Workers' health and safety exposed to crisis

Introduction

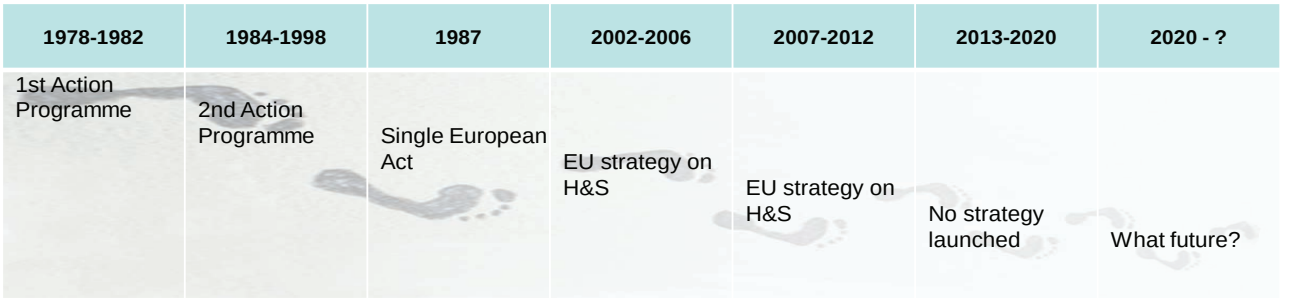
European integration has until now been an important driver of the upward harmonisation of working conditions. From a regulatory point of view, the European level has, especially since 1989, been instrumental in framing and promoting the health and safety agenda in most EU member states, regardless of the current state or stage of the economy or business cycle. In terms of the progress towards better working conditions and prevention, as achieved through the regulations adopted and institutions set up, the impact has overall been positive. Yet this level of improvement serves to conceal growing gaps between specific groups of workers, for example between core workforces and those employed on the peripheries of the labour market where precarious conditions are rife. Still today in Europe between 65,000 and 100,000 workers a year lose their lives because of insufficient prevention.

This chapter on the mid-term assessment of occupational health and safety in the EU will assess to what extent the current situation at the European level corresponds to the challenges faced by workers in the EU. This assessment will start with an overview of the EU strategies in this field, focusing on the specific strategy followed in the health and safety field as well as the larger agenda represented by REFIT (European Commission 2013a). The chapter then turns to examine developments on the labour market and their impact on occupational health and safety. As the situation of workers in general becomes more uncertain and the dire economic situation is leading to cuts in occupational health and safety provision, existing risks are compounded and new risks are inadequately identified and prevented. Companies and governments are cutting back on prevention, leading to an alarming situation in which not only old risks but also 'new' ones such as stress and musculoskeletal disorders are neglected and swept under the carpet. The conclusion sets out the main issues and proposes ways forward.

Topics

Health and safety exposed to crisis

Figure 6.1 Timeline of EU approach to the regulation of health and safety



Source: author's own research.

Change of tack: health and safety issues taken off the priority list; 35 years of momentum lost?

Health and safety has been a pillar in the construction of the European Union for the past 40 years. Back in 1978, the European Commission started the process by adopting the first Action Programme on health and safety at work, its purpose being to focus directly on specific health and safety issues and to confirm the will of the European Community to reinforce the social dimension of the internal market (European Commission 1988). Specific matters tackled included safety aspects of machinery, handling of dangerous substances, monitoring workers' health, occupational safety inspectorates, and improving of human attitudes (European Council 1978).

A Second Action Programme was drawn up for the period 1984-1988, concentrating on safety and ergonomics, health and hygiene, information and training, initiatives for small and medium-sized enterprises and social dialogue, thereby extending the scope and governance methods.

During this period, the EU adopted the Single European Act (1987), which incorporated new health and safety provisions. The Treaty set minimum requirements, allowed the Council to adopt occupational health and safety directives and member states to introduce stricter measures for the protection of workers. The aim was to harmonise conditions in the working environment, to prevent 'social dumping' during the process of completion of the internal market, and to prevent companies from moving to areas with a lower level of protection for the purpose of gaining a competitive edge. A major step forward was the adoption of the Framework Directive 89/391/EEC focusing on the principles of prevention. This Framework Directive aims to improve the protection of workers from workplace accidents and occupational disease by harmonising preventive measures, information, consultation, balanced participation and training of workers and their representatives. In a nutshell, the Directive looks at the humanisation of the working environment. In its wake, a total of 23 individual 'daughter' directives addressing specific issues have been adopted and implemented.

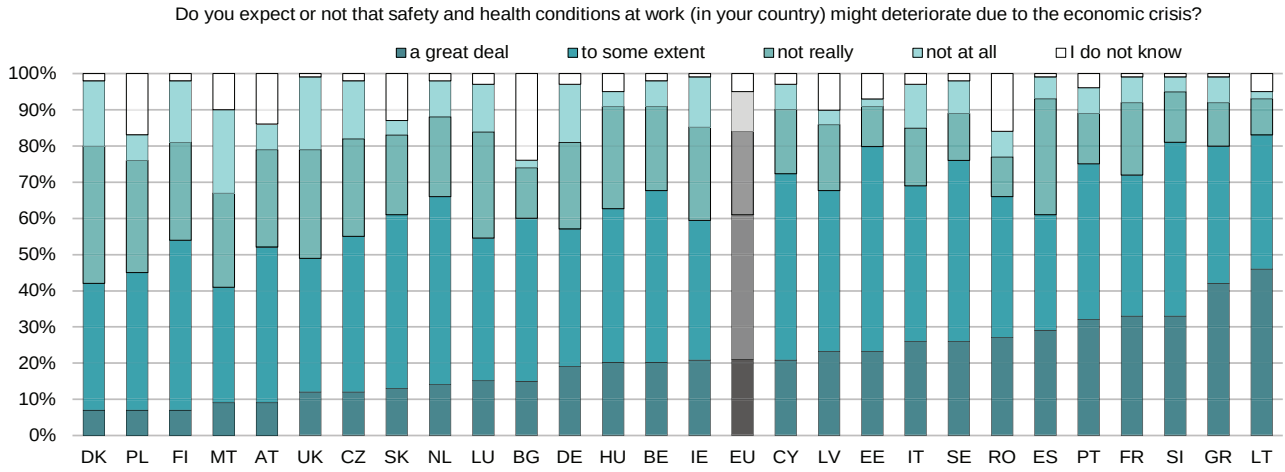
The process of the Community Strategy on Safety and Health at Work started in 2002–2006. It once again expanded the scope by adopting a global approach to well-being in the workplace and emphasised the culture of risk prevention, yet failed to detail a concrete work programme. The follow-up strategy in 2007-2012 once again represented a shift in priority as it focused, rather than on prevention and enhanced well-being, on improving quality, productivity at work and growth.

In 2011 a new strategy was announced for the period 2013 – 2020. Not long afterwards, however, in 2012, the European Commission informally announced a delay, arguing that the priority was the crisis.

In essence, it might be concluded that, over the past ten years, a 'softer' and perhaps less binding and coercive approach has emerged with regard to occupational health and safety. As things stand today, however, in 2014, for the first time in 40 years, the European Union has completely stepped down from its responsibility to ensure the continuous improvement of health and safety at the workplace.

Health and safety exposed to crisis

Figure 6.2 Expected impact of the economic crisis on health and safety - EU27



Source: Pan-European opinion poll on occupational safety and health, EU OSHA (2009).

Deterioration of health and safety expected

Unlike previous crises, the financial crisis triggered in 2008 has profoundly changed, at the company, national and European levels, political consideration of the field of occupational safety and health (OSH). The importance accorded to this dimension has dwindled in spite of the new challenges arising from rapidly changing production models and forms of work organisation.

Figure 6.2 shows the expected outcome on health and safety at work as a consequence of the significant rise in unemployment, continuous restructuring and cost containment at the company level, sharp waves of austerity measures, cutting back of public spending and reduction of sums earmarked for prevention. This has led to a situation in which the three main components of OSH systems – legislation, enforcement and prevention activities – have been undermined due to lack of political will and inadequate provision of resources.

This policy shift stands in stark contrast to the perceived needs of the working population and raises increasing concern about health and safety developments in a majority of European Union member states as shown in Figure 6.2. Expectations of major or some deterioration in different EU member states range from 83% to 41%, with the highest fears reported from Latvia, Slovenia, Greece, Estonia, Sweden and Portugal. Only in Poland, Denmark and Malta did more people report that they expected little or no deterioration. On average 61 per cent reported that health and safety conditions at the workplace were expected to deteriorate a 'great deal' or 'to some extent'.

The European Commission's response to the crisis has been to issue the EU2020 agenda and the Regulatory Fitness and Performance Programme (REFIT) and to postpone the preparation of a new EU OSH Strategy for 2013-2020. Fiscal austerity and the REFIT agenda provide the background framework for current and future EU policies on OSH. The economic rationale of deregulation, lower standards, and interruption in the development of a new updated legislation, as the way to prosperity seems to be taking its toll on the ability to preserve workers' health. REFIT, in particular, represents a challenge to the regulation of prevention as it is aimed at, among other things, reducing regulatory burdens via so-called simplification of legislation (deregulation) or reducing new legislative initiatives. This process has led to the postponement of legislation in progress, to a refusal to transpose the European Framework Agreements (Hairdressers agreement) concluded by the social partners into a directive in line with Treaty provisions, etc. These recent setbacks are likely to inflict tremendous and irreparable damage on the whole system constituted by the EU OSH policies and, above all, on the health and safety of workers.

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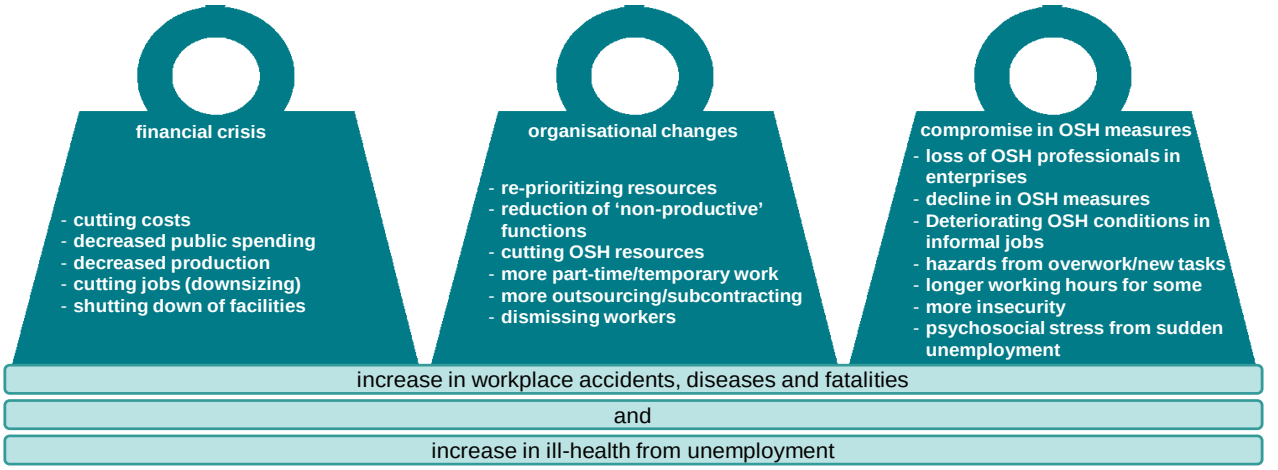
Figure 6.3 The financial crisis and its potential impact on health and safety at work



Source: ILO (2013).

The crisis' multidimensional impact on workers' health and safety

The impact of the economic crisis on occupational health and safety occurs at different levels and encompasses a wide range of dimensions. ILO (2013) sets out a classification grouping the drivers into the macro-economic context of the financial crisis and those occuring from organisational changes and direct measures with regard to OSH policies. Overall, the crises delivers a negative impact to the health and safety of workers due to the overall increase in insecurity, the adverse organisational changes, and the readiness to compromise OSH standards and established measures.

On the macro-economic level the economic crisis puts pressure on public finances, while jobs are cut as companies downsize or shut down. This induces a general feeling of insecurity and increases unemployment, thereby increasing health-related risks. Further, it induces companies to undertake organisational changes and restructuring as they attempt to adapt so as to weather the economic downturn. The organisational changes often bring more sub-contracting, part-time and temporary jobs, workforce cuts and fewer resources for 'non-productive' work. These changes put more pressure on workers and, furthermore, complicate companies' standard health and safety policies and practices (ILO 2013). To compound these negative impacts of the crisis, OSH policies and strategies are impacted directly as OSH personnel are laid off or transferred to other posts, budgets for the provision of OSH services are cut and the associated policies placed on the back burner. The potential impact of the crisis on OSH is, accordingly, multidimensional, entailing a host of interrelated phenomena leading to a potential increase in accident rates, diseases and loss of life for those in employment, alongside increased ill health for those not in employment.

The above analysis clearly demonstrates the need to increase the attention paid to OSH as work organisation becomes more complex and unemployment increases. If improvement is too much to ask in the current environment, then at the very least current OSH standards should be maintained. However, as the previous section has shown, health and safety regulations are to be reviewed and no new Directives will be processed or adopted in the near future.

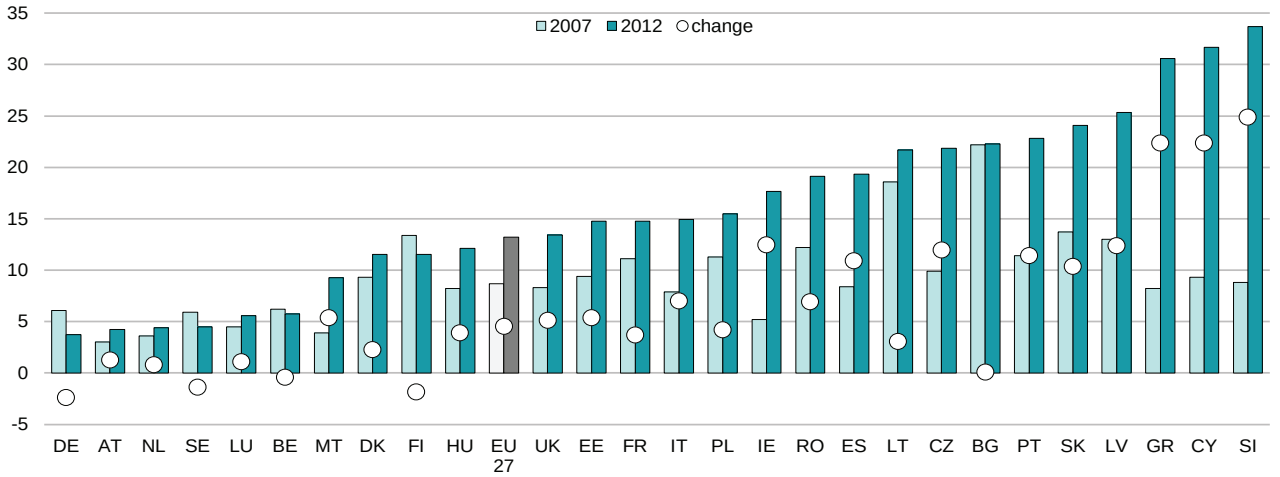
The study findings by ILO (2013) are compounded by a recent survey carried out by the EU OSHA (Rial González et al. 2010). The survey corroborated the thesis that the crisis is impacting OSH negatively; the factors put forward as negatively influencing the health and safety of workers at a time of recession were:

- Lack of resources such as time, money and staff.
- Lack of expertise.
- Unsatisfactory health and safety culture.
- Lack of sensitivity in dealing with health and safety issues.
- Lack of technical support or guidance.

As such, none of the above listed factors are solely linked to the economic crisis, but each of them clearly is affected by the dire situation. In particular at times of crisis, less attention is devoted to the health and safety of workers. The above-mentioned EU OSHA study identifies the major reasons for addressing health and safety issues at the level of the enterprise. Fulfilment of legal obligations and pressure from employees and/or their representatives are ranked as the most important determinants for employers (90 per cent and 76 per cent). Pressure from labour inspectorates comes in the fifth place with 60 per cent. These findings give rise to concern as all three factors are under pressure from the economic situation, the associated policy reforms, budgetary cuts and interruption in new legislative provisions.

New and emerging hazards as a consequence of the crisis

Figure 6.4 Evolution of job insecurity during the crisis



Source: Van Gyes and Szekér 2013.

Job insecurity on the rise

While the policy shift in itself clearly gives rise to concern, the development of jobs and the labour market at large is likely to compound its potentially negative impact. While it is a well-known fact that both the threat of unemployment and the general feeling of insecurity generated by the possibility of impending job loss entail considerable consequences for workers' health, several studies confirm that job insecurity can in itself represent a higher risk factor than actual unemployment for mental – but not only mental – health (Quinlan et al. 2001; Quinlan and Bohle 2009). In this context, the crisis and associated processes of restructuring increase the risk of poor health outcomes for both unemployed and employed, with depression and anxiety being the most frequently cited health problems. About 70% of workers may be exposed to high risk of psychosocial diseases and chronic illness when their employment security is low (Parent-Thirion et al. 2010).

The comparison of job insecurity data from 2008 and 2012 in the European Union member states in Figure 6.4 shows a growing trend toward increased insecurity during the crisis and hence an increased risk of health problems. As we do not have comparable date on job insecurity across the EU, the data in Figure 6.4 is measured in different ways, e.g. self-perceived job insecurity, perceived danger of job loss within a short period of time, associated with the expectation of difficulties in finding a new job. In spite of this difference in the definition of job insecurity which makes it difficult to compare the data across countries, this information does allow us to deduce general trends within countries.

The overall trend shows that the European population is feeling more insecure with regard to job situation and outlook, although there are a few examples of stagnation (Bulgaria) or even improvement (Czech Republic). The perceived increase in job insecurity can lead to psycho-social problems among the workers concerned. Workers may also, under pressure of job insecurity, accept lower OSH standards and agree to work in unsafe conditions, to work longer hours, to overlook minor incident and accidents, to refuse to report work accidents or to request compensation. Job insecurity can lead also to 'presenteeism' which increases the risk for the workers themselves but also for others present in the workplace when workers are determined to be present under whatever conditions out of concern to protect their jobs.

The combination of increased job insecurity, increase in temporary employment (see chapter 2), restructuring, increase in musculoskeletal disorders, stress and other psychosocial factors at work, remain a major hazard. This association between job insecurity and temporary work generates an increased risk for health. Scientific evidence shows that with this type of combination, workers are more likely to be exposed to risks leading to higher injury rates, higher sickness rates and poorer health overall, greater risk of suicide and higher rates of chronic health problems, including heart disease and strokes (Quinlan and Bohle 2009; László et al. 2010).

New and emerging hazards as a consequence of the crisis

Figure 6.5 Work-related stress during the crisis

	Indicator	Survey	Trend
Belgium	Stress at work	SERV: 28.8% problematic in 2007; 29.8% problematic in 2010	↑ (no clear link with crisis)
Bulgaria	Complaints about stress	NWCS: from 22% in 2005 to 40% in 2010	↑
	General fatigue	NWCS: from 22% in 2005 to 60% in 2010	↑
Finland	Experience some stress	Work and Health Survey: 38% in 2006, 34% in 2009 and 35% in 2012	= ↘
France	Mental strain	SUMER data: from 23.3% in 2003 to 23.4% in 2010	→
Ireland	Stressful job	National Workplace Survey: 7% in 2003 to 10% in 2009 ('always')	↑
Netherlands	Burnout score	Netherlands Working Conditions Survey: average burnout score rising from 1.95 in 2007 to 2.06 in 2010 (on a scale from 1 to 5)	highest level in 2010
Spain	Feeling very stressed and coping with too much work	National Survey of Working Conditions: from 20.3% in 2007 to 23.9% in 2011	↑
UK	Rate of illness linked to stress	HSE statistics: from 39% in 2007 and 42% in 2011	↑ stable in 2010 and since then ↘
	Stress as main hazard	TUC survey of safety representatives: from 61% in 2006 to 62% in 2010	→

Source: Van Gyes and Szekér 2013.

Psychosocial hazards: the straw that broke the camel's back

Evidence from previous periods has displayed a link between the dire labour market situation and the increase in stress. While none of the national country studies covered in Figure 6.5 establish a direct causal link between the economic crisis and increased level of stress and other psychosocial factors, since the occurrence of stress at work was reported in the period preceding the crisis, the studies do indicate that stress factors have increased, in some countries to a very large extent.

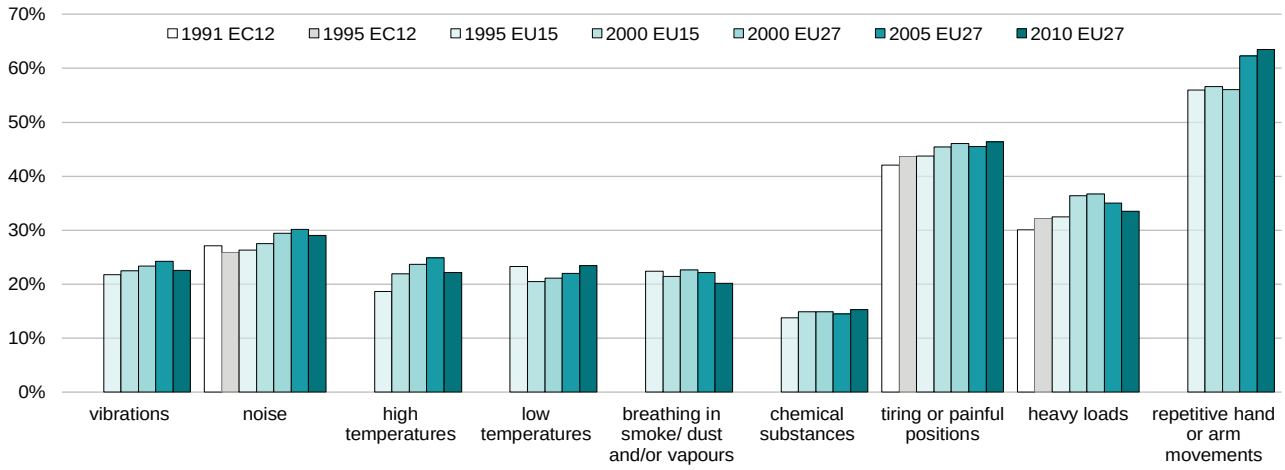
Further evidence from the past four years shows that the potential effects of enterprise descaling on OSH during a global economic crisis could be dramatic insofar as OSH becomes even more important for the health of workers and those facing job losses (Kieffer 2013; Sapelli 2010). An illustration of the above is reported by the French labour inspection body, which concluded that 'pathogenic' management methods to reach a target of 22,000 staff cuts at France Telecom were to blame for an increasing incidence of suicides since the beginning of 2008 (Alternatives Economiques 2010; ETUI 2012) .

The economic crisis, restructuring and further developments in information and communication technology have affected the incidence of the various psychosocial risks. At one extreme, Lundin and Hemmingsson (2009) show in a 26-country study that the large and rapid increase in unemployment is associated with a significant increase in suicide rates. They argue that employees who lose their jobs during a recession are frequently at greater risk of suicide, and that for the least well-educated among such workers, the risks are even higher. The rising suicide rates are a sign of high levels of mental distress among workers and their families.

Hence while it is difficult at this point to establish a direct causal link between the crisis and increase in stress levels at work, there is a clear upward trend in stress at work, calling for reinforced action and attention to combat the working conditions that cause stress. On an even direr note, there seems to be a clear link between the increase in suicide levels and the effects of the economic crisis. Here too action is needed to tackle this problem at both the macro and micro-level.

New and emerging hazards as a consequence of the crisis

Figure 6.6 Development of working conditions in the EU



Source: Parent-Thirion et al. (2010).

The cumulative effect of old and newly emerging hazards

The situation of the health and safety of workers in Europe has not improved during recent years. The latest European working conditions survey published by the European Foundation for the Improvement of Living and Working Conditions reports various indicators showing that things are not improving in this area (Parent-Thirion et al. 2010), although some of the indicators have decreased as a result of decreased economic activity in sectors highly exposed to specific risks, such as construction and manufacturing.

In the EU27 'old' risks (such as exposure to chemicals, physical factors and biological agents) remain high, and risks related to musculoskeletal disorders and chemical agents are steadily rising to reach unsustainable levels. These so-called old risks, though they may in some cases seem to have flattened out, may also impact working life in new ways as they come to be combined with other types of exposure and psychosocial factors.

Job-related psychosocial diseases have been increasing because of work intensification and they are leading to cardiovascular diseases and mental health disorders. The rules on recognising them as occupational diseases and accidents at work, as well as the rules for compensation, vary between countries; only Denmark has such conditions on the list of recognised occupational diseases (Kieffer 2013).

Musculoskeletal disorders are at the top of the national statistics on recognised occupational diseases. These cover a wide range of chronic, inflammatory and degenerative diseases; yet, despite their prevalence, preventive action remains very poor. Based on the current data (see Figure 6.6), they are one of the major workplace health issues in Europe and are the second cause contributing to newly attributed disability pensions (Schneider and Irastorza 2013).

Musculoskeletal disorders have a multifactorial aetiology and are present in all types of jobs and sectors causing long-term sickness absences, unsatisfactory recovery and often ending in disability. The situation becomes even more severe when musculoskeletal disorders are present in workers over 45 years old (Spreeuwers et al. 2011) or in women, as their treatment and recovery is slower and different. In most cases, these complaints are not recognised as occupational diseases and, as most of the member states cover and describe them differently, comparison is not easy.

New and emerging risks appear with new materials, nanomaterials, endocrine disrupter chemicals and new industry sectors. Workers are exposed not only to one single substance, but to mixtures or to multiple substances. The risks, the mechanisms of action in humans, and the impacts on health of direct and indirect exposure, are still not known (Maynard et al. 2010).

The ILO estimates that in Europe, every 3.5 minutes a person dies as a result of work-related accident or occupational disease. It is difficult to obtain an appraisal of the state of occupational diseases in Europe because of the major differences in the criteria for identification, recognition and compensation in individual member states. The fact remains that occupational diseases continue to prove fatal to large numbers of workers.

Conclusions

All on board: not allowing the crisis to become an excuse for inaction or undermining standards

The economic crisis is a major obstacle to ensuring competiveness, productivity and growth in the EU and for reaching the goals of the EU2020 strategy. It was recognised by the European Commission in its document Evaluation of the European Strategy on Safety and Health at Work 2007 - 2012 that 'OSH policy can create benefits (both at the societal and individual company level) which exceed the costs' (European Commission 2013b). This study also recognized that there are numerous factors which affect developments in the incidence of occupational accidents and disease and that a crisis is a highly important determinant within this broad configuration.

An appropriate and meaningful form of prevention provision means, primarily, a modern and comprehensive legislative corpus, sufficient resources – both human and financial – for well-developed and properly functioning preventive structures, and a high level of commitment on the part of both community and authorities to promoting the improvement and sustainable development of working conditions and the working environment. A substantial component of the preventive structures should be the enforcement bodies, in other words, the Labour Inspectorates.

Since resources, including public spending, are cut at times of economic uncertainty, the European Commission (2013b) acknowledges that in many countries the resources for Labour Inspection have indeed decreased. The main activities of labour inspectorates have in the past ranged, the Commission adds, from monitoring and enforcement of minimum health and safety standards and employment conditions to economic issues like the fight against undeclared work. The cutting of resources and shifting of activities compound an already existing chronic lack of resources and undermine the possibility of fulfilling the enforcement provisions contained in new or already well-established legislation.

The crisis also seems to have slowed down or induced inappropriate implementation of the European or national OSH strategies, such that far less has been achieved than anticipated. The number of occupational accidents, meanwhile, fell during the 2007-2012 period, some of the main reasons for this being that high-risk sectors have contracted as a result of the crisis, employment has decreased, and workers tend to fear reporting the accidents.

As the crisis drags on, the challenges to OSH are increasing. The numbers of temporary workers and subcontracted employees are increasing and, at the same time, the European population is ageing so that workers will be required to work longer as the retirement age continues to be raised. Meanwhile, the intensity of work is also increasing.

Last but not least, a lack of awareness is the principal barrier to prevention. Given this worrying evolution (less prevention services, poor work-life balance, workers dying because of unsafe practices), what will be the future scenario for occupational health and safety?

The review of the standstill of the OSH strategy and the rising challenges to OSH call for a new way forward. A first step must be to adopt a new European health and safety strategy as well as to adopt the Directives already on the table. REFIT cannot be the only driver of OSH at the European level. The preventive structures such as labour inspectorates must be provided with the resources and authority to carry out their mandate. Meanwhile, less traditional and yet little dealt with challenges such as psychosocial risks, the ageing workforce and the gendered aspect of OSH, must be accorded the requisite attention. A second element is that key issues still need to be solved: the revision of the carcinogens and mutagens Directive needs to be finalised, the musculoskeletal disorders Directive needs to be addressed, occupational diseases need updated data and prevention structures need to be supported. And last but not least, new risks such as those constituted by nanomaterials and endocrine disrupters, must be recognised and dealt with appropriately.

Assessing the state of OSH half-way through a lost decade leads to the conclusion that the political impulse for OSH has been placed on hold, at the very time when new challenges are arising and there is a need for more, rather than less, attention to be given to these matters.