Community health and safety strategy: going nowhere

2013 got off to a very bad start for EU health and safety at work policies. The strategy for 2007-2012 has ended. But a new strategy is mired in doubts. Will there ever be one? And will it be up to addressing the problems identified in the different Member States?

Laurent Vogel
ETUI

Manual workers have a shortened healthy life expectancy. The European Commission's shelving of its action programme on health and safety at work is a direct snub to the most at-risk workers.

Image: © ImageGlobe
Occupational health policy planning has been around for thirty-plus years. The European Commission adopted its first action programme on the matter in 1978. Every five years since, a new such programme has set the priorities for Community action to harmonize working conditions by laying the foundations of common legislation. From 2002, the terminology changed. The "action programme" became a "strategy" — a military metaphor, but also a misnomer. The action programmes were often to the point, accurate and better targeted. They listed the actions that the European Union had to take. They reflected the policy thrust set by the Community Treaty in 1992: harmonizing working conditions upwards on the basis of directives. The trend has been for "strategies" to be long on description and short on urging all concerned to contribute to health and safety at work policy. Commitments to legislate were often fuzzy and lacking a firm timetable.

The last strategy was for the period 2007-2012. When it was adopted a hard target was set for the last minute for a 25% cut in work accidents over the period. This priority given to the headline item of work accidents was more about number-crunching than an analysis of trends in working conditions. There are European statistics on work accidents which even with underreporting enable a trend to be tracked over time. Health problems, it is known, have a more devastating impact and are often less straightforward to prevent. European occupational disease statistics are more fragmented than those on work accidents. Researchers looking for more detailed information on some work-related diseases often use worker-perception surveys. Statistical difficulties aside, the prevention of work-induced diseases is the area where EU action has most value to add.

The understanding was that the 2007-2012 strategy would be evaluated to define a new strategy for the period 2013-2020, enabling it to be adapted to the lessons learned and changing working conditions.

**A build-up of delays**

The groundwork for the new strategy started out on schedule: a mid-term review of the 2007-2012 strategy, positions taken by the European Parliament and the Luxembourg-based European Committee for Safety and Health at Work composed of government, trade union and employer representatives from the 27 Member States. Ostensibly, there was no issue with the policy commitments. At the end of 2011, the European Commission went into dither mode. Was a health and safety at work strategy really necessary when economies were in crisis? Perhaps there should be a large-scale exercise in e-democracy first to enable anyone concerned to comment on a website set up for the purpose?

Could the old strategy just be extended? Oughtn’t firms to be relieved of the administrative burden of existing legislation? The delays have piled up. There was a perceptible backlash growing against the aim of improving working conditions. Behind the increasingly gnomic utterances, the subtext became clear: in a crisis, a job is what counts, but a good job might well be just an indulgence. Also, the approaching end-of-2012 deadline showed that the key legislative initiatives on the 2007-2012 strategy agenda (revision of the Carcinogens Directive and adoption of a musculoskeletal disorders directive) were stalled. With the current strategy under-resourced and inconsistently applied, it became increasingly difficult to embrace the need for a bold strategy for the future.

On 14 February 2013, replying to a question from MEP Karima Delli, Employment and Social Affairs Commissioner László Andor dodged any express mention of adopting a new strategy, writing only that "the Commission will take account of the views of the stakeholders when setting priorities for future policy action on health and safety at work". This is no form of pledge, as it can safely be said that the different stakeholders will express differing opinions. The current Commission’s term of office runs out in 2014. It can therefore be assumed that if a policy decision is not taken before the end of summer, the matter will go back to the next Commission and the next Parliament.

**A reality-check**

A look at recent data on work trends in Europe may counter this idea that a downward spiral could help get the EU economy on its feet again.

The European Working Conditions Survey done in 2010 by the Dublin Foundation shows a rise in inequalities in many areas. The gap between national situations is particularly worrying for a large number of indicators. The divides are even sharper within countries. The overall situation has deteriorated for all manual workers going by a highly effective synthetic indicator: the perception of still being able to do the same job when they reach 60. A recent study published by the European Trade Union Institute also shows significant between-occupation differences.

The trend in work accidents does not give a handle on the decline in working conditions. In all developed countries, the long-term downward trend in work accident rates is linked to various factors: job displacement between sectors, technological improvements, shifting risks to other parts of the world, a generally better-educated workforce and the accumulated results of a century of prevention efforts focused in this area. The main aim of work accident prevention must be to minimise differences between jobs by tackling insecurity and acting on subcontracting.

By contrast, where the long-term effects of working conditions on health are concerned, the challenges are huge. Most manual and a significant proportion of non-manual workers find their current working conditions unbearable. They are reducing healthy life expectancy sharply for the less well-off categories, and reducing their life expectancy of any kind where working conditions-related cancers are concerned.

**What drives prevention?**

The Bilbao-based European Agency for Safety and Health at Work ran a survey to try and pin down the drivers and barriers of a systematic prevention policy in workplaces. It is based on nearly 36 000 telephone interviews with private and public sector enterprises employing at least ten workers. The first person contacted is the enterprise owner or a senior manager. If he reports the existence of a workers’ health and safety rep, that person is also interviewed separately to get two views of what goes on in the enterprise. The questions are on health and safety management generally, how psychosocial risks are dealt with, and worker participation. The replies give an idea of the preventive measures adopted in the workplace, the key drivers for action and the biggest barriers.
One question is on what motivates the taking of preventive action. The answers are clear-cut and fairly consistent for all sizes of enterprise. The main thing that motivates enterprises to develop a prevention policy is the existence of legislation. 90% of enterprises said that fulfillment of legal obligations impelled them to act. In 22 of the 27 countries, this was the leading reason. The between-country gaps are less than for other factors. Where psychosocial risks are concerned, for which the legal framework is often poorly developed compared to more traditional risks, fulfillment of legal obligations remains the main driver for action (63% of replies), far ahead of all other factors with scores ranging from 36% (requests from employees or their representatives) to 11% (concerns at high absenteeism rates).

The second most frequently-cited factor prompting preventive action is requests from workers or their representatives. This is cited by three out of four enterprises. Between-country gaps are wider here, however, ranging from a low of 23% in Hungary to a high of 91% in Finland. Economic reasons – be it client requirements or concern about reputation (67%), absence management and staff retention (59%), or other economic or performance-related reasons (52%) – play only a limited role. Pressure from the labour inspectorate also appears as a less-important factor (57%) – understandable given the under-staffing of labour inspectorates and the low probability of inspection that entails. There are also very significant differences for labour inspection: 16% in Hungary versus 80% in Germany. Where psychosocial risks are concerned, pressure from labour inspectorates is lower, cited by just 15% of enterprises.

The survey bears out employer un-der-resourcing of prevention. The most common response in identifying obstacles is the lack of resources such as time, staff or money, concerning 36% of enterprises. Here too, the differences are significant: three in four Romanian enterprises against one-fifth of Austrian ones.

These facts suggest two consequences for the future of the Community HSW strategy. One is that improving the Community legislative framework is crucial to harmonizing national situations. Most of the directives in force were adopted between 1989 and 1995. To think that the real effort made two decades ago drew a final and satisfactory line under all problems would be a triumph of hope over reason. Also, the primary aim of Community action must be to strengthen the underpinnings of preventive activity by extending and better-resourcing workers’ representation in occupational health, developing real and independent multidisciplinary preventive services, and resourcing labour inspectorates adequately. If the new strategy were to adopt quantitative indicators, these three pillars of prevention should be given priority.

Broadly-speaking, an economic downturn often sees an initial decline in work accidents — all the more so in that the most crisis-hit sectors may be those with high work accident rates (like the construction industry). It would be dangerous to see this as a reason to scale back prevention. Thereafter, work accident rates often tend to rise beyond a simple knock-on effect from an increase in the numbers in work. Various factors are involved: reduced investment in more modern and less dangerous work equipment; the loss of experience that comes with spells out of work; often resulting in greater vulnerability; workers’ abilities to fight back undermined by a context where keeping one’s job is the main priority.

Where the health impact is concerned, a crisis is unlikely to bring any reduction in work-induced diseases. The various factors already mentioned in regard to work accidents are compounded by the psychological toll taken by the crisis. In some user-facing sectors like health, social services and education, an economic crisis most often means a substantially increased workload at a time when governments are cutting funding for these services. In the 1970s, Swedish researchers found that the concentration of women in these activities could explain more drastic effects on the health of young working women.

Behind the increasingly gnomic utterances, the subtext became clear: in a crisis, a job is what counts, but a good job might well be just an indulgence.

The impact of the crisis

To claim that the crisis renders the adoption of a new strategy pointless is a flawed argument. The experience of other crises shows that they actually force working conditions down so that health and safety at work policies are essential to offset the harm.
European news 4/4

The causes of the crisis included rising social inequalities and general business-friendly deregulation.

MSDs: Commission buries head in sand... until at least 2020

The scale of work-induced musculoskeletal disorders (MSDs) has been clear for over twenty years. They top the tables of national statistics on recognized occupational diseases. Their prevalence in the population is a function of working conditions and risk factors that demand a policy of prevention. The record of preventive actions in most EU countries, however, is very poor.

Three of the four main disease groups in the Dublin Foundation’s European Working Conditions Survey are MSD-related. Backache is suffered by 47% of female and 46% of male workers; neck ache and upper limb pain affect 45% of women and 41% of men workers; while lower limb pain is experienced by 30% of women and men alike.

The effects of MSDs build up over and beyond working life. They are a factor in forcing many workers out of their jobs, impair the quality of life of older people and can lead to an increased death rate from the long-term consequences of inflammatory diseases.

Most EU Member States have no specific legislation to guide preventive action against MSDs. There are two reasons why: the lack of an EU directive, which leaves most states sitting on their hands, and employers’ opposition to anything that touches on work organization. Work accidents are unwelcome to employers since they harm both workers and production, whereas MSDs are seen as the inevitable sacrifice that workers have to make of their bodies in the cause of productivity. The fact that work accidents mostly affect men and MSDs mostly women is also a factor in putting down MSDs to unsubstantiated complaints, lifestyles or biological factors claimed to be unrelated to working conditions.

The Community legal framework addresses only a small number of factors like vibration, screen work and manual handling of loads that contribute to MSDs. A comprehensive strategy should include physical factors (like poorly designed equipment), work organization, and the pace, intensity and mental pressure of work.

After twelve years of consultations, discussions with technical experts and unspecific undertakings, the Commission has said it is no longer looking at a directive, but merely a recommendation – i.e., a non-binding instrument that could provide for groundwork on a directive to resume around 2020. This about-turn is a big concession to employers. On 26 March 2012, Business Europe and most of the employers’ organizations in industries where poor working conditions cause a high rate of MSDs (construction, cleaning, shopwork, etc.) had written to Commissioners Tajani (Industry and Entrepreneurship) and Andor (Employment and Social Affairs) calling on them to give up the idea of a directive. The lobbying paid off.

In May 2012, the Commission put forward yet another impact assessment for a possible MSD Directive to its Impact Assessment Board (IAB), an internal, supposedly purely advisory body. The assessment showed the benefits of legislating. The IAB’s comments betrayed its ideological opposition to the principle of social directives. Instead of addressing these comments in a full report, the Directorate General for Employment and Social Affairs decided to back down and settle for a recommendation.

Further reading

