Occupational health

Eight priority action areas for Community policy

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Introduction

Over a hundred thousand people in the European Union are killed each year in an accident or by a disease caused by poor working conditions. Truth to tell, this is no more than an approximate minimum, because no exact figures can be put on it. It is a conservative and certainly under-stated guesstimate. Whenever authorities or researchers attempt to determine what measurable impact working conditions has on some aspect of health, they uncover new problems. Men and women workers do not need specialists for that. Surveys tell us of the fatigue, pain, disabilities and illnesses they suffer on a massive scale. The European Trade Union Technical Bureau for Health and Safety was set up fifteen-odd years ago specifically to get workers' perceptions and views recognized as a real source of expertise. The TUTB works through its trade union networks and contacts with other players in prevention to expand its knowledge of workface realities, in order to change them. Because of that, one of its key activities is helping the European Trade Union Confederation and its member organizations to fight for healthier working conditions. Over these fifteen years, we have been active in a wide range of areas : from the safety of machinery to cancer prevention, from ergonomics to the operation of preventive services, from policy debates in the European Parliament to supporting initiatives by trade union reps in the European Works Councils of various international companies. And we have gradually won recognition from public authorities and prevention professionals for the importance of the work done by a small team whose main focus is to ally technical expertise to a robust commitment from workers and their unions.

Occupational health is a hidden issue. It is rarely front-page news. The authorities do not get much exercised about research in the field. To cite just one example, far more money is poured into genetic research on cancer than the scant funding allowed to research into the role of occupational exposures in cancers.

There is often a misperception that workplace health problems are mainly technical. We think not. We believe occupational health to be first and foremost a political issue that reflects societal choices.

This brochure sets out to give a broad-brush picture of some of the ongoing debates on workplace health problems in the European Union.

It is not meant to be a comprehensive review. More detailed analyses can be found in other TUTB publications and the special reports on its website. We wanted to make it an easy road map through what can be a tangled web of complex discussions. To keep it short and to the point, some topics have been left out, not because they are less important, but simply because other TUTB publications already exist on them. They include the debates on work equipment design, technical standardization and market surveillance.

It bears briefly pointing out that a series of issues will be up before the European Parliament in 2005. Some are directly and only to do with occupational health. Others cover different areas but will have a big impact on occupational health. Some of the discussions will probably carry over into 2006, if not beyond. Key issues on the parliamentary agenda include :

- The REACH proposals for reforming the rules governing the chemicals market, which have been savaged by the chemicals industry and the Bush administration.
- The proposal for a revision of the Working Time Directive put forward by the Commission in September 2004, which could significantly reverse the gains made.
- The proposed amendment to the Directive on protection for workers exposed to carcinogens to include mutagens and reprotoxins. This would be a big step forward for the protection of reproductive health.
- The discussion on the Commission's 2004 review of the practical implementation of the 1989 Framework Directive and five other health at work directives.
- The discussion on the Commission's forthcoming report in early 2005 on the mid-term review of the Community health and safety strategy.
- The discussion on the Commission's forthcoming Communication on Community initiatives to prevent musculoskeletal disorders.
- The proposal for a directive on the liberalization of services (sometimes called the "Bolkestein Directive") which is likely to affect levels of health and safety in many sectors (especially the construction industry and any sector that uses temporary agency staff).

Other issues not yet formally on the European Parliament's agenda also need debating. They include :

- The health and safety impact of casual hire-and-fire jobs.
- The need for a gender-equal approach to occupational health that guarantees gender balance in all jobs in conditions conducive to life-long health.
- Better controls on the work equipment market through effective practical implementation of the Machinery Directive (whose revision is nearing completion).
- The linkages between Community public health policies and occupational health, in particular with a view to reducing social inequalities in health.

All the issues raised here are debated both in the Community bodies and at national level. From the very first, the TUTB has consistently attempted, through exchanges of experiences and cooperation between trade unions, to see that Community action is permanently informed by national experiences, and the lessons of their successes and failures.

The challenges are given even greater immediacy as enlargement has added to the diversity and complexity of the European Union. The new Member States have had to take over the Community *acquis* (established body of laws and regulations) in just a few short years. A new Commission took office in November 2004. The European Parliament was renewed some months earlier. The enlargement of the EU does not automatically mean that things will get better or worse for workers. It all depends on the social and political dynamics in each Member State and how they feed into Community policies. Occupational health is an area where people's everyday lives and big policy decisions are constantly interacting. This brochure aims to help build a productive dialogue between MEPs and trade unionists. By doing so, it means to play into an overall dynamic that will help shape the face of tomorrow's Europe.

Marc Sapir
Director of the TUTB
November 2004

1. Occupational health
A key area for reducing social inequalities in health

Social inequalities in health are still in evidence, and often getting worse, across the entire European Union. Life expectancy, the probability of disability, and the prevalence of many illnesses and disorders differ with the individual's social class.

Working conditions are a major cause of these health gaps. Poor working conditions are a factor in reduced life expectancy, either directly as causes of fatal accidents or diseases, or indirectly by contributing to a general worsening of health. Work-related stress, for example, is associated with a range of illnesses and disorders, not least coronary heart disease.

Why is Community action important ?

The European Union is a single market. It ensures free movement for capital, services, workers and goods. That in turn means developing a Community legal framework to harmonize national laws. One main aim of such harmonization is to prevent uncontrolled competition operating at the cost of worsening working conditions and further damage to workers' health and safety.

Since it was set up, and, especially, since the Single European Act of 1986, the European Union has framed a large body of occupational health law. Along with the gender equality provisions, it is the most highly developed sphere of Community social policy.

But this body of legislation has still not been enough to deliver significant improvements in working conditions. It has been a real factor for progress in all Community countries, but remains flawed by a number of gaps and failings. Also, work is changing. Some risks overlooked in the past are coming to the surface with a vengeance. New problems are appearing or getting worse, while others fade into the background. Technical and scientific data are improving. Workers' expectations are changing. For that reason, Community occupational health legislation remains a work in progress. The vigorous surge of legislation between 1989 and 1992 tailed off sharply thereafter, and there is now lost ground to make up.

But Community action is about more than just passing legislation. It must be supplemented by an overall strategy underpinned by a range of functions like following-up on practical implementation and an ongoing assessment ("monitoring") of situations, policing and enforcement actions towards States that do not fulfil their obligations, information, research, mainstreaming occupational health across other Community policy spheres, etc.

Joined-up action between different Community institutions and agencies - like the Bilbao-based Agency for Safety and Health At Work, the Dublin Foundation, the tripartite Luxembourg Advisory Committee, as well as more specialized, less well-known bodies, like SLIC (Senior Labour Inspectors Committee) and SCOEL (Scientific Committee for Occupational Exposure Limits) - is particularly key here.

To get this kind of joined-up working going, the European Commission itself must give proper emphasis and resourcing to health at work. Both the European Parliament and the Economic and Social Committee have repeatedly expressed disquiet about cuts in the funding and staffing available to the Commission for giving momentum to workplace health policies and checking that the Directives are being properly implemented in practice in the different Member States. The enlargement of the European Union to 25 countries and the importance of the ongoing debates emphasize the need to expand these resources. So far, no moves have been made to do so. We do not believe that mainstreaming occupational health across other social policies is enough. Without a central core focused exclusively on health at work, the policy is at risk of having holes driven through it and losing all coherence.

Data on the health impact of working conditions

Working conditions can be analysed against different criteria, as is shown by the Dublin Foundation's survey on working conditions done in 2000. In terms of immediate perceptions, 27 % of workers in the Europe of Fifteen considered that their health and safety were at risk because of their work. From a "sustainability of work" perspective, the situation seems more critical still : 42 % of workers in the Europe of 15 thought they would be unable or unwilling to keep doing the same job until the age of 60. The figures in the new Member States are apt to give even greater cause for concern.

The 1999 labour force survey in the European Union included a module on occupational health. It transpired that out of 100,000 respondents, 5,372 had a health problem caused or made worse by their present or past working conditions, not including work-related accidents. One consequence of this situation is 350 million lost working days a year.

Some fundamentals

Occupational health legislation may be seen as a highly technical matter which only specialists can fully grasp. And yet the basics of that legislation are all to do with fundamental societal choices. Since the very start of the industrial revolution, it has been questioned where the responsibilities of the authorities lie if wealth accumulation by a few does serious harm to the life and health of the majority of the population. Labour movement action checked the economic liberalists' "laissez-faire, free-for-all" approach. It became apparent that mere self-regulation by firms, acting in their own long-term economic interests, or from feelings of compassion or social responsibility, was not enough. Government had to step in, and set conditions and limits. From the first half of the 19th century, rules were framed to outlaw child labour, set minimum conditions for ensuring the safety of machinery, and police workplace hygiene.

Whenever legislation to protect health and safety at work has been on the agenda, the proposed reforms have been savagely attacked, usually less for their content than their putative cost. Scaremongering estimates have always branded the legislation as a threat to the economy. 19th century industrialists predicted that outlawing mine work by children was the slippery slope to economic decline in Europe. Even now, the opponents of Community health at work legislation vastly over-exaggerate the probable costs, let alone job losses. It must not be forgotten that the costs of prevention produce substantial gains for society and those protected.

It is obviously not possible to legislate all problems out of existence, but it is the essential starting point. Without binding rules, there will always be competition between employers motivated by profit at any cost - including workers' deaths - and other more prevention-minded ones.

The point of legislation is to apply it in practice. So a strategy for occupational health must be framed at Community level and in each Member State. That strategy must be properly resourced, promote joined-up working between the authorities concerned, put policing and enforcement systems in place. It cannot be framed without consulting trade unions, and it must be evaluated on a regular basis to enable timely changes to be made when new problems arise or when failings are identified.

Health cannot be imposed from outside. It is preserved individually and collectively by daily action. That is what makes trade unions into crucial players in occupational health. The existence of a dense and active network of workers' health and safety representatives is a key to the success of any occupational health strategy. In the European Union today, large numbers of workers are denied any form of representation in health at work either because of the size of their firm, their employment status (e.g., temporary agency workers), or on other grounds.

Further reading

- The TUTB will be publishing a brochure on the functioning of European health and safety at work policy in 2005.
- Eurostat, *Work and health in the European Union - A statistical portrait*, Luxembourg, Office for Official Publications of the European Communities, 2004. Consultable on : http://europa.eu.int/comm/eurostat > Publications.
- European surveys on working conditions done by the Dublin Foundation. See : http://www.eurofound.ie/working/surveys/index.htm.
- On the contribution of psychosocial factors to social inequalities in health : special issue of *Social Science and Medicine*, Vol. 58 (2004).

2. The Community strategy for the period 2002–2006
The means for the job ?

In March 2002, the Commission adopted a Communication outlining a strategy on health and safety for the period 2002-2006.

A closer reading of this document, however, leaves misgivings about the coherence of the measures proposed.

The Commission Communication contains much interesting analysis. But the practical proposals are weak, and there is no time frame setting specific deadlines. At the end of 2004, a rapid mid-term evaluation shows that new measures have been less than thick on the ground...

Musculoskeletal disorders (MSD) offer an illustration. This term covers a set of disease conditions that affect large numbers of workers in Europe. The Commission Communication rightly calls them a priority of workplace health and safety. But instead of proposing specific measures, the Commission announced in 2002 that it would be publishing a Communication on MSD. That Communication should have looked into their causes and proposed amendments or new legal provisions in fields in which coverage is still incomplete. In fact, nothing had yet been done by the end of 2004, and no such Communication has been forthcoming.

The big issue that the Commission's Communication tries to dodge is this : the Directives are the main instrument of Community action on occupational health. This was accepted by all the States that were members of the EU when the Treaty was revised by the Single European Act in 1986. Whatever advances have been made to date have come only in areas where Community directives have set a common and binding benchmark. Elsewhere, where only non-binding benchmarks (Recommendations) have been set - recognition of occupational diseases, for instance - the failure is clear to see.

The Commission's enthusiasm for "soft law" (a mixed bag of non-binding measures) and its unclear plans for any new legislation raise serious questions about whether there really is a Community health at work strategy for the current period. The Prodi Commission's initiatives since 2002 have been few and questionable. Some improvements have been put up (chiefly the planned revision of the Carcinogens Directive), but many issues are stalled (especially musculoskeletal disorders), the revision of the Pregnant Workers Directive has still not happened, despite urging from trade unions and the European Parliament, and the

political pledge given in 1992. On working time, the Commission bowed to employers' pressure and tried to roll back the gains. When put on the spot, the Commission tends to call on the "good will of the social partners" rather than taking a clear stand that might put employers' or some governments' backs up. Also, the ongoing debates on regulation of the chemicals market (REACH) and the revision of the Machinery Directive show that occupational health has not been properly dovetailed into trade policy. Some proposals in other areas, like the proposal for a directive on the liberalization of services (the "Bolkestein Directive") could be extremely bad for occupational health.

What role does the European Parliament play ?

The European Parliament is a joint legislative body in framing Community occupational health laws. The amendments it passes can help produce more coherent and more effective legislation. But Parliament can also reject measures that roll back social gains. This is what happened in November 2003, when it voted down a proposal for a directive drawn up by the Commission in February 2001 which seriously undermined dockers' working conditions. Large-scale trade union action during the two years of debates helped inform Parliament, which did the right thing in November 2003 by throwing out in its plenary session the draft directive worked out in the conciliation procedure. (See the timeline of events below.)

But Parliament's role is not limited to law-making. It can examine issues of importance on its own initiative, and identify needs on which Community action is justified. In the past, the European Parliament has held hearings to take stock of a particular question (such as musculoskeletal disorders).

Parliament also has a role to play in evaluating the practical implementation of Community legislation, and the outcomes of Community policies. It has repeatedly expressed its disquiet about the swingeing cuts in the Commission's staffing resources for occupational health and safety.

Any MEP can table written questions that call the Commission and Council to account over issues relating to Community action, or the compliance of national laws and practices with EU rules.

Timeline of parliamentary debates and union action on port work

- **13 February 2001**. European Commission publishes its proposal for a directive on market access to port services.
- **25 September 2001**. First action day called by the European Transport Workers' Federation. Protests by British, Spanish and Belgian dockers.
- **14 November 2001**. European Parliament amends the Directive, but leaves the self-handling principle intact.
- **13 December 2001**. Several thousand dockers join the ETUC demo at the Laeken European Summit (Belgium), getting a big public focus on their demands.
- **19 February 2002**. European Commission brings forward a new proposal, which ignores the changes called for by Parliament.
- **14 March 2002**. Dockers are prominent in the ETUC's Barcelona European Summit demo.
- **June 2002**. First strikes in six different countries (including Norway) against the European Commission's proposals.
- **25 June 2002**. Council of the Ministers adopts a common position, which includes even worse self-handling provisions.
- **January 2003**. Second action day with 24-hour strikes across 17 countries.
- **17 February 2003**. 500 dockers in 13 European countries respond to the European Transport Workers' Federation's call to protest their demands outside the European Parliament building in Brussels.
- **18 February 2003**. European Parliament's Transport Committee works out a compromise that limits the Directive's most dangerous aspects, but still accepts self-handling on certain conditions.
- **20 February 2003**. 250 dockers demonstrate in Antwerp against the visit of European Transport Commissioner Loyola De Palacio.
- **10 March 2003**. 3,000 dockers from five countries demonstrate outside the European Parliament building in Strasbourg beneath the slogan "Leave it to the specialists. It's our job".
- **12 March 2003**. European Parliament votes through the Directive on second reading, with the requirement that self-handling should be subject to prior authorization.
- **15 April 2003**. Council of Ministers rejects the European Parliament's amendments. Conciliation procedure initiated.
- **9 September 2003**. Strike actions in Belgian and Dutch ports.
- **29 September 2003**. Rotterdam sees a protest by 9,000 dockers from nearly a dozen countries (including a delegation from the United States). Work stoppages in Belgian, French and Dutch ports. Dockers from southern European countries hold a protest march in Barcelona.
- **30 September 2003**. Conciliation procedure results in a text which allows self-handling in certain conditions. Voting is very close-run in the European Parliament delegation. The very same day, the European Transport Workers' Federation rejects the outcomes of the conciliation procedure. It announces further action by dockers against the Directive, which still has to be approved by Parliament in plenary session.
- **17 November 2003**. A petition of 16,000 signatures is handed in to the President of the European Parliament protesting against the conciliation procedure compromise text. In Belgian ports, workers start each break an hour ahead of time. Massive email campaign to MEPs.
- **20 November 2003**. European Parliament rejects the conciliation procedure directive by 209 votes for, 229 votes against and 16 abstentions. This is only the third time in 10 years that a conciliation procedure text has been voted down in Parliament's plenary session.

Further reading

- The trade union proposals on the new Community strategy are in Vogel, Laurent, *A new impetus for Community occupational health policy*, Brussels, ETUC-TUTB, June 2001.
- Smismans, S., Towards a New Community Strategy on Health and Safety at Work? Caught in the Institutional Web of Soft Procedures, *The International Journal of Comparative Labour Law and Industrial Relations*, Vol. 19/1, spring 2003, pp. 55-84.
- A forthcoming *TUTB Newsletter* will carry an appraisal of the implementation of the Community strategy.
- TUTB website : http: //tutb.etuc.org > Main topics > Community strategy.

3. Prevention systems
For a coherent strategy

One failing of the laws passed between the early days of the industrial revolution and the 1960s is that they were framed as specific responses to identified risks. Legislation tended to come some time after the risk, and sought to provide a technical solution for eliminating or reducing the risk. The drawbacks of this approach were :

- it was more reactive than preventive : legislation generally followed long after the risk first emerged ;
- it developed too slowly, and was not appropriate to all work situations ;
- it disregarded many risks that the preferred option was to gloss over ;
- it created the misconception that a set of specific technical responses was enough to ensure workers' health.

In the 1960s, new approaches began to emerge in occupational health, focussing on an overall strategy interfacing at different levels :

- a national prevention strategy, with a more seamless continuum between occupational health, public health and environmental protection; stricter regulation of the market in work equipment and chemicals; monitoring, early warning, policing and enforcement systems ;
- sectoral and territorial strategies that accommodate the distinctive features of a specific industry sector or geographical area ;
- mainstreaming occupational health requirements across all areas of business management and strategic choices ;
- active participation by workers and labour organizations in framing and implementing prevention policies.

Community legislation mainly addressed the latter two levels of action. Mainly, it laid down rules to ensure that every firm

On the agenda...

- ➜ Parliament will be debating the Commission's report on the practical implementation of the 1989 Framework Directive and five individual directives. It can use this opportunity to fashion a more overall approach for Community and national occupational health strategies.
- ➜ Parliament can support initiatives that enable a more systematic follow-up of working conditions and their health impact, as well as prevention activities in the different competent EU agencies (Dublin Foundation, Bilbao-based HSW Agency, Eurostat, etc.).
- ➜ Parliament will be examining the implementation of the Community strategy for 2002-2006; it could look closely at its failings and propose specific measures with a firm timetable. A Commission Communication is planned for early 2005.
- ➜ Parliament could look at how occupational health priorities are mainstreamed across other Community policy spheres, especially environmental protection, the marketing of work equipment and chemicals, gender equality, employment policies, public health, and Community research policies.

adopted a coherent prevention policy. It gave no systematic consideration to the role of the public authorities, nor the contents of national prevention strategies. That notwithstanding, the recent debates have made it clear that the only way to get workplace provisions applied in practice is through a national prevention strategy. In other words, there is an essential connection between the existence of an overall strategy and the putting in place of specific workplace arrangements.

For example, medical check-ups done for health surveillance requirements have only a very limited effectiveness unless they are backed up by an overall follow-up of workers' health on a national scale, epidemiological research and the development of preventive solutions which, in many cases, goes beyond the factory gates.

Labour inspectorates are central to the implementation of national occupational health strategies. Their activity should ensure that all workers enjoy equal rights in terms of safety and health protection. But the understaffing and under-resourcing that currently beset national labour inspection systems in all European Union countries reduces their effectiveness in a context of extreme production segmentation, and the spread of subcontracting and casual hire-and-fire.

In early 2004, the Commission published its first report on the practical implementation of the 1989 Framework Directive and five individual directives. It shows that national prevention strategies are deeply flawed. In many cases, States have carried the Directives over into law, but have not resourced their proper practical implementation.

Further reading

- Preventive Services, Special Report, *TUTB Newsletter*, No. 21, June 2003, pp. 19-37. Consultable on the TUTB website : http://tutb.etuc.org > Newsletter.

4. Work organization
A mix of important factors

It is not only tangible things like work equipment and chemicals that cause workplace health problems. Intangible factors - like working hours, pace, rostering, how appropriate training, information and other available forms of support are for the jobs to be done, cohesion amongst workers, dignity, etc. - also play a big part.

Prevention policies have traditionally overlooked many aspects of work organization. Only working hours have been regulated for more than a century and a half. And yet work organization is a key area for improving occupational health. Some of the issues that need to be taken into account are considered below.

Working time : length and organization

There are big differences between European Union countries as regards working hours. In a country like the United Kingdom, the very widespread practice of individual exemptions from the maximum weekly working hours rules effectively forces people to work very long hours, which is bad for their health and safety. The British government reports that 3,742,000 workers work longer than a 48-hour week. That amounts to approximately 20 % of all full-time employees[1]. This is not a problem unique to the United Kingdom. The Dublin Foundation's survey on working conditions found that, in the Europe of Fifteen, 14 % of workers were working more than 45 hours per week in 2000, and approximately one in three workers had long working days (more than 10 hours per day). Average working hours in the new Member States are above those for the Europe of Fifteen.

Length of hours is not the only relevant factor in the relations between working time and health. How well the hours of work fit in with the individual's other non-work activities is also a major consideration. Some non-standard working hours (night work, week-end work) can reduce social life, and interfere with work-life balance. These work schedules are also incompatible with human beings' biorhythms. Night work in particular is implicated in sleep and digestive disorders, cardiac diseases, etc.

A third important factor is the regularity and predictability of work schedules. Frequently changing work schedules, switching from spells of long-hours to short-hours working and, especially, not know-

[1] Source : Department for Trade and Industry, *Working Time – Widening the Debate*, London, June 2004. Consultable on http://www.dti.gov.uk/consultations/files/publication-1252.pdf.

ing work schedules for the weeks and months ahead, have calamitous effects on health. Such situations are becoming increasingly common as a result of flexible working time policies that make people an adjunct to immediate production needs. So, periods in which an employer requires a worker to be available cannot be equated with free time in terms of the quality of rest, organization of domestic duties, choice of leisure pursuits, etc. Even though the current Working Time Directive falls well short of meeting workers' expectations, the proposal for its revision will roll back some gains made. That would set a very dangerous precedent of forcing the standards of worker protection down.

That is what will make the revision of the Directive a litmus test for the future of EU social policy.

How will the revision of the Working Time Directive be a test ?

The 1993 Working Time Directive included a few minimal gestures towards improving health and safety (articles 3 to 13). It was probably the only Community Directive to give a bigger place to a long and complicated series of flexibility, opt-out and exception clauses (articles 16 to 18) than to substantive measures. In many ways, it was not unlike Penelope's Web - everything put together by the legislation to ensure health and safety could be unpicked later by States or employers. Some of the opt-outs and exceptions had been provisionally included at the request of the United Kingdom, on the understanding that a more coherent directive would be put forward after a seven year transitional period.

The Directive was beset by controversy from the very start. The United Kingdom tried to have it declared void by the Court of Justice, but failed. A series of questions for a preliminary ruling gave answers to problems of how different provisions should be interpreted and penalized failures to transpose it properly. Although well aware of the countless abuses that individual opt-outs led to, the Commission failed to bring any irregularity proceedings against a Member State, depriving Community citizens of guaranteed equal fundamental social and employment rights.

The only significant advance was the gradual extension of the scope of the Community provisions to jobs and sectors excluded from the original directive.

In September 2004, the Commission put forward proposals for a revision of the Directive. Companies are allowed more flexibility in regard to the maximum 48 hour weekly working time. The reference period used to calculate weekly working time can be increased to a year.

The proposal still allows individual opt-outs for employers. In some cases, but not all, opt-outs will require prior collective agreements. The proposal is already so clear that such abuses will take place, that it feels compelled to set a second maximum weekly working time of 65 hours. This is not a mandatory maximum : opt-outs will be possible by employer-worker agreements or collective agreements.

The proposal contains a definition of "on-call work", which allows employers to force employees to be present in the workplace at the employer's disposal, without having to count that time as working time. This provision violates international labour standards as laid down by the International Labour Organization as far back as 1930 ! ILO Hours of Work (Commerce and Offices) Convention No. 30 provides that "the term hours of work means the time during which the persons employed are at the disposal of the employer". This Convention No. 30 definition was broadly re-enacted in Hours of Work and Rest Periods (Road Transport) Convention No. 67 (1939).

If a supermarket check-out operator has to be in the workplace from 9.00 am to 8.00 pm, but only actually performs work activities for 5½ hours of that time, the new proposals will mean that she can be said to have worked for only half the time that she actually has to spend in her workplace at her employer's disposal. Workers could end up shouldering the whole burden of irregular work organization stemming from customer demand or production flow.

The proposal for a revision of the Working Time Directive is therefore a big test of the shape of Community social policy to come. The basic choice is between deregulation which will further widen social inequalities, or improved living and working conditions for everyone.

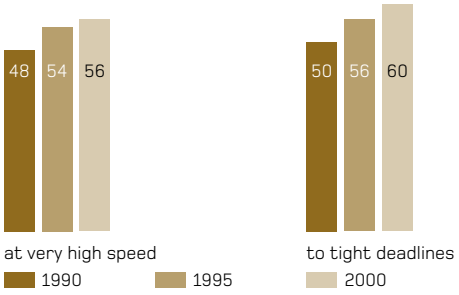
Workload

Workload is a determining factor in workers' health. It is also an aspect of work organization on which prevention policies are still too half-hearted.

Workload is a very complex issue involving both physical and intellectual effort, and psychological and emotional involvement. It is very much bound up with the individual's control over how they do their work, forms of cooperation between the individual and their colleagues, support provided through training and information, the suitability of work equipment for the job to be done, etc.

Generally, there has been a sharp rise in work intensification in recent years. Between 1990 and 2000, the number of people working at very high speeds has risen from 48 % to 56 %, while the numbers working to tight deadlines have gone up from 50 % to 60 % (Dublin Foundation figures).

Working at very high speed or to tight deadlines - 1990-2000 (%)



Source : European Foundation for the Improvement of Living and Working Conditions, *Ten years of working conditions in the European Union*, 2000

This intensification has many adverse health effects :

- increased stress and associated psychological disorders (general fatigue, insomnia, depression, irritability, etc.) ;
- psychosomatic problems which significantly increase many physical disorders ;
- a significant rise in a set of medical conditions classed together as "musculoskeletal disorders" ;
- work intensity is also a factor in work-related accidents. "Rush" work does not always leave scope for coping with unforeseen circumstances.

Work intensity is a big factor in the exclusion of ageing workers in particular. For women who have difficulties in juggling paid working life with unpaid domestic responsibilities, it may act to exclude them from paid work, or to segregate them in part-time work.

Monotonous and repetitive work exacerbates the harmful effects of work intensification. The Dublin Foundation's survey findings highlight the damaging effect of repetitive work on health. The very rapid spread of musculoskeletal disorders shows the damage to health that often results from a combination of the following factors :

- work intensification ;
- extent of monotonous work and repetitive tasks ;

- poor work organization, ergonomically unsuitable work equipment ;
- work-related stress.

Table 1 **Health problems related to repetitive movements** - 2000 (%)

	Backache	Muscular pains in neck and shoulders	Muscular pains in upper limbs	Muscular pains in lower limbs
Repetitive movements	48	37	24	21
No repetitive movements	19	11	4	5
Average	33	23	13	11

Table 2 **Health problems related to working at very high speed** - 2000 (%)

	Backache	Stress	Muscular pains in neck and shoulders	Injuries
Working continuously at high speed	46	40	35	11
Never working at high speed	25	21	15	5

Table 3 **Health problems related to working to tight deadlines** - 2000 (%)

	Backache	Stress	Muscular pains in neck and shoulders	Injuries
Working continuously to tight deadlines	42	40	31	10
Never working to tight deadlines	27	20	17	5

Source : European Foundation for the Improvement of Living and Working Conditions, *Ten years of working conditions in the European Union*, 2000

Current Community legislation gives nowhere near good enough guidance to policies to prevent musculoskeletal disorders. The existing directives cover only some of the problems (work with display screen equipment too centred on vision, manual carrying of loads). A gender analysis shows that the failings of this legislation particularly affect women workers, who tend to be concentrated in jobs that involve repetitive movements, constrained postures, and little discretion in how to organize their own work.

Violence, harassment and stress : danger signals for psychosocial workload

A series of national and European surveys report a rise in problems associated with both physical and psychological violence, different forms of harassment (sexual and psychological), and stress at work. The reasons for this are :

- Problems which already existed but were suffered in silence and isolation are now being brought into the open.

- Dehumanization of working conditions, often as a result of increased productivity demands, and making people an adjunct to production requirements.
- Management systems that create competition between workers and destroy forms of cooperation through encouraging all-out inter-worker rivalries.

There are several major problems where prevention of psychosocial risks is concerned :

- Action in this area is not usually possible without calling work organization into question. But employers regard this as their exclusive preserve, determined by reference to their interests (generally shareholders' profits).
- Looking at psychosocial aspects necessarily means considering the exercise of power in the firm. The creation of competition between workers, "management by stress", racial discrimination and male domination are specific aspects of power relationships.
- Multidisciplinary practices are not widespread in preventive services.
- Company management tends to prefer the individual approach of dispute management to collective approaches of transforming working conditions, as is clearly shown by practices on sexual harassment and bullying.

Without going into a detailed analysis of these issues, there is no doubting their priority for workplace preventive activities today. An approach to occupational health focused only on physical hazards is not good enough. The European Trade Union Confederation has negotiated a European framework agreement on stress with the employers' organizations to give an impetus to prevention practice. The agreement was signed in October 2004. How much effect it has will depend very much on the extent to which its provisions can be taken over into the different EU countries.

On the agenda...

- → Be involved in the Working Time Directive revision, fighting for improved working conditions and rejecting attempts to reverse gains.
- → Get the Commission to put forward a proposal for a Directive on the prevention of musculoskeletal disorders, and frame Parliament's requirements for it.
- → Make sure that the European Parliament's Resolution of September 2001 on the need for Community measures against harassment at the workplace gets implemented.
- → Keep the application of the agreement between European employer organizations and trade unions on stress at work under review. Evaluate the need for new Community legislation if national collective bargaining cannot ensure that all workers are covered.

The existence of a framework agreement does not absolve the Community legislature of responsibility in this area. Industrial relations systems vary widely across Europe, and national collective bargaining machinery alone will never guarantee equal protection for all workers in the European Union.

Further reading

- Boisard, Pierre, *et al., Time and Work : work intensity*, Dublin, European Foundation for the Improvement of Living and Working Conditions, 2002. Consultable on : http://www.eurofound.eu.int/publications/files/EF0248EN.pdf.
- Daubas-Letourneux, Véronique, Thébaud-Mony, Annie, *Work organisation and health at work in the European Union*, Dublin, European Foundation for the Improvement of Living and Working Conditions, 2002. Consultable on : http://www.eurofound.eu.int/publications/files/EF0206EN.pdf.
- Stress at work, Special Issue, *TUTB Newsletter*, No. 19-21, September 2002.
- Working without limits? Reorganising work and reconsidering workers' health, Special Issue, *TUTB Newsletter*, No. 15-16, February 2001.
- Musculoskeletal disorders in Europe, Special Report, *TUTB Newsletter*, No. 11-12, June 1999, pp. 11-40.

All *TUTB Newsletters* are consultable on : http://tutb.etuc.org > TUTB Newsletter.

5. Chemical risks
Major cause of occupational health-related mortality

Chemical risks are a major cause of worker mortality in European Union countries today, and a far bigger killer than work accidents. Recent Spanish research[2] gave as a conservative estimate that work-related diseases were the cause of 15,000 deaths a year in Spain. The main disease involved was cancer, and the main cause was chemical risks. Other national studies of work-related mortality have come to similar conclusions[3].

Exposure to chemical agents is a major explanatory factor of social inequalities in health. British researchers found over thirty years ago that occupational exposures accounted for a third of the aggregate social differences in total cancer-related mortality[4]. Generally, all the available data point to an unequal distribution in the incidence of cancer by social class[5]. Depending on the type of cancer, occupational exposure may play a decisive role (nasal, lung, liver cancer, for example) or a relatively minor one (prostate cancer).

As regards disease prevalence, occupational exposures are a significant factor in social inequalities in health for respiratory tract diseases, skin diseases and allergies. They also have a major impact on reproductive health.

The available exposure indicators show that very large numbers of workers are exposed to chemical risks. The 1994 Sumer survey[6] in France, for instance, reported that 54 % of manual workers, 27 % of technicians and associate professional, 21 % of office workers and only 8 % of senior management staff were exposed to chemicals. 15 % of exposed workers (about 610,000 people) were exposed to more than five different chemicals. A million workers in France are exposed to recognized carcinogens, over 22 % of them for more than 20 hours a week.

There are three main strands to Community legislation on chemical risks :

- Rules on workplaces - these lay down the employers' duties to their workers.
- Rules on marketing - these lay down the obligations of manufacturers and importers of chemicals[7], and the competent national authorities.
- Rules on major accident risks (Seveso directives) - these impose safety obligations on firms for the threats they pose to the environment and the safety of communities living near production or storage sites.

[2] García, A.M., Gadea, R., Estimación de la mortalidad y morbilidad por enfermedades laborales en España, *Archivos de Prevención de Riesgos Laborales*, 2004, 7 (1), pp. 3-8.

[3] Nurminen, M., Karjalainen, A., Epidemiologic estimates of the proportion of fatalities related to occupational factors in Finland, *Scandinavian Journal of Work, Environment and Health*, 2001, vol. 27, n° 3, pp. 161-213.

[4] Logan, W.P.D., *Mortality from cancer in relation to occupation and social class*, Lyon, IARC, 1982.

[5] See in particular: International Agency for Research on Cancer, *Social Inequalities and Cancer*, Lyon, 1997.

[6] Heran-Le Roy, O., Sandret, N., *Enquête nationale SUMER 94. Premiers résultats*, Paris, ministère du Travail et des Affaires sociales, sd.

[7] For brevity, the term "chemicals" is used here to mean both chemical substances and preparations.

The Community legislation on chemical risks at the workplace was developed in two stages.

Between 1978 and 1988, the approach was to develop mandatory exposure limits. The first Framework Directive 1980 was the kingpin of the legislation. The attempt to lay down a set of mandatory exposure limits fell through, as reflected in the dropping of the proposal for a Benzene Directive. Of the provisions adopted in this stage, only the 1983 Asbestos Directive (as revised several times) remains in force. But the adoption of indicative exposure limits, planned for from 1988 by the revision of the 1980 Framework Directive, follows on directly from this stage.

From 1989, the adoption of the Framework Directive marked a turning point in the approach. A series of specific directives on the prevention of chemical risks were adopted under the Framework Directive. They relate to :

- Carcinogens (first Directive adopted in 1990 and revised repeatedly).
- Pregnant workers (1992). This Directive fails to pronounce clearly between elimination of risks at source or measures to manage risks by reference to individual situations. As implemented in practice, it shows how greatly reproductive risks are under-rated as part of an overall prevention policy.
- Chemical risks (1998). This is the most comprehensive Directive, and brings a coherent approach to the provisions of the 1989 Framework Directive.

Meanwhile, work on adopting indicative exposure limits goes forward. Even though the chosen instrument is a Directive, the fact that the exposure limits are only indicative makes it a non-binding instrument in practice. The definition and use of exposure limits are still behind major inconsistencies between the different European Union countries.

Some general trends can be identified in the enforcement of chemical safety regulations.

• The hierarchy of preventive measures is going largely ignored

Dangerous substances are still only exceptionally being replaced by other safe or less dangerous ones unless it is an express statutory requirement or under official pressure (as with asbestos). Personal protective measures are apt to be favoured over collective controls.

• There are wide gaps between sectors, not to say activities and/or occupations in the same sector

The focus on collective control measures seems to lessen with every step away from the basic chemicals sector. This is strikingly so in chemical-using industries where, for various reasons, there is a traditional passive acceptance of chemical risks. There is empirical evidence for that in farming, textiles, some manufacturing sectors, the food industry, as well as in service activities like cleaning, garages, hairdressing and health care. That is not to say that prevention levels in the basic chemicals industry are necessarily satisfactory, as is shown by the failings of measures to prevent the long-term effects of exposure (carcinogens, reprotoxins, etc.).

• Scant attention is paid to the long-term effects of chemical exposure on workers

The sheer numbers of workers exposed to carcinogens at work bears witness to this problem. And the situation is worse still for mutagens and persistent organic pollutants. It is a problem made worse by the impossibility of getting many work-related illnesses recognized as occupational diseases.

• Prevention policies disregard many effects that are not immediate and serious

Little consideration has been given to effects linked to low level and combined exposures. It is an area where compliance with exposure limits affords little protection, and there is no systematic feedback from health surveillance to inform risk assessments and the reworking of prevention plans. Many European Union countries have no health surveillance provision for workers exposed to dangerous chemicals, because the dangers of exposure are not recognized by their employer.

• Preventive service activities are not properly addressing the problems of chemical risks

Only a minority of workers today enjoy access to multidisciplinary services versed in industrial hygiene and health surveillance. In most EU countries, what preventive services actually do is governed by two overriding criteria : sector and company size. These criteria are clearly inappropriate in light of how widely chemical risks are dispersed among workforces.

On the agenda...

- ➜ The adoption of REACH is the biggest opportunity to improve the health at work situation since the 1989 Framework Directive. Parliament can play a decisive role in countering chemical industry lobbying. The report submitted in 2004 (Sacconi Report, 2003/0256 COD) is a useful basis for Parliament's work on this.
- ➜ Beef up the content of the Seveso major industrial hazard Directive by including provisions to regulate subcontracting and involving workers' health and safety reps in measures to prevent major accidents.
- ➜ Get the Commission to speed up the adoption of exposure limits based on the SCOEL recommendations (Scientific Committee for Occupational Exposure Limits).

Further reading

- *REACHing the workplace*, TUTB brochure to be published in 2004.
- TUTB website : http://tutb.etuc.org > Main topics > Chemicals.

REACH : a big issue for occupational health

What are the connections between market regulation and the clear failings in prevention at the workplace ?

Prevention at the workplace depends very much on the information that is available on the market. Chemical risks are not necessarily visible to the naked eye, and in most cases, the real level of prevention activities depends on the information supplied with the product, like classification, safety data sheets, risk phrases, etc.

The preparatory works for the Chemicals White Paper identified a string of failings in that information. Misclassification, some effects omitted from the risk assessments done by producer industries, failings in public evaluation machinery, etc. There is a woeful lack of information, illustrated by especially tragic cases like the deaths of 6 textile workers in Spain (the Ardystil case) and problems linked to glycol ethers in France.

Improving market rules will not deliver a knock-on improvement in all aspects of prevention at the workplace. It is the practical conditions of use that dictate the level of prevention. But reforming the market rules could create conditions much more conducive to prevention activity.

How can the REACH proposals improve prevention at the workplace ?

1. REACH's key benefit relates to market information

The duty to register is coupled in different ways with an obligation of evaluation. The proposed improvements should reduce instances of misclassification (which nearly always results in an under-estimation of the risks).

2. A more dynamic and systematic information flow

An evaluation system will only deliver results in terms of prevention if it is assertively managed. An initial evaluation produces decisions (classification packaging, labelling, safety data) which need to be checked, adjusted or modified. In all but the very few cases where authorities have intervened, producers' initial evaluations have so far been apt to become entrenched as final evaluations. That kind of system is not informed by experience and offers no way of turning problems found at the workplace to account. REACH should deliver better monitoring of the health impacts of production.

3. Increased responsibility for all the actors involved

At present, there is a clear demarcation between producer and user activities. There are two drawbacks to this. Producers are little inclined to innovate in health and environmental protection. Final users tend towards passive acceptance, and the risk assessments they must perform as employers are apt to be fairly superficial when it comes to chemical risks. A more systematic information flow should lead to a greater acceptance of responsibility by the parties involved. More specifically, it could give a fresh impetus to practical risk assessment at the workplace.

4. Renewed proactivity from the public authorities

The setting-up of the European Chemicals Agency and its linkages with the competent authorities in the different Member States, as well as the procedures for authorization and restriction of certain chemicals, should encourage the public authorities to take a more proactive approach.

Asbestos : the tragic consequences of industry self-regulation

Asbestos came into large-scale industrial use in the closing third of the 19th century.

The first significant alarm bells about high mortality among workers exposed to asbestos began ringing at the turn of the 19th century.

Asbestos mainly causes three diseases : asbestosis (a silicosis-like fibrosis of the lungs that causes severe breathing difficulties and can be fatal), lung cancer and mesothelioma (a pleural cancer). It also causes other forms of cancer. Asbestos has been a well-established cause of serious respiratory diseases since 1920. There has been strong enough scientific evidence of the carcinogenicity of asbestos since 1950. The World Health Organization classified asbestos as carcinogenic to humans in 1977.

The asbestos producer and user industries have long had the public authorities hamstrung. Under the guise of preserving jobs, they have pushed for continued "responsible" asbestos production backed up by industrial hygiene measures - a controlled use strategy that has failed. It has been instrumental in delaying the banning of asbestos, and contributed to tens of thousands of avoidable deaths in European Union countries. It still stands in the way of an asbestos ban in the main user countries, now in Asia, Latin America and Africa. Not until 1999 did the European Union decide to prohibit all varieties of the asbestos (for 1 January 2005).

Asbestos-related mortality is now running higher than work accident-related mortality in industrial countries, and will continue to do so for decades to come. This is because the latency period between exposure to asbestos and the development of mesothelioma can exceed 40 years. Also, very many buildings still contain asbestos, which poses a big threat to public health. The preventive measures involved will be a heavy cost burden to society for generations to come.

6. Job insecurity
A big issue

Tens of millions of workers in the European Union work in "non-standard" jobs. They may be given the same legal rights on paper, but in practice, they often lack the guarantees typically enjoyed by workers with permanent, full-time contracts.

Most occupational health research finds that contingent workers are among the most vulnerable. They suffer a higher rate of work accidents and have less access to preventive services than others. They have less regular health surveillance. They tend to get less information and training on work-related risks, and more rarely have health and safety representation.

Contingent work has often been held out as a miracle cure for unemployment. But in reality, it does not offer a long-term route into the labour market for many workers. For some, it can lead them into a downward spiral of social exclusion and a life increasingly close to the brink of poverty. Casual hire-and-fire is one of the main reasons behind the growth of the "working poor" in Europe, i.e., people who live below the poverty line despite being in work. This particularly affects women and young people.

On the agenda...

- Debate the Commission report on the practical implementation of the Temporary Workers Health and Safety Directive 1991, and use this as an opportunity to put forward improvements to the content of the Directive. This report, written in April 2004, contains only very superficial information, even though more than ten years have gone by since the Directive came into force.
- Support initiatives for a critical evaluation of the linkages between employment policies and occupational health in the European Union.
- Be involved in framing the General Conditions of Temporary Work Directive and ensure that social and employment rights in this area are not levelled down.

Increasingly insecure working conditions are not entirely due to contingent employment. Subcontracting often leads to types of insecurity, including among permanent workers, by putting working conditions under the constant pressure of cost competition and outside control by customer firms. Recent factory disasters like AZF in Toulouse and Repsol in Spain have highlighted the dangers created by subcontracting. Self-employment / independent contracting is another highly insecure form of work.

There remains a mighty job to do on contingent employment. The few Community rules that do exist fall well short of addressing the scale of the problems. This issue is given added urgency and acuity by the spread of insecure working conditions in the new Member States.

Agency employment and safety : some national figures

In Spain, a close correlation has been observed between contingent employment and high work accident rates. Most of the available data does not distinguish between temporary employment by a firm (on a short-term contract) and agency employment. A systematic study of work accident statistics for the period 1988 to 1995 reveals a steady trend : in the eight years under review, the accident incidence rate per thousand workers was 2.47 times higher for temporary than permanent workers. The fatal accident incidence rate was 1.8 times higher[8]. Some research has shown that temporary agency employees have significantly higher accident rates than other types of temporary worker, but the National Institute of Occupational Safety and Health does not keep specific statistics for temporary agency staff. A study done in 2003 on statistics for the period 1996-2002 found that the situation is getting worse[9] - the work accident frequency rate is rising much more sharply among temporary and short-term workers than permanent workers. Between 1996 and 2002, the temporary worker rate rose from 101 to 121 per thousand workers, compared to from 42 to 45 per thousand for permanent workers.

The table below shows the higher work accident frequency rate among temporary workers in Belgium.

The comparison is between temporary agency workers in 2002 and all workers in 2001.

Table 4 **Work accident rates : temporary agency workers compared to all workers in Belgium**

	Manual employees		Non-manual employees		Manual 66.5 % + Non-manual 33.5 %	
	All workers	Temporary workers	All workers	Temporary workers	All workers	Temporary workers
Frequency rate	61.7	124.56	7.25	15.03	41.25	87.27
Real severity rate	1.4	2.41	0.14	0.25	0.98	1.66
Aggregate severity rate	2.65	6.48	0.265	0.67	1.86	4.45

Source : central prevention service figures for work accidents reported by temporary employment agencies in 2002

[8] Boix, P., Orts, E., López, M.J., Rodrigo, F., Trabajo temporal y siniestralidad laboral en España en el período 1988-1995, *Cuadernos de relaciones laborales*, n° 11, 1997, pp. 275-319.

[9] Unión General de Trabajadores (UGT), *Evolución de la siniestralidad en España 1996-2002*, Madrid, 2003.

7. Reproductive health and maternity
Improving knowledge and prevention

The working environment harbours many reproductive risk factors. Examples include chemicals whose toxicity has not been properly assessed, and physical factors like heat, ionizing radiations, etc. The organization of work itself can also pose risks. Long working hours and night work, for instance, have been implicated in miscarriages, foetal development problems (especially low birth weight) and premature births. Stress related to fast-paced work also often adversely affects sex drive.

There are two issues here :

- Work-related reproductive health risks are under-researched. There are big gaps in the data. Only a handful of European regions (Tuscany in Italy is one) keep registers which enable abnormalities to be linked to occupational exposures. The chemical industry is very unwilling to have comprehensive assessments done of the risks that its production poses in this area.

Glycol ethers

Glycol ethers are found in a wide range of fast-moving consumer goods, as well as at workplaces. They are used in household cleaning products, adhesives, varnishes and paints, air fresheners, cosmetics, medicines and more.

Recent Community legislation has banned some known reprotoxic glycol ethers for use in consumer goods, but nothing has been done about occupational exposures in the workplace. As a result of legal action taken by workers in the United States, a trade union survey was done among workers at the IBM factory in Corbeil (France) in 2000. It discovered 11 cases of testicular cancer, 17 other cancers, and 10 cases of birth defects. Suits were filed against IBM which had exposed workers to glycol ethers between 1970 and 1995. Mina Lamrani worked as a glycol ether bottle packer and used the ethers to clean boxes used to store silicon wafers in the unventilated workshops of a small subcontractor firm working for IBM. She gave birth to a child with a severe facial abnormality. Thierry Garofalo worked with glycol ethers at the Corbeil factory. He now suffers sterility and intense muscle pains. Lobbying by trade unions and victim support groups called the use of glycol ethers into question in France, and new Community legislation is planned. Evidence in cases brought by 157 workers from different IBM factories in the United States has shown that the multinational had been warned by the federal authorities in the early 1980s that some glycol ethers caused serious foetal malformations in animals, and could present a risk to human reproduction. The cases in the US courts point to exposure to some glycol ethers as the cause of cancers among workers (especially testicular cancers) and severe birth defects (where either the father or mother was exposed).

- Even where data do exist, the policies in place often disregard first-line prevention (in particular, elimination of risks) in favour of individual management just for the duration of the pregnancy.

The Directive of 19 October 1992 on the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding is ambiguous and flawed as regards both occupational health strictly so-called and protection of rights (protection against dismissal, no loss of pay, etc.).

Risk assessment is central to the Directive, which lays down no specific preventive measures but simply gives a non-exhaustive statement of risk factors which must be taken into account when deciding on preventive measures. Can employers put off a risk assessment until informed of her condition by a pregnant worker, or must all employers assess and eliminate or reduce risks before a pregnant worker informs them of her condition ? We take the view that it must be the latter, but the Directive is very unclear on this point.

A risk assessment carried out after a worker has informed her employer of her pregnancy cannot give a basis for an effective prevention policy. The scientific literature indicates that the foetus is most at risk during the earliest stages of pregnancy. In most cases, it is too late to prevent these risks by the time the employer is informed of the pregnancy. Even where the work setting encourages early notification, the average time for informing the employer is 7.5 weeks into the pregnancy. The risk of foetal malformation is highest between the 3rd and 8th weeks of pregnancy, peaking at different periods according to the organs affected. For the great majority of women, that means that measures to prevent exposure to teratogens will be ineffective.

The Directive says that the employer must adopt preventive measures based on a risk assessment. The priority is to eliminate risks and prevent risks at source, failing which the employer must make temporary adjustments to the working conditions. If this is not technically and/or objectively feasible, the employer must move the worker to another job. If moving her to another job is not technically and/or objectively feasible, the worker must be granted leave for the whole of the period necessary to protect her health. The Directive offers no criteria for judging what is not objectively feasible. Are cost grounds alone enough to exempt an employer from taking measures ?

In practice, it seems that they are. The most common course taken is to move a worker in a high-risk job to another job. This turns pregnancy into a disorder that justifies exclusion from the workplace. There are two issues with that. One is that the lack of sufficient income guarantees means that financial pressures may drive a number of workers to stay working in hazardous jobs. The other is that first-line prevention by eliminating the risks at source is not seen as a priority.

On the agenda...

- Get the Commission to put forward a proposal for revision of the 1992 Directive in line with the European Parliament Resolution of July 2000.
- Support the inclusion of mutagens and reprotoxins in the scope of the Carcinogens Directive.
- Support REACH and improve its core provisions.
- Stimulate research into reproductive risks.
- Follow up on available data on the reproductive health risks of working conditions.
- Help to frame an overall strategy for reproductive health that includes work-related risks.

Unlike the other health at work Directives, the 1992 Directive has no provision for consulting workers' reps on preventive measures. This reinforces the tendency to see the safety and health protection of pregnant workers as an issue involving individuals put in an abnormal situation rather than a collective issue of occupational health in all firms.

The Directive fails to provide sufficient income maintenance guarantees during maternity leave. The protection against dismissal provisions can be easily flouted by the employer simply claiming grounds unconnected with the pregnancy.

The adoption of the Directive caused a furore between the Member States. Italy would only vote it through subject to a commitment to improve the Directive at an early date. The Commission was supposed to have submitted proposals for amendment by October 1997. In July 2000, the European Parliament cast a critical eye over the practical implementation of the Directive and called for it to be revised. As yet, the Commission has still failed to put forward any proposals whatever for improvements.

The most effective preventive approach would be to limit maternity protection to a range of pregnancy-specific conditions (chiefly in the fields of ergonomics, working time and work pace, but also improved protection against certain pathogens and ionizing radiation) and considerably tighten up policy on the prevention of chemical risks based on the elimination and replacement of substances that are hazardous to reproduction (in both women and men) and, in cases where elimination is not technically feasible, effective control measures to reduce exposure to the lowest levels. To this extent, the Commission proposal to include chemicals that are hazardous to reproduction within the scope of the Carcinogens Directive is a first step in the right direction. But it will only be effective if the chemicals industry has an obligation to properly evaluate reproductive risks. The REACH proposal is an opportunity to move things forward on this front.

8. Recognition of occupational diseases
Learning the lessons of failure

To set prevention priorities on the basis of reporting and recognition data for occupational diseases in Europe would in many ways be nonsensical, as the available evidence tells us more about practices of concealment than the reality of health at the workplace.

Under-recognition of occupational diseases is common to all European Union countries. Its most immediate consequence are :

- Less general visibility for many diseases that are not seen as prevention policy priorities.
- A wholesale transfer of resources to the employer's benefit, with much of the cost burden being shared between victims (e.g., loss of pay as a result of re-assignment or redundancy, most other consequences of work incapacity, etc.), and general health budgets (social security coverage of diseases, incapacity and unemployment, national health system, etc.).

The gender issues in under-recognition of occupational diseases bear analysis. This amounts to systematic discrimination that waters down prevention policies as respects diseases more common among women workers and that affect women more than men. In most European Union countries, women fall within a bracket of 25 % to 40 % of recognized occupational diseases. In the United Kingdom, the proportion is under 10 %. In Belgium, it is around 15 %.

And yet, expressed in full-time equivalents, the adjusted aggregate data for the European Union collected by Eurostat for the 1999 labour force survey indicate that, in all the countries surveyed apart from Greece, work-related diseases are actually more prevalent among women[10].

The predictable failure of a Community policy

The earliest Community initiatives on workplace health aimed to harmonize national systems for the recognition of occupational diseases and to create a common framework for occupational medical services. These were in the form of Commission Recommendations, i.e., non-binding instruments. The first was adopted on 23 July 1962, and focussed on compensation for occupational diseases. It called for a uniform list of diseases or agents capable of causing them to be drawn up, and for

[10] See : Dupré, Didier, "The health and safety of men and women at work", *Statistics in focus, Population and social conditions*, theme 3-4, Eurostat, 2002. Consultable on : http://europa.eu.int/comm/eurostat > Publications.

The failure of a Community policy in figures

A Eurogip study published in 2002 illustrates the wide gaps between national systems for the reporting and recognition of occupational diseases, and the scale of the social inequalities they create.

The EU States covered by the study range from a low of 3.3 recognized occupational disease per 100,000 workers in Ireland to a high of 177 in France.

There is no real convergence to be seen between national systems either in the aggregate data summarized in this table, nor as regards the main diseases. The gap between the extremes has remained virtually unchanged over ten years, discounting Sweden. But the ten-year trend reveals wide between-country differences. The Scandinavian countries, Austria and Italy have seen a remarkably sharp fall in the number of recognized occupational diseases (with a slight rise in Italy and Sweden over the past two or three years). Restraint policies have been a key shaping factor here. A material, though less marked, decline has occurred in Belgium. But the opposite has happened in France and Spain, which show steady growth in the number of recognized diseases, attributable to improved recognition of musculoskeletal disorders in both countries, and asbestos-related diseases in France. In Germany, the number of recognized diseases increased between 1990 and 1996, falling steadily from 1997 onwards. In the United Kingdom, the number of recognized occupational disease is very low compared to other EU States. There was no significant change throughout the 1990s, which averaged over 3,000 pulmonary diseases and about 4,000 to 5,000 other recognized diseases a year. The most recent years (1998-2000) show a sharp fall in recognized pulmonary diseases and no change in other diseases.

Table 5 **Reported and recognized occupational diseases in 12 European Union countries** - 1990-2000

	New cases of reported occupational diseases per 100,000 workers			New cases of recognized occupational diseases per 100,000 workers (% of cases accepted)		
	1990	1995	2000	1990	1995	2000
Austria	151	133	103	78 (51.8 %)	52 (39.3 %)	42 (41.7 %)
Belgium	431	336	277	186 (43.2 %)	204 (60.9 %)	112 (40.5 %)
Denmark	549	669	545	90 (16.4 %)	131 (19.6 %)	124 (22.8 %)
Finland	320	331	238	160 (50 %)	110 (33.1 %)	64 (27 %)
France	63	103	237	44 (70 %)	76 (73.8 %)	177 (75 %)
Germany	192	235	211	35 (18.3 %)	66 (27.9 %)	49 (23.1 %)
Greece	-	5.3	4.5	-	4.7 (90 %)	3.5 (78.1 %)
Ireland	4.4	6.4	7.5	2,3 (52 %)	5.5 (87 %)	3.3 (44 %)
Italy	354	211	160	93 (26.2 %)	39 (18.5 %)	33 (20 %)
Luxembourg	113	49	82	8 (6.7 %)	15 (30.9 %)	14 (16.9 %)
Portugal	-	57	55	-	42 (73.1 %)	27 (48.9 %)
Sweden	1,524	642	309	1,242 (81.5 %)	258 (41.3 %)	138 (45 %)

Source : Eurogip, 2002

systems to grant recognition to all diseases which could be proved to be occupational in origin. It also aimed to set up a reporting system for certain non-listed diseases so as to keep the list regularly updated.

Four years later, on 20 July 1966, the Commission adopted a new Recommendation on the victims of occupational diseases. It was much more specific than the 1962 one, aiming for Member States to submit biennial reports as the basis for regular revision of the European Schedule. The 1962 and 1966 Recommendations have gone largely ignored.

On 22 May 1990, the Commission adopted a new Recommendation. This again urged the Member States to put into practice the principles laid down over a quarter of a century previously. It also updated the European Schedule for the first time in 24 years, which had been supposed to be updated every two or three years. It concluded that most Community countries were still not applying the mixed system : only Denmark and Luxembourg's systems seemed to comply with the guidelines of the 1962 and 1966 Recommendations.

The new Recommendation contained a final plea in which "the Commission requests the Member States to inform it, at the end of a three-year period, of the measures taken or envisaged in response to this recommendation. The Commission will then examine the extent to which this recommendation has been implemented in the Member States, in order to determine whether there is a need for binding legislation". Work on a Directive might reasonably have been expected to get under way around 1993-1994, therefore.

On 20 September 1996, the Commission adopted a Communication on the European Schedule of Occupational Diseases. It concluded that it would "at the present time be premature to propose binding legislation to replace the 1990 Recommendation". The Commission thought that "this possibility could nevertheless be given consideration in conjunction with any future update of the European Schedule of Occupational Diseases".

That update was carried out in September 2003. While the content of the Schedule was improved, the fact that it is still just a Recommendation places serious question marks over its effectiveness.

On the agenda...

- Get the Commission to put up a proposal for a Directive on minimum conditions for the recognition of occupational diseases in the different European Union countries.
- Follow up on Eurostat's initiatives to produce comparable data on occupational diseases in the European Union.
- Take action against the systematic under-recognition of occupational diseases specific to women workers as a form of indirect discrimination in the field of social security.
- Give impetus to research into diseases of suspected occupational origin so as to improve preventive strategies.
- Get the Commission to revise the European Schedule of Occupational Diseases at regular intervals so as to take account of best practices in the Member States and new medical research findings. In particular, ensure that better recognition is given to work-related cancers, low back pain and mental health-related disorders.