenty in Germany, because it doesn’t exist!

Extract from an employment contract

Danuta Joanna Dunajewski comes from Poland and has lived in Germany for 11 years. She has worked as a nursing auxiliary for three years.
of the Polish nurses I advised had previously worked in the operating theatre at the university hospital in Warsaw. And, all of a sudden, she was asked to clean the floor! With a contract that does not allow her to resign!'

Many resign anyway, in the hope that their employers will not go to court to obtain the thousands of euro claimed. Elsewhere, they find more highly qualified and better paid jobs. Like Maria, who quickly found a job at the university hospital in Berlin. Sylwia Timm says with regret: 'Foreign nurses are not always aware of their value on the German labour market. Their employers hide it from them well.'

The remuneration awaiting them in Germany is EUR 1 400 gross on average.

There are companies which operate on the basis of the casual work directive but often do not meet the required conditions. Since this involves home working, nobody checks it and the German authorities cannot in any case keep an eye on companies which are based in Poland, Sylwia Timm explains. And then there are women working as freelances and other employees working entirely on the black economy. For all of them, whatever their status, it is anyway very difficult to prove that they have worked such and such a number of hours or even that they have worked for such and such a person. These women carry out all the care and home help tasks they are asked to, but they have no right to paid holidays, nor sick leave, and not always even sickness insurance. They have almost no rights.'

Home care assistants: ‘They have almost no rights’

According to the German Services Trade Union Federation Verdi, between 115 000 and 300 000 migrants from eastern Europe are working in the home care sector for elderly people. It is impossible to establish a more precise figure since many of these workers, the great majority of them women, are invisible. ‘They disappear shortly after arriving at the homes of the individuals who employ them’, says Sylwia Timm, a Polish adviser for the personal care sector at the German trade union confederation DGB, as part of the European project for assistance to casual workers Fair Mobility. ‘They are not represented, not organised and, whether it be in Germany or in Poland, no government is looking out for them.’

But there is much to do. Germany is short of between 150 000 and 190 000 care staff, nurses, care assistants and unqualified staff to look after elderly people. The sector already makes great use of migrant workers to meet this demand for labour. The phenomenon is set to expand since the number of people needing home care is about to increase from 2.3 to 3.4 million by 2030, according to forecasts by the German Statistics Institute.

What with the difficulty of the job – carrying people, endless hygiene care, etc. –, the emotional stress, very often availability for 24 hours a day and extremely low wages, the working conditions of these home employees are particularly difficult. ‘Their working hours are not defined at all. Staff often sleep at the place where they work, being present seven days a week’, notes Dietmar Erdmeier, responsible for health policy and the question of care for elderly people at the Verdi trade union. ‘They are most usually women aged between 45 and 60 years’, adds Sylwia Timm. ‘Some of them have little chance of finding a job in their own countries and they often underestimate the difficulty of this work. Others are already receiving a small pension, but not enough to live on.’

However, the remuneration awaiting them in Germany is poor: EUR 1 400 gross on average according to data gathered by Verdi for full-time attendance on elderly people. ‘Since these people work for more than 48 hours a week, the wage is well below the minimum wage for the care sector’ (EUR 9.40 gross at present in western Germany and EUR 8.65 in the east), the trade union concludes in a 2014 study*. Remuneration which is also below the general minimum wage in force in Germany since 1 January 2015, amounting to EUR 8.50 gross per hour. ‘The minimum wage should clearly apply for these workers. But they will have to claim it and there will have to be checks’, says Sylwia Timm.

However, checks are made even more difficult by the profile of the companies in the sector covering home care for elderly people. This sector is dominated by a whole bunch of private enterprises who send staff to their patients. There are more than 12 000 of them. The sector also relies on foreign companies, which send casual workers, or on organisations which put families in direct contact with staff working as freelances, a status open to all kinds of abuse.

*‘Migrantinnen aus Osteuropa in Privathaushalten’, Problemstellungen und politische Herausforderungen, Berlin, March 2014. The figures mentioned here are all taken from this study.
MSDs: why wholly technology-based solutions do not work

Nursing is strenuous work and in most European countries a high proportion of workers want to leave the profession. Physically demanding tasks are a major factor: manual handling of patients (getting them on their feet, moving them, transferring them, lifting and repositioning them) and having to maintain restrictive and uncomfortable positions while treating them are the main cause of musculoskeletal disorders (MSDs) among nursing staff. Technology alone will not improve the situation.

Marianne De Troyer
ETUI

Image: © Belga, AFP
To reduce accidents, absences due to incapacity for work and occupational illnesses related to musculoskeletal disorders, risk prevention staff recommend limiting exposure to risk during manual handling tasks by acquiring assistive technology and equipment and training staff to adopt the right movements and postures. Equipment of varying levels of sophistication has appeared on the market, including slide sheets, transfer boards, lifts, ceiling track hoists and electric beds.

Training, meanwhile, focuses on helping nursing staff to master the different techniques for different patient handling situations (manual transfers with one or more nursing staff; handling operations using ‘small’ equipment such as trapeze bars, ergonomic handling belts and rotating footboards; or those using ‘large’ equipment such as mechanical lifts and sit-to-stand hoists). Such training, which is very widespread in Europe and is followed by large numbers of workers, gives staff an understanding of the principles of safe manual handling, but it often bears little resemblance to ‘real’ working situations.

This biomechanical approach to tackling MSDs has shown its limits. Many studies suggest that working conditions in the hospital sector have deteriorated considerably, with barely any reduction in the physical workload borne by nursing staff, who continue to suffer from MSDs in large numbers. Evidently, patient handling equipment and assistive technology alone are not sufficient to solve this problem. An overall analysis of the working situation of nursing staff and the environment in which manual handling is performed, and in which such equipment is used, must be conducted in order to ensure that the equipment is properly integrated in the working process.

The need for testing

Before assistive technology is acquired, it must be tested. The participation of hospital staff in this testing is vital. Yet work equipment is still often bought from a catalogue with no account taken of the needs of nursing staff or patients, or of the architectural reality of the buildings, care units and wards. In Europe, the importance of designing ergonomic hospital structures is often neglected. Few hospital development or renovation projects make the effort to understand the specific working realities of the care units and technical departments and to design premises tailored to nursing staff’s needs and expectations. To give just one example, many wards are so cramped that they hinder work, force staff to adopt unsuitable postures and cannot accommodate assistive technology.

It is vital that thought be given to the environment in which assistive technology will be used. More specifically, can the assistive technology be moved around freely within and between the floors and care units? Is there sufficient space around the patients in the wards to perform manual handling? Does the lift fit through the door? Can it be properly positioned at the patient’s bedside? Do the baseplate and forked base fit under the bed? Does the floor covering influence the way the lift is used? As well as the size of the working equipment, difficulties in moving or pivoting it in the working environment may also be neglected.

Once the assistive technology has been purchased, a robust maintenance programme must be established for the equipment. Failure to maintain the assistive technology or to replace damaged technology when necessary increases the risks of repetitive strain and adoption of inappropriate positions.

In the care sector, the manual handling of patients accounts for a considerable proportion of nursing staff’s work. There must be prior and continuous assessment of patients, which must take into account various criteria to determine the most appropriate handling technique: the nature of the transfer to be performed1, the patient’s medical condition, the patient’s needs, his/her ability to understand and cooperate, his/her morphology (obese or large patients) and his/her degree of functional independence. If assistive technology is used, its compliance (choice of straps, etc.) must be assessed in relation to the specific characteristics of each patient. Such an assessment must be performed each time a new patient arrives in the department or whenever there are changes in the care workload. Manual handling by care staff in a hospital environment often turns out to be more complex than one might think.

In other words, each handling operation or transfer must be thought of as unique and be assessed beforehand to ensure that it is performed in the safest possible manner for both patients and nursing staff. The use of handling equipment must be integrated in daily care practice and must not be considered a waste of time, a delaying factor or, indeed, a miracle solution that does not require any concomitant human investment.

Do not neglect interpersonal care

Ergonomic studies in hospitals have shown that the fragmentation of nursing staff’s work and the many constraints they face tend to prevent them from cultivating a personal relationship with patients. The interpersonal aspects of nursing work are being increasingly neglected because they are deemed superfluous in a profit-centred world. Yet patients cannot be handled or moved around like crates of vegetables or parcels. The way in which nursing staff listen to, talk to and act with them can bring patients real comfort, whereas assistive technology may discourage or even frighten them. Being suspended in the air in a harness or sling is not easy. Ergonomic studies in hospitals have shown that the fragmentation of nursing staff’s work and the many constraints they face tend to prevent them from cultivating a personal relationship with patients.
patients will be satisfied by its reassuring appearance or appreciate being handled in this way. The Japanese authorities are supporting a number of robotics research programmes designed to make up for labour shortages in several sectors, including health.

Over the last two decades, the approach taken by researchers and ergonomists to MSDs has changed. Such disorders are now examined in correlation with other risk factors such as psychological-organisational constraints, psychological-social factors, the intensification of work, and technical constraints. Among these factors, psychological-organisational constraints have a considerable impact on nursing staff’s work. Such constraints include a lack of room for manoeuvre, insufficient breaks, disruption to schedules, urgent work, frequent interruptions to the task in hand (answering the telephone, colleagues asking for help, patients calling for assistance), a lack of regular recognition of their work by their management, stress, and failure to replace sick staff.

In hospitals, the intensification of work is reflected not only in a shortening of patient stays, but also in the introduction of productivity requirements, the need to comply with a rising number of procedures, and an increase in administrative tasks due to computerisation (see article on p. 12). In such a context, it is difficult to improve the working conditions of hospital staff and, in particular, to implement effective and lasting solutions to reduce MSDs.

**Possible avenues to explore**

What actions could be reproduced on the ground to better protect the health of nursing staff? Various reviews of scientific literature on the manual handling of patients have shown that interventions based essentially on technique training of nursing staff have little impact on their working practices and injury rates. Conversely, multi-factorial interventions have proven to be the most appropriate for reducing rates of musculoskeletal injury. Two ergonomists from the University of Loughborough (UK)\(^1\), Sue Hignett and Mike Fray, have identified seven strategies, which they have combined and integrated in a generic programme to improve the occupational health of nursing staff: equipment provision; initial and in-service training in manual handling techniques; evaluating staff’s physical workload; examining the policies and procedures implemented in the hospital; a patient assessment system; analysing the design of the working environment; and analysing work organisation and working practices.

For several years, the European Panel on Patient Handling Ergonomics was involved in drafting an international technical report on the safe manual handling of patients in the healthcare sector\(^2\). This report presents an overall prevention strategy, based on an analysis of the risks involved in handling and transferring patients, and taking into account all the factors (organisational, structural and training-related) that might affect this aspect of nursing staff’s work.

In order to measure the effectiveness of ergonomic measures on patient handling and transfer, Fray and Hignett also developed an overall evaluation tool\(^3\). Based on the examination of twelve individual dimensions, it establishes a single indicator for evaluating an intervention. The dimensions examined are: safety culture; musculoskeletal health measures for staff; an instrument for observing and assessing the techniques used by nursing staff for manual handling of patients; statistics on staff absences and the reasons for them; the quality of care provided; the number of patient handling accidents and incidents reported; the psychological well-being of nursing staff; patient condition; MSD exposure measures; patient injuries during handling (lacerations, tissue damage, etc.); and an estimate of the direct and indirect costs of MSDs among hospital workers.

In 2013-2014, the Swedish labour inspectorate\(^4\) studied the health of female health workers involved in handling and transferring patients (in hospitals and social care), after the Swedish government tasked it with preventing the exclusion of women from the work of work due to factors related to the working environment. The inspectorate aimed to increase awareness of the risks associated with MSDs and knowledge of how to prevent and detect them. Across the 692 healthcare institutions visited, 75% of employers received one or more requests from the inspectorate with the aim of addressing shortcomings in MSD prevention!

The hardest aspect in the hospital sector is probably improving the working conditions of nursing staff in order to make their work tenable, while also preserving quality of care and patient comfort at a time when they are coming under pressure from new economic management criteria.

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**Patients cannot be moved around like crates of vegetables.**
Chemotherapy: a risk ignored by nursing staff

With the constant increase in the number of people affected by cancer – according to the WHO, there will be a 70% increase in the number of new cases over the next two decades – nursing staff are required to treat a growing number of cancer patients, notably with chemotherapy. This type of treatment uses medicines that prevent the rapid growth and division of cancerous cells.

These medicines, known as cytotoxic or antineoplastic agents, also damage healthy cells and therefore pose a serious health risk to the people who prepare them (dispensers and pharmacists), transport them (logistical support staff), administer them to patients (nurses and doctors), carry out certain cleaning duties* and dispose of any waste (orderlies, cleaning staff).

Anti-cancer drugs can irritate skin, eyes and mucous membranes, and cause nausea, vomiting, diarrhoea, dizziness, hair loss, etc.

They have serious effects on the health of foetuses, including miscarriage, congenital defects and low birth weight. As a result, pregnant workers or those trying to conceive must not carry out any tasks that involve handling anti-cancer drugs.

In addition to these proven reprotoxic and teratogenic effects, many medicines currently used in chemotherapy are recognised as being carcinogenic or probably carcinogenic to humans by the International Agency for Research on Cancer. A notable example is cyclophosphamide, which is used to treat numerous cancers (breast cancer, ovarian cancer, leukaemia, lung cancer, etc.)

The development of chemotherapies has been accompanied by increasingly strict risk prevention measures. For example, cytotoxics are prepared in a specific room with air exchange and in a vertical laminar flow hood or isolator (see photo).

Staff administering cytotoxics to patients are required to wear personal protective equipment (mask, gown, double gloves, cap, protective glasses, etc.).

However, according to the authors of a study carried out among Île-de-France hospital staff, ‘these rules are not always followed because of a lack of awareness of the risks (especially from excreta and waste), inadequate structures or equipment, and staff being used to "invisible and contradictory" dangers from drugs.'

It is almost 10 years since that study was published and awareness has not always increased, as can be seen from the recent alert issued by the National Institute for Occupational Safety and Health (NIOSH) in the United States.

‘Chemotherapy drugs save lives of cancer patients but also can result in adverse health outcomes in workers who are exposed to these drugs, including cancer, reproductive problems and organ damage when recommended safe handling guidelines are not followed’, said John Howard, NIOSH Director, in October when the report was presented.

NIOSH surveyed more than 2 000 healthcare workers involved in the administration of antineoplastic drugs. The results show that many of them underestimate the risks involved in handling these drugs and neglect to follow the recommended safety measures: 80% do not always wear two pairs of chemotherapy gloves while 15% do not wear any at all. Other figures stand out, too: 42% do not systematically wear a protective gown and 12% take home potentially contaminated work clothing.

Since the beginning of the 1980s, many studies have sought to identify traces of anti-cancer drugs in the urine and blood of healthcare professionals**. A recent Canadian study detected cyclophosphamide in more than half (55%) of the urine samples of 201 healthcare professionals.

What is even more worrying is that since 2000 a dozen studies have shown that hospital staff in contact with anti-cancer drugs have a higher risk of genetic alterations than the general population.

‘Handling antineoplastic drugs, even if under safety controlled conditions, represents a considerable genotoxic risk for healthy subjects occupationally exposed to these chemicals’, say the authors of a study recently carried out among nursing staff in five Italian hospitals.

Several of these studies have shown that nurses are more at risk than their pharmacist colleagues who prepare the medicines. According to the scientists, this is because the conditions in which the drugs are prepared are safer and better controlled. That is a worrying observation at a time when it is becoming more and more common for patients to have chemotherapy treatment at home.

* For example, those who handle laundry potentially contaminated by the biological fluids of a patient who received cytotoxic drugs in the previous 48 hours.

** The NIOSH list contains around 200 references: www.cdc.gov/niosh/topics/antineoplastic/monitoring.html.

More information


A night in Accident and Emergency

Saint-Pierre University Hospital is the oldest hospital in Brussels. Located in one of the city's most working-class neighbourhoods, Les Marolles, it occupies the site of a medieval leper colony. That social calling has lasted down the ages and is a key part of the institution's identity. The hospital describes itself as 'secular and social' and is proud 'to welcome all patients, regardless of their origin, philosophical or religious convictions, or social status'. We spent a night at Saint-Pierre, shadowing the hospital’s accident and emergency nurses.

Denis Grégoire
ETUI

Photographs:
Martine Zunini
Wednesday, 11 February – 9.45 p.m.

The staff working the afternoon shift hand over to the night team. The two teams are gathered together in a glass-walled room reserved for doctors and nursing staff, known as 'HQ'. They are huddled around a set of wooden pigeonholes containing various documents about patients, such as requests from doctors to run tests. A nurse passes on the key information about the patients receiving treatment: 'In cubicle 3, there's a gentleman we know well. He comes every three months. It's extremely difficult to insert his drip.' 'In cubicle 4, we have a gentleman who has come in because he's confused. He's quite fretful and he's pulled his drip out. He's on valium,' … and so on. The night team takes over.

10 p.m.

A security officer makes his way towards the triage unit, which lies just behind the automatic doors separating the emergency wards from the waiting room. This is where patients have their first contact with clinical staff, having had their details taken by administrative staff sitting behind a pane of glass at reception.

A few minutes ago, Julien was shoved by a man who was under the influence of alcohol. The nurse is not hurt and does not appear to be shocked, but a security officer saw the incident on one of the hospital's many surveillance cameras and wants to know more about what happened. 'Physical violence is pretty rare,' say the A&E workers, putting the incident into perspective. Verbal aggression, on the other hand, is commonplace, particularly at night and at the weekends, when inebriated revellers flock to the emergency department. They are taken to the 'stretcher room' to sober up.

At the start of the night, the main corridor of Saint-Pierre’s emergency unit is invaded by a constant stream of patients' friends and relatives, cleaning staff, security officers, police officers, paramedics and even prison wardens accompanying inmates from the nearby jail in Saint-Gilles.

10.30 p.m.

Julien is soon back at work after the incident. He flicks a switch to open the automatic doors leading to the waiting room, and calls out the name of the next patient. There is a lady aged 60 or so who cannot stop groaning. 'Who is she to you? Do you know anything about her health problems?', the nurse asks the woman accompanying her. 'I'm her neighbour. She's had a hernia operation but that's all I know,' she replies.
After checking her medical history and conducting a brief physical examination, the nurse suspects biliary colic. ‘We’ll put you on a drip to stop you vomiting; then we’ll run some tests,’ he explains to the patient.

On to the next patient. ‘Hello, Mrs Mukanga (not her real name). Can you tell me what is the matter?’, asks Julien. The young woman, who is pregnant, has lost blood. The nurse contacts the gynaecologist on his mobile. The woman is quickly taken to the emergency gynaecology ward.

The glass-walled triage unit is occupied by doctor and a nurse. Together, this pair must prioritise the cases. ‘If we didn’t triage, we’d be done for,’ says Julien. ‘It’s important to look carefully at the people in the waiting room. The ones who are the most on edge aren’t necessarily the most worrying cases. The people who are waiting calmly in a corner might actually be in much greater danger: elderly people who daren’t show that they are actually in a really bad way, for example. With experience, you learn to spot them,’ he explains.

10.40 p.m.

A man turns up with a cut on his hand. Diego administers first aid. The average age of accident and emergency nurses at Saint-Pierre is low: many of them are around 20. The doctors don’t push the average age up much either, the reason being that at night, all the doctors are juniors. Of the 43 emergency department nurses at Saint-Pierre, fewer than 10 are over 40. It is becoming increasingly rare for nurses to spend their entire career in an emergency department. The hours, which make family life difficult, the night shifts (limited to no more than five nights a month) and the stress, among other factors, drive emergency nurses away to other departments, often within 10 years. For the time being, Diego likes working nights, not least because of the convivial atmosphere. ‘You also get paid extra for nights,’ he admits.

11 p.m.

A woman sits on one of the wooden seats that line the corridor. She has just arrived from France and she is not feeling well. ‘I’ve been here for over two hours. I know there are cases much more urgent than mine, but still …’, she complains to Julien. ‘The only advice I can give you is to take some paracetamol,’ he tells her. The lady remains courteous, but mutters a few choice words as she returns to her husband out in the waiting room. In recent years, Saint-Pierre has seen an influx of patients turning up at A&E for problems that are really medical, but people think it will speed things up. It’s part of the job. Working in this neighbourhood, you get used to it,’ says an irritated Julien.

11.50 p.m.

All the nurses rush to the triage unit. A woman who had been waiting in the corridor has just collapsed. She is placed on a stretcher. Her vital signs are checked and she is immediately taken to the resuscitation room. Very quickly, calm returns.

‘We don’t develop the same type of relationship with our patients as they do in other departments, where the patients stay much longer. Of course, we have our “chronic patients”, who we sometimes see more often than our own families, and who we become attached to, but most of them are just passing through. Still, we sometimes call the other departments to get the latest news and find out if they are OK,’ says Maité, a young nurse full of compassion.

Thursday, 12 February – 2 a.m.

The nurses generally eat together between 2 and 3 a.m. There are a few Tupperware containers brimming with home-made salad on the table, but mostly it’s takeaway containers and ready-meals. A call comes in. The mobile intensive care unit, or SMUR, has been called out to attend an incident. Julien has to abandon his pasta.

Just half an hour or so later, the emergency nurse is back. ‘A lot of the callouts we get are for minor problems. People call an ambulance for trivial things because they think it will speed things up. It’s part of the job. Working in this neighbourhood, you get used to it,’ says an irritated Julien.

To ease the pressure on the SMUR, which in theory should only intervene in potentially fatal cases, a dozen or so hospitals in Belgium now have a PIT, Paramedical Intervention Team, made up of an emergency nurse and an ambulance driver, but no doctor.
Julien loves the PIT. 'I like the feeling of independence you get when you go out on those calls, when there is just a nurse and an ambulance driver. In the PIT, you're pretty much on your own,' he says with relish.

3 a.m.
Two paramedics bring in a man aged around 60 who is suffering from a COPD (chronic obstructive pulmonary disease). Maïté takes charge of him and puts him on respiratory support. The medical team decide to perform an ABG (arterial blood gas), a blood test to assess a patient's respiratory function.

3.30 a.m.
This time it is a pair of police officers who show up, accompanied by a man in handcuffs who is clearly irritated that his night has not turned out as planned. In the statistics, he will be counted in the 'seen and examined' category. That's the term used to refer to people who are brought to A&E before being remanded in custody for 'minor' crimes (burglary, breach of the peace, disobeying police, etc.). The law requires the police to file a document certifying that the person in question is physically capable of spending a night behind bars. These special cases are often referred to Saint-Pierre, whose social mission has not escaped the police.

'Saint-Pierre is not like other hospitals. We are located in a very disadvantaged neighbourhood, with a population who neglect their health and who live in often squalid housing. We deal with a lot more infectious diseases than other hospitals,' explains Fabienne, who is the senior nurse on duty tonight, with 17 years of A&E experience under her belt.

Maïté, too, emphasises the special identity of Saint-Pierre University Hospital. 'Saint-Pierre is the only hospital where nurses and doctors greet each other with a kiss on the cheek, where nurses address doctors using the informal "tu" form and where the doctors don't wear ties,' says the young nurse with surprise. She previously worked in the intensive care unit of a large university hospital in one of the capital's most upmarket suburbs.

In intensive care, the diagnosis has already been made. It's less exciting. We've got a great relationship with the doctors here, too. A lot of them don't hesitate to ask the nurses for advice, which is rewarding,' adds Julien.

4 a.m.
After the rush at the start of the night, the corridor and waiting room have gradually emptied out. Staff members chat, share a joke and wind down over a cup of coffee. Maïté and a recently hired logistics assistant are having an impromptu debate about the changes occurring in the hospital sector. They mention a hospital in the poshest area of Brussels that has just opened VIP wards and where the security officers wear suits. 'They look like bouncers,' they joke.

'Here, everyone is welcome. You don't need to bring a credit card,' says Virginie, who applied directly to Saint-Pierre on completing her training because she couldn't imagine working anywhere else. That was in 2002, aeons ago by A&E standards. Many emergency nurses join other departments after a few years or reduce their working hours.

'T'm an emergency nurse at heart and I love my job, but two years ago I said to myself, "I need to either cut back my hours or leave". I know a few people who are close to burnout but don't realise it,' says one concerned member of the team.

The debate is interrupted by one of the two homeless people who have been taking shelter in the department's corridor since the middle of the night. In a trance-like state, he wanders into HQ. After insulting a young doctor, he is politely asked to leave.

5.30 a.m.
It's all hands on deck again. Everything has to be ready for the morning team. The entire team of five nurses (there are seven during the day) set about filling trolleys, checking that equipment is working properly, changing bedding, etc. Some patients have woken up and require treatment again.

6.30 - 7.00 a.m.
The staff working the morning shift begin to arrive. It is time for the traditional handover. 'In cubicle 1, there's a gentleman with partial cure of tuberculosis. He panics easily.' 'In Resuscitation Room 4 is a 70-year-old lady with a history of cardiac problems who has come in with chest pains. The doc wants to keep her in... 

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Making occupational illness visible: a call for a coalition between scientists and workers

Some 40 trade unionists and researchers coming principally from Belgium, France, the Netherlands, Spain and Italy took part in a seminar organised jointly by the ETUI and the Belgian association Santé & Solidarité. The purpose of the event was to present projects involving participation by both researchers and workers in the service of a common goal, namely, to make the impact of work on health visible. Of some 30 initiatives submitted to the organisers following a call for proposals, seven were selected and presented on 30 January in Brussels.

Denis Grégoire
ETUI

A research project involving workers at Nantes-Saint-Nazaire Port and experts revealed widespread exposure to carcinogens among the dockers. Image © Laurent Guizard
Paraphrasing Clemencenau, Laurent Vogel opened the seminar by stating that: ‘Health is too important to leave to the experts’. The ETUI researcher justified his provocative statement by the fact that epidemiological studies and other research into working conditions have not yet sparked public debate about the considerable impact that work has on our health.

The scientific and institutional instruments that currently exist are not sufficient, as illustrated by the official figures on occupational diseases, which underestimate these illnesses in all European countries. Existing measures have unfortunately tended to ignore actual working conditions, leave out workers who have retired or been forced to give up work due to a deterioration in their health, and dismiss the gender dimension (in Belgium 90% of recognised occupational diseases affect men).

Laurent Vogel called for the perception of workers to be taken into account in scientific work. However, to make the impact of work on health visible, a coalition between researchers and workers is needed so that there can be a balance of power with those who have an interest in maintaining the status quo.

The first of the initiatives presented on 30 January provides a good illustration of the ETUI researcher’s point. It related to a research project on occupational cancers that grew out of a movement of dockworkers at Nantes-Saint-Nazaire. Having noted a high number of cancers among their co-workers, a group of dockers initially carried out their own enquiry. This confirmed cases of lung, prostate and kidney cancer, among others. A sociologists’ collective took the work further, conducting an in-depth investigation designed to reconstruct the occupational history of some 20 cancer survivors. In this way they were able to show that dockers had suffered exposure to a range of carcinogenic substances.

‘We did not find a single case of a docker not having been exposed to at least four carcinogens. We identified that some of them had been exposed to 25 carcinogenic substances throughout their occupational history’, commented Véronique Daubas-Letourneux from the University of Angers.

This initiative arose out of the momentum created by the GISCoP 93 project, which was launched in the early 2000s in the French department of Seine-Saint-Denis. This project highlighted the occupational origin of a number of cancers occurring in this industrial department located to the north-east of Paris. It grew out of a movement of local trade unions, doctors, mutual insurance companies and researchers linked to the University of Paris XIII, among others. The latter reconstructed the occupational history of around 1,200 patients and tried to identify the various carcinogens to which they had been exposed in the workplace. The investigation established that 89% of men and 64% of women surveyed had been exposed to at least one carcinogen.

In Italy, the INCA, an occupational welfare service linked to one of the Italian trade union confederations, the CGIL, conducted a wide-ranging investigation on musculoskeletal disorders in sectors as diverse as footwear, fisheries, motor manufacturing, wholesale and retailing, etc. Over 1,000 fishermen took part in the investigation. In the Apulia region, in the south of the peninsula, 89 cases of occupational illness were recognised out of a total of 1,411 declarations, which was welcomed by Marco Bottazzi, an occupational doctor with INCA (read the interview in the box). The project also led to herniated discs among lorry drivers being added to the list of occupational diseases.

In Belgium, an investigation using the same methodology (based on the ‘Nordic questionnaire’) was conducted among cleaners, retail and wholesale workers, and industrial maintenance workers in the Charleroi area.

In the Netherlands, which has no official system for the recognition of occupational disease, a service set up by the FNV trade union confederation offers support to victims of occupational disease in their legal fight for damages.

The head of this service, Marijan Schaapman, presented the highly detailed research work carried out by her service, based on the cases of two workers whose health has been irreparably affected by their work.

In the autonomous community of Asturias, in northern Spain, the Comisiones Obreras trade union launched a protest movement against occupational cancers. The mobilisation resulted in the identification of 680 cases of cancer possibly linked to work, 5.6% of which were recognised as occupational diseases proper and 11.7% as in some way linked to the workplace.

In the Basque Country, Comisiones Obreras has highlighted the problem of silicosis in the construction industry. Far from belonging to the past, this illness continues to claim many victims. The arrival on the market of new products containing much higher concentrations of silica than traditional materials could cause new tragedies (see the box, p. 40).

These examples show that trade unions are in a position to act as ‘whistle-blowers’ and prevent workers from being blackmailed over their jobs, as has happened too often in the past: think back, for example, to the asbestos tragedy.

Due to their indisputable practical knowledge, workers are the leading experts on their work. As a result, greater attention should be paid to them in scientific work on the issue of occupational health and safety, and more generally working conditions. This was precisely the intention of the seminar organised by the ETUI with the association Santé & Solidarité (www.sante-solidarite.be). Other initiatives will follow in the coming months.

More information

’Health is too important to leave to the experts.’
Laurent Vogel
Trade unions ‘blow the whistle’ on the reappearance of silicosis in Spain

In Europe, silicosis is sometimes regarded as a problem from the past, and as just a subject for study by experts in industrial history. Some time ago, the press reported on the reappearance of the disease among workers in the textile industry. However, the European Union was spared because the process of spraying sand at high pressure to fade jeans, and therefore satisfy the demands of fashion, was banned in Europe. Since then, the young Turkish workers and their lungs have been rather forgotten given that, under pressure, their government decided to follow Europe’s lead.

Did the Turkish case forewarn of a similar health problem, but this time affecting the European Union? In 2009 the Spanish trade union Comisiones Obreras was the first to sound the alarm. One of its members, Daniel Ramos, had just learned that he was suffering from silicosis even though he was only just 29. Six years later, a fresh report tells of seven victims of silicosis among the 14 workers at the Novogranit marble factory in Lemoa, an industrial suburb to the south-east of Bilbao.

How could the Comisiones Obreras trade union representative and his colleagues have developed this disease at such an early age, when miners were generally diagnosed on retirement?

“We were making kitchen worktops from quartz composite, a material that contains 95% crystalline silica, unlike natural stone that contains between 15% and 20%, explained Daniel Ramos in 2011 in the regional press.

Pure quartz is mixed with resins and pigments to obtain quartz conglomerates. This product was first sold in the 1990s, particularly under the trade name Silestone belonging to the Spanish group Cosentino. The Israeli company, Caesarstone, is also a major player in this growth market. According to the Spanish daily newspaper El País, it was these two brands that were mainly being used in the Basque marble factory. Again according to the Spanish newspaper, the labour inspectorate considers that Cosentino and Caesarstone bear some of the responsibility due to having failed to inform the marble factory about the risks posed by their products.

This is not an isolated case. Respirologists at a hospital in a small Basque town have identified six cases of silicosis among 11 workers at a family-run marble factory, which mainly fits composite stone worktops. Andalusia is also affected. From 2009 to 2012, 47 cases of silicosis were diagnosed in four municipalities in the province of Cadiz (Andalusia). Most of the victims, including one who died during the study, were once again young workers who had, on average, been involved in worktop manufacture for 11 years.

In 2013 the courts ordered Novogranit, which in the meantime had closed its doors, to pay Daniel Ramos a total permanent disability allowance. Together with the company, the prevention service that should have monitored the health of the workers was also given a heavy fine by the Basque authorities on the grounds that it had concealed, for two months, the worker’s true state of health. The service had declared him fit for work without even waiting for the results of chest X-rays that eventually revealed the illness.

‘The real guilty parties in this situation are the multinationals that sell this highly dangerous material’, states the young worker who, with the support of Comisiones Obreras, has set up an association for victims. They are demanding a ban on quartz conglomerates that contain a high percentage of crystalline silica.

More information


Pascual S. et al. (2011) Prevalence of silicosis in a marble factory after exposure to quartz conglomerates, Archivos de Bronconeumologia, 47 (1), 50-51.


Other studies have also reported cases in Tuscany, Israel and Texas.
Between 2004 and 2008, INCA, a trade union body that helps Italian workers with social security issues, carried out a survey of the health of fishermen. Around 1200 workers taking part. Musculoskeletal illnesses accounted for 60% of the health problems reported, followed by digestive complaints (10%), problems with the nervous system and psychological problems (7%), and cardiovascular illnesses (6%). In April INCA launched the survey in the regions of Italy that had not previously taken part. Interview with Marco Bottazzi, head of INCA's occupational diseases office.

Interview by
Denis Grégoire, 4 May 2015

Why did the INCA decide to carry out a survey of workers in the fisheries sector?

Marco Bottazzi — Until 2010 the fisheries sector had an autonomous insurance scheme for occupational accidents and illness of the Italian Workers' Compensation Authority (INAIL). That change meant that it was necessary to learn more about the health problems facing workers in that sector.

To what extent were the trade unions involved?

The fisheries trade unions were very closely involved in the survey and proved to be extremely sensitive to the issue of health and safety. Workers in this sector have quite special characteristics. Their link with the sea is so strong that it could be said that fishermen never really retire. Apart from that cultural dimension, there is also an economic problem: numerous workers in the fisheries sector continue to work past the legal retirement age because their pensions are too low. In addition to workers, many fishing vessel owners took part in the survey.

The fisheries sector still has the image of being quite a macho environment. How did you get them to talk about their health problems?

In general, we began the interviews with young fishermen, who had a somewhat different relationship with their work than previous generations. They place more importance on health issues as they do not wish to age prematurely. With the reform of the pension system, they know that they will have to work until they are almost 70. However, their work requires them to be in excellent health. The issue of health and safety was thus a very natural one to examine.

What impact did the survey have?

The survey enabled many of the participants to have their health problems recognised as an occupational illness by INAIL and thus to obtain compensation. We are also pursuing our efforts to have the table of occupational illnesses amended. For example, we would like to include exposure to vibrations on vessels in the table of vibration-linked illnesses. We also are working on the issue of primary prevention. We are preparing proposals for ergonomic improvements to fishing vessels. This process is being carried out in close collaboration with the fishermen because we noted that they have often put in place their own 'home-made' measures to reduce occupational risks. We are looking into whether or not these methods could offer pertinent solutions from an ergonomic point of view.
Bhopal: the long flight from justice

Last December marked the 30th anniversary of the worst industrial disaster India has ever known. Three decades after Bhopal, among the survivors and their descendants, the wounds have not yet healed. Above all, these people continue to be haunted by the sense that justice has failed them.

Rob Edwards
Free-lance journalist, www.robedwards.com
On a hot and hectic street in the Indian city of Bhopal, the flames licked up the two giant corporate logos. The blue of Union Carbide and the red of Dow Chemical Company, with added skulls, were incinerated to nothingness within seconds. Just a few metres away, across a high security wall, was the cause of the angry effigy-burning: the derelict and overgrown pesticide factory that leaked toxic gas 30 years ago and has killed more than 25,000 people.

The disaster at Union Carbide’s chemical works in Bhopal, in the crowded, poverty-stricken heart of India, on the 3 December 1984 was one of the world’s worst industrial accidents. It has since become one of the world’s grossest examples of environmental injustice.

Union Carbide and the US chemical giant that took it over in 2001, Dow, are fugitives from justice. Over the decades, they have repeatedly refused to appear before Indian courts to answer criminal charges against them. They have never apologised.

It is no wonder that they were targets for the fierce and passionate mass protests that took place in Bhopal on the 30th anniversary.

**Bhopal: timeline of disaster**

3 December 1984: A tank full of 40,000 kilogrammes of highly toxic methyl isocyanate at Union Carbide pesticide plant explodes and showers the city of Bhopal, killing at least 3,800 people within hours.

7 December 1984: Union Carbide chairman, Warren Anderson, is arrested on arrival in Bhopal, bailed and then flown out of the country on the orders of the Indian government.


14 February 1989: Indian Supreme Court approves $470 million settlement between Indian government and Union Carbide, causing civil and criminal legal actions to be dropped.

1 February 1992: Bhopal court says Warren Anderson has ignored four summonses and is ‘absconding from justice’.

26 November 1996: Drinking from community wells is banned after they were found to be contaminated by Union Carbide chemicals.

6 February 2001: Union Carbide is taken over by the US chemical giant Dow.

28 August 2002: Bhopal’s Chief Judicial Magistrate demands the immediate extradition of Warren Anderson from the US to face charges of culpable homicide.

22 November 2002: Documents released in a New York court case reveal that Union Carbide found contamination in soil and water around its Bhopal plant, but covered up the findings.

3 October 1991: The Indian Supreme Court agrees to reopen criminal cases against Union Carbide.

3 December 2004: An activist group, the Yes Men, pretending to be Dow executives, announce a $12 billion compensation fund for the Bhopal disaster live on BBC television.

6 January 2005: Bhopal’s Chief Judicial Magistrate summons Dow to appear in court to explain why its subsidiary, Union Carbide, had failed to face charges.

7 June 2010: Eight former Union Carbide managers in India are convicted for negligence leading to the Bhopal disaster.

29 September 2014: Warren Anderson dies in the US, still a fugitive from justice.


3 December 2014: Thousands of protestors take to the streets of Bhopal for 30th anniversary rallies demanding justice from Dow.
of the disaster in December 2014. ‘These days a corporation’s image is everything so we wanted to hit them where it hurt most,’ said leading Bhopal campaigner, Sathyu Sarangi.

‘We thought we would profane their sanctum,’ he explained, sitting in the busy office of the medical trust he helped set up for disaster survivors. ‘We want to give their executives ulcers. They have done huge damage to human health and the planet and have been getting away with it.’

Dow argues that compensation has already been paid to the victims and their families, and that it has no remaining liability for the actions of its predecessor, Union Carbide. But these arguments are angrily dismissed by campaigners.

Sarangi pointed out that the $3.2 billion compensation settlement agreed by a Dow subsidiary in 1998 for health problems caused by silicone breast implants in the US was 100 times more than that given to Bhopal survivors in India. After a court tussle, Dow had also accepted liability for Union Carbide asbestos claims in the US, he argued.

Dow was guilty of ‘double-standards’ and ‘environmental racism’ because the value it put on lives in India was much lower than on lives in the US, Sarangi said. He also accused the company of employing ‘dirty tricks’ to defend its interests.

Fugitive from justice

For three decades the main target of Indian anger and effigy-burning has been the former US chairman of Union Carbide, Warren Anderson. Four days after the accident in 1984, he was arrested when he arrived in Bhopal. But he was then bailed and quickly flown out of the country with the backing of the Indian government, never to return.

In 1989 Bhopal’s Chief Judicial Magistrate issued a warrant of arrest against Anderson for repeatedly ignoring summons. In 1992 the Bhopal court said he had ignored four summonses and was ‘absconding from justice’. In 2002, the court demanded the immediate extradition of Anderson from the US to face charges of culpable homicide.

But he ignored all that the Indian judicial system could throw at him, and stayed in his secluded homes in the US. On 29 September 2014, aged 92, he died at a nursing home in Vero Beach, Florida, still a fugitive from justice.

His notoriety, however, will doubtless live on, and could grow because of a new feature film. ‘Bhopal: A Prayer for Rain’, which stars the well-known West Wing actor, Martin Sheen, as Anderson, opened in the US and India in 2014, and is due in Europe.

In the film Anderson says that Union Carbide had ‘plausible deniability’ on the Bhopal disaster. Sheen has himself lent support to the campaign for justice for thousands of survivors who are still suffering.

With Anderson gone, Indian campaigners decided to mark the 30th anniversary by pointing out that, hated though he was, he was not the only person responsible for the continuing tragedy in Bhopal. In a loud, long and furious protest, activist groups use drum rolls to name and shame Dow, Union Carbide and more than 70 leading industrialists, officials, judges and others for failing to deliver justice to Bhopal survivors.

Like Anderson, Dow has ignored a series of summons from Indian courts to appear and answer charges. In 2005, the US company was summoned by Bhopal’s Chief Judicial Magistrate to explain why its subsidiary, Union Carbide, had failed to face charges. As recently as 12 November 2014, Dow again failed to appear in court in response to another summons.

Compensation ‘woefully inadequate’

Dow’s behaviour has been lambasted by the human rights organisation, Amnesty International. The $470 million compensation granted in 1989 was just 14 per cent what was asked for and averaged less than a thousand dollars per person, according to the group’s secretary general, Salil Shetty.

'Several of those who have fought so hard for so long are aware they may now die without ever seeing justice.'
The families of the thousands of victims of the Bhopal accident have only received paltry compensation to date.

*Image: © Belga*

'This was a woefully inadequate amount which, I think, exposes a shocking level of indifference and contempt towards the victims in India,' he said. Union Carbide and Dow had been given a haven from justice in the US and displayed an 'arrogant contempt' for the Indian judicial system.

'Those who have survived have faced a three-decade-long marathon campaign having to fight every step of the way for the few reparations which have been offered; the most basic medical treatment, insufficient clean water and so little financial compensation it is insulting,' Shetty declared.

'Sadly, several of those who have fought so hard for so long are aware they may now die without ever seeing justice. But the fight is being picked up by new generations – their children, and their children’s children – who have been born with illnesses and exposed to ongoing contamination from the abandoned factory site,' he said.

Shetty accused Union Carbide of failing to take critical safety precautions at the Bhopal plant before the accident. 'As generations of survivors continue their fight for accountability, they have had to battle corporate spin to prove this was not a tragic accident but a disaster which could have been avoided,' he said.

**History of leaks**

According to campaigners, there was a leak of toxic gas at the plant in December 1981, which killed a worker. In January 1982 another leak put 25 workers in hospital, followed by another leak in March and another in October, which caused hundreds of local residents to go to hospital.

A Bhopal journalist, Rajkumar Keswani wrote a series of articles in the local press about alleged dangers at the plant, and an audit by US company experts was said to have found 61 hazards, 30 of which were regarded as major. In 1983 a local lawyer served a legal notice on the plant saying it posed a serious risk to health and safety.

The December 1984 accident started when a lethal gas used for making insecticides, methyl isocyanate, escaped from a tank at the plant. The regional government put the immediate death toll at 3 787, but survivors say the real number was more like 8 000.

The gas seared the lungs, and burnt the eyes of anyone exposed. In the three decades since, campaigners say the death toll has reached 25 000 'and counting' because of an epidemic of diseases caused by lingering water and soil contamination around the plant.

As many as 150 000 are still battling chronic illnesses, with tuberculosis and cancers 'rampant', they say. There are estimated to be 50 000 still living in the vicinity of the plant whose groundwater is contaminated by toxic chemicals and metals that have leached from hazardous waste dumps.
Bhopal: woken early to agony

When Rashida Bee woke at her home in the Indian city of Bhopal early in the morning of 3 December 1984, her eyes were watering. ‘It felt like someone was burning chillies,’ she says. ‘We didn’t know what was happening.’

Outside people were running, screaming that everyone would die, and her whole family got up and ran. ‘My eyes were tight shut. I could not open them because of the pain. Whenever I did manage to squeeze them open, all I saw were piles of corpses scattered around.’

People were blindly running over the bodies, and Rashida joined them. ‘That’s when I heard an announcement saying that gas had stopped leaking from the Union Carbide factory. That was the first time I heard the name of Union Carbide.’

A leak of highly toxic methyl isocyanate from a pesticide plant run by the US chemical company, Union Carbide, spread over packed neighbouring communities and killed up to 8,000 people within hours. It burnt their retinas, tore their lungs, and suffocated them. Rashida’s friend, Champa Devi, was woken by a neighbour saying that everyone had to leave or they would die. ‘The moment we opened the door, gas gushed into the house,’ she says. ‘We began coughing and our eyes burned. It was difficult even to breathe. We rushed out of the house in whatever clothes we were wearing.’

She has never forgotten what she saw. ‘People were running, coughing and screaming for death. I couldn’t see a thing, except a hazy white mist and a mass of humanity ahead of us. Those who fell lay on the ground with no-one to pick them up.’

Champa got a lift to the hospital, which was overwhelmed with people crying and shrieking. ‘Corpses were piled high, like sacks of wheat in a stack. Anyone who fell or fainted was thrown on the pile. The doctors had no clue how to deal with the situation or what medication to offer. I was scared.’

Dead bodies, dead bodies, dead bodies

There are thousands of memories of that terrible night, many of them movingly gathered together in the Remember Bhopal museum. Set up by survivor groups and campaigners, it opened in a suburb of the city in December 2014.

The museum was designed to pre-empt an official memorial planned by the Madhya Pradesh government on the site of the deserted Union Carbide factory. Survivors are opposed to the official memorial, blaming the government for some of the injustices they have suffered.

Local resident Ruby Parvez talks about how she still cries and trembles when she thinks about what happened. ‘We were sleeping and I felt a burning sensation in my eyes, and felt dizzy,’ she says.

‘Suddenly I started to cough and my eyes began to inflame. Then, along with my family, I started running in the same direction as everyone was running. From my house to the bus stand, there were dead bodies, dead bodies, dead bodies and only dead bodies.’

In the first room of the museum, there is a furry orange babygrow stretched out inside a black case. It was what little Sajid was wearing when he died in 1984, choking on the poison gas belching from the Union Carbide plant.

When his mother, Bismilla Bee, saw it at the museum opening three decades later, she couldn’t stop the painful memories from flooding back. Oblivious of the activists, journalists and dignitaries crowded around her, she started shaking with loud sobs, rising and falling.

She had donated the babygrow to the museum, but seeing it on display unleashed an overwhelming grief. There are a series of other tragic personal reminders on show: a battered doll, an old cricket bat, a bridal dress, a walking stick, a stethoscope and a pair of crutches.

‘I felt my life was empty and barren, and I was in a state of mental paralysis.’
Flames not flowers

Rashida Bee and Champa Devi, now in their late 50s, are two of the survivors behind the museum. More than most, they bear witness to the continuing cost of the Bhopal ‘holocaust’, as it’s called in India. Lingering contamination from the accident is now reckoned to have killed 25,000 people and made many more ill.

Champa’s son, unable to bear the agony of constant chest pain from the gas leak, committed suicide in 1992, and her husband died of bladder cancer in 1993. Her daughter was paralysed six months after the accident and, despite extensive treatment, still has a twisted mouth.

‘I felt my life was empty and barren, and I was in a state of mental paralysis,’ she recalls. ‘But seeing the families around me, I soon realised there were many like me who had lost their loved ones to the gas. Life would have to go on. That’s how I decided to dedicate the remaining days of my life fighting for justice for the Bhopal gas victims.’

Champa and Rashida, both raised in purdah without a formal education, are now two of the veteran leaders of the movement for justice for Bhopal survivors. They won the international Goldman Environmental Award in 2004 and donated the $125,000 prize money to setting up the all-women Chingari Trust, which runs a health clinic for children of Bhopal survivors.

Chingari means the spark that starts the fire, and it’s echoed in the rallying cry used by Champa and Rashida. ‘We are the women of Bhopal, we are flames not flowers,’ they say.

They help run a stationery factory to employ women survivors, and have formed a trade union to try and make sure they get fair pay and conditions. Surrounded by their fellow workers, they stood in the hot sun in the factory courtyard in December, sounding indomitable.

‘It is the willpower of all the women combined that has never let us down,’ declares Rashida. ‘When tragedy brings suffering in your life, you should have confidence, and be strong. Keep fighting and you will find that you will win in the end.’

International solidarity

The campaign against Dow has been backed by trade unionists in India and from across the globe. A delegation of six trade unions from the UK was in Bhopal for the 30th anniversary to show solidarity with the survivors, along with activists from many other countries.

According to Eurig Scandrett from University and College Union in Edinburgh, if trade union concerns about safety and corner-cutting had been listened to, the accident would never have happened. ‘Instead companies blame the workers and put their profits above the health of workers and the safety of the environment,’ he said.

The Scottish Hazards Campaign, which aims to improve health and safety at work, described what happened in Bhopal as ‘the worst industrial disaster of our time’. The campaign’s spokeswoman, Kathy Jenkins, said: ‘The commitment, strength and endurance of the people of Bhopal provide inspiration to all of us to continue our struggles for safe workplaces.’

In a prepared statement, Dow described the 1984 gas release as a ‘terrible tragedy’ which should never be forgotten. ‘Let’s also not forget the facts or rewrite history,’ said a company spokesman Scot Wheeler.

‘The facts are that Dow was never in Bhopal nor is there any assumed liability as misrepresented by some groups. It is important to note that Dow never owned or operated the plant,’ he said.

‘Dow acquired the shares of Union Carbide Corporation more than 16 years after the tragedy, and 10 years after the $470 million settlement agreement – paid by Union Carbide Corporation and Union Carbide India, Limited – was approved after review by the Indian Supreme Court in 1991.’

Wheeler added: ‘As Dow never owned or operated the Bhopal facility, any efforts to directly involve Dow in legal proceedings in India concerning the 1984 Bhopal tragedy are inappropriate, misguided and without merit.’

There are estimated to be 50,000 still living in the vicinity of the plant whose groundwater is contaminated by toxic chemicals and metals.
Advocating a new ‘hands-on’ approach to science

Her rejection of the Légion d’Honneur in August 2012 gained her a great deal of publicity. Was this through some sense of bravado, a desire to be talked about or did she simply delight in being provocative? No, not at all. It is true that Annie Thébaud-Mony has never sought to ‘hobnob’ with the political – or academic – elite but the French sociologist would undoubtedly, and modestly, have accepted this award if after a 30-year-long university career she had not come to the conclusion that there was widespread indifference to the growing social inequalities in health among scientific, institutional and political circles.

‘In 1984, a worker’s risk of dying of cancer was four times that of a senior manager. By 2008, this risk was 10 times as great’, she writes of the situation in France. ‘I find it unacceptable in this day and age that workers should suffer and die from industrial poisoning’, she explains to justify her new book on inequalities in illness and death. Unlike her previous works, this time she is bold enough to write in the first person, in the singular but above all the plural. Although aimed at publicising occupational health scandals, this book is notably a tribute to her companion in life and work, Henri Pézerat, a toxicologist who died in 2009 and who is credited with bringing the asbestos scandal to light in France. While asbestos brought Henri Pézerat some media attention, his tireless work on behalf of the victims (of ten workers) of other toxic substances is unfortunately far less well-known.

This is something that Annie Thébaud-Mony intends to change. She recalls how, in the final years of his life as his health was deteriorating, he still continued to fight alongside former miners suffering from broncho-pulmonary cancers, farm workers poisoned by pesticides and the staff of an animal vitamins factory affected by renal cancer.

This work, however, is not simply a book dedicated ‘in memory of’. While she writes most tenderly of her partner, her pen can suddenly turn sharp when she has a target in her sights. Annie Thébaud-Mony has not forgotten that the struggles they both led against the industrial lobbies and the promoters of ‘a strategy of doubt’ were often also struggles against their own community, sometimes even their own colleagues.

‘Some of them choose to work on different subjects but they are in a minority. Most are sure of their place and their power within the institutions so they generally also receive funding from foundations and these are the instruments by which manufacturers control research.’

One of her particular targets is the study of epidemiology, which she blames for having set itself up as the only tool necessary for preventing cancer.

‘This obsession with mathematical evidence has paralysed mainstream science in terms of our understanding of the links between toxic chemical substances and health. Over time, the demand for such evidence has resulted in a “hands-off” epidemiology that repeatedly refuses to acknowledge the evidence of the facts and the materiality of exposure’, she states. This approach ‘merely counts deaths’, she adds later in the book.

Henri Pézerat and Annie Thébaud always preferred a ‘hands-on’ approach to their research, which they conducted directly with the workers. ‘We always refused to distance our work as researchers from its roots in cooperating with those individuals and groups that we consider to be the sentinels of health’, she states.

At the turn of the century, Annie Thébaud founded a scientific interest group on occupational cancers, a research project that brought together the University of Paris 13 and the cancer departments of three hospitals in Seine-Saint-Denis, the poorest department in metropolitan France. Between 2002 and 2012, her team reconstructed the career paths of nearly 1,200 workers affected by cancer. From this research it emerged that 83% of these patients had been exposed to at least one carcinogen during the course of their working life. Over the 10 years of the study, nearly 300 patients thus had their illness recognised as occupational cancer.

Now retired, the sociologist no longer has to battle institutional inertia. Her energies are now devoted to the foundation that bears her partner’s name, one that is aimed at ensuring that workers no longer have to suffer in silence.

— Denis Grégoire
There's nothing accidental about these disasters

Mining disasters have been happening for centuries, as if working in the entrails of the Earth demands human sacrifices. Michael Quinlan’s book questions the fatalism with which this slaughter is sometimes viewed. It analyses mining disasters in five highly developed countries: Australia, the United Kingdom, Canada, New Zealand and the United States.

It is almost 30 years since the young Australian sociologist Michael Quinlan first went down a coal mine at Pike River, New Zealand. During the 1980s he carried out research in collaboration with the miners’ trade union in the state of Queensland (Australia). He was able to assess the work of the inspectors appointed by the trade union to protect miners’ safety. The trade union gave him access to all of its records. He presented an initial analysis based on this field work in 1986 and, since then, his interest in questions of health and safety in mines has not waned.

Michael Quinlan has become one of the world’s most renowned specialists in this field. He uses working methods that value the collective experience of miners and their trade unions. He has served on various commissions of inquiry in Australia and New Zealand.

In November 2010 a new disaster resulted in the death of 29 miners at Pike River. The youngest of them, Joseph Dunbar, had had his 17th birthday the day before. It was his first day working in the mine. Quinlan played an important role on the commission of inquiry set up by the New Zealand Government to look into the causes of the disaster. The two volumes of the detailed report published by the commission in November 2012 led to a strengthening of the legislation, despite an unfavourable political context.

Quinlan has identified 10 pathways contributing to disasters. The actual design of mines, organisation of production and errors made in the selection of methods and maintenance play an important role. In the case of Pike River, the decision to make use of the hydraulic extraction method, which uses the power of water jets, had been taken without being accompanied by adequate infrastructures. As the mine was exploited, unforeseen difficulties appeared but they were not resolved owing to the financial pressure to make the installations profitable as quickly as possible. The mine management seemed to have total confidence in the technology. Its own position in the allocation of work led it to ignore the alarm signals coming from the miners. Management systems are often deficient while risk assessment is inadequate. Complaisant audits are unable to rectify such errors. Economic pressures play a central role. Sometimes financial difficulties result in safety being neglected. In other cases, the desire for a quick profit from installations and the pressure piled on subcontractors to meet deadlines cause disasters. At Pike River, bonuses were distributed to the miners on the basis of productivity. This system got in the way of prevention. Quinlan has identified 10 pathways contributing to disasters. The actual design of mines, organisation of production and errors made in the selection of methods and maintenance play an important role. In the case of Pike River, the decision to make use of the hydraulic extraction method, which uses the power of water jets, had been taken without being accompanied by adequate infrastructures. As the mine was exploited, unforeseen difficulties appeared but they were not resolved owing to the financial pressure to make the installations profitable as quickly as possible. The mine management seemed to have total confidence in the technology. Its own position in the allocation of work led it to ignore the alarm signals coming from the miners. Management systems are often deficient while risk assessment is inadequate. Complaisant audits are unable to rectify such errors. Economic pressures play a central role. Sometimes financial difficulties result in safety being neglected. In other cases, the desire for a quick profit from installations and the pressure piled on subcontractors to meet deadlines cause disasters. At Pike River, bonuses were distributed to the miners on the basis of productivity. This system got in the way of prevention. The role of state inspections should not be ignored. In Australia surveys have shown that the inspectorate is loathe to stipulate precise measures and tends to favour self-regulation by companies. Miners often express worries prior to disasters. Nobody listens. Management believe that they know better than the workers and do not implement effective communication systems. The outcome of disasters is made worse by the inadequate resources to deal with emergency situations.

This book has the merit of not isolating disasters from the daily reality of working conditions. As the author states, although disasters attract the attention of the media, public and governments, they are a distraction from the fact that the greatest number of deaths are caused by accidents occurring during the normal course of production. The author stresses the underlying political dimension in any discussion on improving prevention. Clearly written and with an obvious knowledge of the technical questions, this book provides a review of the predominant themes in the field of safety at work.

— Laurent Vogel

Ten pathways to death and disaster. Learning from fatal incidents in mines and other high hazard workplaces by M. Quinlan, The Federation Press, Sydney, 2014

By the same author: Road haulage in Australia: keeping vulnerable workers safe and sound, HesaMag, 6, 2012.