A NEW IMPETUS FOR COMMUNITY OCCUPATIONAL HEALTH POLICY

For years, trade unions have criticized the lack of a Community workplace health strategy. After a spate of legislative advances from 1989-1992, Community action has fizzled out for a number of reasons.

Worsening working conditions also point up a series of problems that need to be addressed.

The Commission has said it intends to work out an action programme on health at work for the period 2002-2006.

The trade unions on the Luxembourg-based Advisory Committee on Safety, Hygiene and Health Protection at Work adopted their own policy document on the Community strategy in May 2001. The position paper was approved by an ETUC Executive Committee resolution on occupational health on 15 June 2001.

A NEW IMPETUS FOR COMMUNITY OCCUPATIONAL HEALTH POLICY

Contribution by the Workers' Group of the Luxembourg Advisory Committee for Health and Safety to the framing of the Community action programme on health and safety (May 2001)

1. Health at work is a high priority for the trade union movement. One main reason behind the formation of the first labour organizations at the time of the industrial revolution was to protect lives and health endangered by profit-seeking. The ongoing issue in this struggle is to free the individual from a contractual relationship which is apt to reduce them to a production input or "human resource" and commodify them through the action of economic constraints. The struggle for health is part and parcel of organized collective action to change working conditions. Without worker-initiated collective action, neither medical nor technological progress lead to enduring improvements of their own accord, which is why the protection of health at work is still today in Europe an integral part of trade union action. In every European country, the overwhelming majority of workers' health representatives are trade union activists, even where legislation allows the election of representatives with no trade union ties. Asbestos, musculoskeletal disorders and workplace bullying are recent examples of how the protection of health at work is inseparable from the ability to bring individual health problems to light, turn them into elements of a collective consciousness, and channel that collective consciousness of problems into action for better working conditions. Trade unions have a key role in this process.

2. Working conditions have felt the effects of close to a quarter-century of mass unemployment. The resulting job insecurity has taken many forms in practice. Declining unemployment, a growing awareness of the particularly heavy toll taken by job insecurity and a vague awakening to the dehumanized working conditions which had grown up in many industries re-opened the debates on the quality of work. Waves of labour protests have put this item on the agenda. National debates are taking place everywhere on workplace bullying, stress and musculoskeletal disorders. What all these debates have done is to put a focus on a broader understanding of health in the sense of assured well-being at work. Some key aims of the struggles of the '70s to create humanized working conditions and for workers and society to have control over technological changes are resurfacing in new forms and different conditions. This awakening to the environmental damage being wrought by modern production methods has added a new dimension to these aims and opened up opportunities to broaden trade union alliances.

3. Over the past two years, the European Union's institutions have embarked on a more purposeful discussion of this issue. It was on the agenda of the Lisbon Summit in 2000, and was the topic of a major conference called by the Swedish Presidency in January 2001. The ETUC believes it must be a central focus of the social agenda in the coming years. With this statement, therefore, the Workers' Group of the Advisory Committee aims to set out its priorities for the preparation of a new Community action programme on health at work.

1. A disturbing picture of the health impact of working conditions

4. Facts and figures published in the European Union prompt us to get the debate moving again on health and safety as priority areas of Community social policies.

Even allowing for the inadequate benchmarks and lack of consistency between national data, the evidence is that the complacency about the benefits of technological changes on health at work is misplaced.

5. Reported employment injury figures show a declining long-term trend over reference periods of 10 to 20 years. This general trend is partly due to far-reaching structural changes in economic activities (declining share of the workforce employed in resource and manufacturing industries, collapse in employment in most of the high hazard industries like mining, the steel industry, etc.). Technical developments have also shaped the problems of health at work: accident injuries are a less significant hazard in many industries than gradual wear-down or some diseases. Finally, the employment injury figures reveal glaring inequalities between different types of employment relationship. Temporary workers in particular have a much higher work accident frequency rate. Inconsistency between the figures, and the high rate of under-reporting, limit the validity of inter-country comparisons. Eurostat figures reveal the very high work accident under-reporting rate in many countries.

6. Figures for occupational diseases mainly reflect the attributes of the different national recognition and compensation systems. They show how far there is still to go in setting up a fairer system open to recognition of all work-related health problems, and the wide equality gaps between countries, between men and women, and between classes of victim according to type of disease. Large numbers of workers suffer health problems which are not readily recognized to be occupational diseases. Some (like musculoskeletal disorders, asthma made chronic by occupational exposure, etc.) may have serious ill-effects and leave the victim unable to work again.

7. It is hard to assess the significance of absence and invalidity figures. They are partly tied to changes in social security systems. Short absences do not necessarily point to poor working conditions. Long-term absences and invalidity figures are more relevant for assessing working conditions.

8. Indicators more sensitive to real-life problems are a must for a proactive policy on health at work. This is a problem in almost all Member States and shows up a major failing in Community action. What is needed is a set of indicators focusing on at least three things:

- monitoring of risk factors and exposure;
- monitoring of health conditions, not just using the standard indicators of work accidents and occupational diseases, but also based on studies of the linkages between different diseases, social and occupational groups;
- what workers themselves think of their working conditions and their health impacts.

All these indicators should also include the gender dimension of health at work and ways of gauging how far working conditions address medium- and long-term health demands. Indicators like working life expectancy by occupation and the health of older or retired workers by reference to their past working conditions, in particular, deserve special attention.

The European Union needs to set up a permanent monitoring system on working conditions based on a mix of indicators so as to deliver a rapid response to specific problems.

9. The "traditional" risks related to safety of equipment and work processes, exposure to chemicals, physical factors and biological agents are still causing thousands of fatalities and tens of thousands of disabling injuries each year, even though generally well-established preventive solutions do exist. In some countries, the number of reported work accidents is even rising with the spread of casualization. The asbestos debates have also demonstrated the inability of preventive systems to respond rapidly to major health hazards whose consequences first came to light nearly a century ago.

10. Work organization-related hazards seem to be rising steadily. The Dublin Foundation's third survey of working conditions reveals that a growing number of workers consider that they are exposed to this type of risk and that their health has suffered from it.

11. Work intensification is a major feature of reorganized production methods. The proportion of workers who report working at a very fast pace has risen from 48% in 1990 to 56% in 2000, and those working to strict deadlines from 50% in 1990 to 60% in 2000. These European figures are generally borne out by available national surveys.

Musculoskeletal disorders are a particularly widespread consequence of work intensification. In 2000, 33% of workers complained of lower back pain, and 23% of neck and shoulder pain. High proportions of workers are also affected by stress and burn-out.

12. There is also evidence that workplace bullying is a problem that affects a large number of workers and can take a heavy toll. It is tied in with a range of things, but work intensification, management methods competitive work practices are major factors. It is an employment relationship and work organization issue to be addressed by requires collective preventive action. To that extent, it is on a par with other issues to be addressed by working environment policies.

13. The brighter employment outlook from slowly receding unemployment has not led to equivalent improvements in the quality of work, anything but. Job insecurity - in different forms and to varying degrees - is a trait all EU countries now share. Countries with the highest rates of job insecurity also have the worst employment accident records (Spain in particular).

14. Worsening working conditions are also part of the wider picture of widening health gaps between workers. It is a process observable in most Community countries and part of a more general trend of rapidly growing inequalities between workers worldwide. Granted, working conditions are only one of the causes of this situation, but it takes little working out to see that without a vigorous resumption of Community action on health at work, they could help undermine social cohesion in Europe on the particularly vexed issue of health.

2. The reopening of national debates and concerted labour action

15. National debates on health at work are now being set rolling again. No wide-ranging debates were mounted in most Community countries prior to transposing the Framework Directive or other health and safety Directives. All barring a few governments took the view

that this was essentially a job of updating existing legislation, and raised no real issues about the general operation of the preventive system. With the incorporating legislation in place, therefore, the mood turned upbeat. Existing systems had been modernized. A break from new legislation and policy discussion was the order of the day for many. The difficult transition to practice and, especially, worsening working conditions put an end to this respite. These debates are now starting up again in what are still very largely different national contexts. It quickly became clear that while the Framework Directive had made a real contribution in laying down ground rules for the workplace, it stopped short of addressing the full range of prevention issues. This meant also reviewing national prevention policy and giving it the tools to do the job.
Part of the difficulty in the changeover to practice can be put down to the strategies followed to incorporate the directives. Word-for-word transpositions have rarely been effective because they have not slotted easily into the existing preventive system. In some countries, that has caused huge problems. In Portugal, for instance, it was not until early 2001 that a tripartite agreement was finally reached on the substantive content of certain provisions of the framework directive incorporated right back in 1991.

16. In France, asbestos played a major role in building the momentum for the first public debate in nearly a quarter of a century. From having downplayed the danger of asbestos for decades, the French government put a blanket ban on asbestos use in 1996. Asbestos soon became the litmus of the failings of the preventive system as such in its different functions (policy-making, research, use of medical surveillance data to set prevention priorities, problems raised by the joint management of occupational risk compensation agencies, linkages between public health and occupational health, etc.).

17. In Italy, worrying levels of reported work accidents, the highly inconsistent operation of the joint industrial bodies set up at different levels, and the many issues remaining unaddressed since the passing of the 1994 legislative decree to transpose the Framework Directive led to the first full political debate for over twenty years on the coherence of the preventive system. A major conference was called by the government in December 1999, while the trade unions were behind the first national assembly of workers' safety representatives in Modena in September 2000 which laid down a programme to step up trade union action on health at work.

18. In the United Kingdom, the comforting upbeat tone taken by the Health and Safety Executive for the past twenty-odd years has now given way to a more balanced assessment of what has been achieved, and, especially, to real concerns about the ability of the preventive system to address the new challenges. A stark run of “disasters” from the Piper Alpha drilling platform to the wreck of the Herald of Free Enterprise off Zeebrugge, from the BSE epidemic to the Paddington rail crash showed how an approach which favours employer self-regulation and forsakes public control machinery and the balancing force of the unions in favour of profit-seeking has painted itself into a corner. The articulations of health at work and public health issues with broad public policy guidelines are clearer than ever. It is telling that some of these disasters happened in areas outside the Health and Safety Executive’s purview. Deregulation, privatization of public services, the indiscriminate use of forms of “soft law” or voluntary self-regulation by private players have been key contributors to these disasters.

19. In Spain, as in Italy, the immediate trigger for the debates was the stark work accident figures and the clear link they revealed between the spread of casualization and the rising toll

of accidents. After the generally upbeat mood of 1996-1997 which followed the passing of the Occupational Risks (Prevention) Act, there are alarming signs that the Act is still not being properly applied, and that the policing and enforcement system is not working. An action plan directed at accident-prone firms has been put into operation, to achieve joined-up action by all public authorities. Trade unions have their own proactive plan which involves contacting all prevention reps and giving them the necessary support to get preventive measures followed in accident-prone workplaces. The trade unions have also developed their own means of acting on workplace health.

20. Rising absence rates in both the Netherlands and Sweden reflect worsening working conditions. Dutch trade unions have levelled a series of criticisms at the preventive services, which in practice do not always give priority to improving whole-workplace working conditions.

21. The debates in other countries may be lower-key, but a number of common concerns are emerging: how to enforce compliance with the rules, how to address changing patterns of work, how well have the prevention policies pursued in recent years performed? Generally, deregulation, the undermining of policing systems, under-representation or no representation of employees in small and medium-sized firms have been important factors. But behind these abiding issues for preventive systems lies a more essential basic problem. The employment policies pursued have often created more job insecurity. And the fact that an insecure job is also generally a harmful job is one which must be brought into the equation.

22. In some countries, the debate has gone beyond institutions and is backed up by labour action, as witness two well-supported general strikes in the Spanish building industry in February 2000 and March 2001, and the health and safety down-tools in Italy on 20 October 2000. Generally, demands related to safety, health and dignity at work have been increasingly frequent themes in industrial disputes across Europe. They have also been at the heart of some transnational protests, notably in the road transport industry. They are agenda-topping issues for a growing number of European Works Councils, especially in the textile, and iron and steel industries.

3. The need for a Community policy debate

23. Sad to say, the different national debates have not so far resulted in a real Community debate. The odd documents published by the Commission - especially the midterm report on the Community programme concerning safety, hygiene and health at work (1996-2000) - hugely underestimate the issues involved and paint too rosy a picture of the transposition of the Community Directives. The Commission is unable to give a strong political impetus in this area. The strategy which has occasionally trailed of linking health at work to employment policies, is unlikely to prove effective unless clear targets are set which address real workplace health needs. Whereas the Commission itself should have been fully-equipped to monitor the implementation of the Directives adopted, its own material and human resources for health at work have in fact decreased alarmingly. How it will ever be able to ensure that EU enlargement passes muster without sufficient human and material resources is a mystery. The Commission's failure to publish a report on the application of the framework directive and associated problems exemplify how its role has been watered down. But the Commission cannot use the lack of an overall assessment to justify its neglect in face of what are acknowledged as far-reaching issues, and it must not wait on the assessment to take new initiatives.

24. Notwithstanding its March 1995 resolution on the transposition and application of Community social legislation, the European Council has taken no major recent initiatives on health at work. The failure of the SAFE programme points up the difficulty of getting political agreement in Council on health at work issues. Likewise, even qualified majority voting has not stopped most of the proposals for Directives submitted by the Commission to the Council over the past five years making tortuously slow progress through the legislative process, in some cases with disappointing outcomes (proposal for a Directive on transport of disabled workers deadlocked, highly piecemeal and restrictive approach to physical agents, etc.).

25. The Luxembourg Advisory Committee is a crucial forum for tripartite consultations on all health at work issues. It has mapped out the possible broad guidelines for its own reform to accommodate the changes made by the Amsterdam Treaty and the forthcoming enlargement. The ETUC and UNICE have worked out a set of joint proposals on this. The Committee must be more deeply involved in all aspects of Community action which touch on health and safety. More specifically, it should be closely involved in drawing up the detailed assessment of the application of the directives.

26. The Bilbao Agency has at times been portrayed as usurping the Commission's policy discussion and guideline-setting role. The Agency has a key role to play as an information provider and the ETUC would like to see it develop that. But its information processing and dissemination activities are very definitely no substitute for the Commission framing a specific, coherent Community policy, and its properly-funded and -resourced implementation. It is important to develop a real tripartite approach in all the Agency's activities, especially its national focal points. Information collected and disseminated by the Agency will only be any real use if the way it is dealt with allows broad common problems and viable solutions to be evolved. What is needed is not patchy national data just lined up in comparative tables, but qualitative assessment of the data collected. More consideration needs to be given to all information users, including workers, particularly as regards the language used and the physical form it is published in.

27. The Dublin Foundation gives extremely valuable input through its research brief, which covers all aspects of living and working conditions. This wide-ranging approach enables it to look into the interactions between on- and off-workplace life. The survey of working conditions - repeated three times over the past ten years - has also provided important building blocks for Community health at work policy. This survey should be carried forward and linked into the more detailed targeted surveys and research conducted in all Community countries.

28. The European Parliament has taken positive steps, like holding hearings on working conditions and the assessment of the Pregnant Workers Directive. On 25 February 1999, it adopted a major resolution addressing the key aspects of Community policy in this area, with relevant proposals for strengthening it. That resolution was based on a general report written by Ms Outi Ojala. In it, the European Parliament highlighted a series of problem areas not covered by the Community legislative framework (asbestos, occupational cancers, transport industry, stress, burn-out, violence and harassment in the workplace, musculoskeletal disorders, monotonous and repetitive work) and recommended that a policy be adopted to take account of the special problems of women. It called for the scope of legislation to be

extended to categories of worker that fall outside it (self-employed workers), or are insufficiently protected (teleworkers, workers under atypical contracts or working for subcontractors). It was concerned that health at work was not receiving due attention in enlargement policies and called for health at work to be given a central place among the international agreements signed by the EU. Most of the issues raised by this resolution have not gone away, despite the progress recently made in specific areas (like asbestos and scaffolding, for example).

29. In December 1999, the Economic and Social Council adopted an own-initiative opinion which creditably takes a more rounded view of the discussion on Community health at work policy, and A new opinion on the future of Community policy in this area is in the works.

30. The Court of Justice has also helped clarify the interpretation of article 118A (now incorporated in new article 137) and the health at work Directives. The bulk of its case law stems from referrals for preliminary rulings. The Court has stressed that the Community has wide powers in relation to the working environment. It has ruled that Member States have full powers to adopt or maintain national measures which guarantee workers a higher standard of protection. It has laid the groundwork for better cooperation with the International Labour Organization within the framework of a policy of upwards harmonization focused on more favourable standards - whether Community or international. This approach has also led it to interpret certain provisions of the Directives (especially on the definition of working time). Finally, the Court has established a solid body of case law on the Member States' ability to adopt rules which restrict the free movement of goods on health grounds. However, the Court's role has been held back by the inability of trade unions to bring proceedings within the narrow confines of preliminary ruling referrals, and the time taken by the Commission to deal with irregularity proceedings. Some fundamental issues which the trade union movement has been pointing out for nigh on ten years have still not come up for Court rulings (whether the employer's safety obligation is a strict liability, numerous problems with the organization of preventive services in different Community countries, the failings of some national legislative provisions on employee representation, etc.).

31. The fact that a range of institutions have helped shape Community action on health at work is no reason to gloss over its increasingly piecemeal nature, the inability to come up with relevant responses to emerging problems, and the vast number of barriers to the effective application of Community rules in the Member States. The debate should start from a detailed assessment of the application of the Directives, and focus on opportunities for more effective Community action based on the Treaty requirements.

4. Wanted: a detailed assessment of the application of the Directives

32. A thoroughgoing review of how Directives are being applied involves more than just adding up the figures on the number of Directives transposed in the different Member States, so the criterion used in the Commission's 1998 mid-term review (the transposition rate has risen to 95%) is not germane.

In our view, the general level of application of the Directives is still very patchy (between but also within countries, by industry sector, category of worker and type of firm). On the bonus side, the Directives have set in motion or given impetus to an overhaul of national legal

frameworks, but this initial momentum has been undermined by a series of factors, specifically:

(1) The deregulatory onslaught which has tried to hold incorporating legislation down to simple paper compliance and turned Community minimum requirements into maximum goals.
(2) The Commission's failure to give a proper political impetus to EU-wide debate on the issues involved in transposition and application. This political failing was aggravated by the failure to apply the Decision of 24 February 1988 providing for a Community information system to be set up on developments in national regulations on health at work.
(3) Gaps in the Directives themselves made it essential to look closely at various aspects of national preventive systems where provision was haphazard. So, Member States' systems for employee representation in occupational health tend not to cover all workers, access to preventive services likewise remains limited, and the roles of public inspection, policing, enforcement, research and information agencies have not always been redefined for joined-up working.

33. National reports on the application of the Directives have been drawn up. While the scheme of evaluation intended as a template for them is grossly inadequate, putting them up for discussion in a Community tripartite framework should be a way to pinpoint common problems, frame necessary changes to the Directives or proposals for new Directives so as to plug the loopholes in the existing framework and more effectively address emerging issues.
By nature, this is a political exercise. Policing the legal compliance of national transposing measures is another vital and distinct task, essentially for the Commission. The steps taken to date in this area are inadequate in our view. Granted, procedures are gone through behind closed doors which now and then persuade Member States to put at least some failings right before irregularity proceedings ever get referred to the Court of Justice. But we still regard it as disturbing that nothing has been done to remedy significant foot-dragging and various cases where serious failings are evident. Time and again in cases referred for a preliminary ruling, the Court of Justice has found that certain transposing measures are flawed, but been powerless to do anything about it (Italian case on work with display screen equipment, Spanish case on the definition of working time, which also involves other national transposing measures). In her reply of 28 March 2000 to the parliamentary question tabled by Mr Alavanos, Ms Diamantopoulou suggested that the Commission might institute irregularity proceedings if Member States failed to properly police and enforce compliance with the Framework Directive. We take this as a very positive sign and hope it will be put into practice. Finally, the ETUC again argues that recognition of trade unions' rights to bring proceedings in the Court of Justice where Community social rules are concerned is long overdue.

5. Harmonization of legislation: the basis of Community action on health at work

34. Since the Single Act of 1986, health at work has become a cornerstone of Community social policy. The aim is harmonization while maintaining the improvements made, achieved principally by adopting Directives which lay down minimum requirements applicable in all Member States. Unlike other areas - like employment policy - the Treaty sets loftier goals than straightforward convergence of national policies.

Harmonization of legislation has a mixed agenda. One purpose is to give similar protection of workers' lives and health in the different Community States. But it is also to ensure that health at work does not take second place to competition, and that goods which move freely in the EU are healthy and safe.

35. Work on harmonizing working environment laws advanced rapidly in the post-Single Act period. The adoption of the Framework Directive in 1989, followed by individual Directives, were major gains which presented all Member States with a unique opportunity to overhaul the legal framework of workplace health and develop their preventive arrangements. After 1992, that momentum petered out for a variety of reasons. Powerful pressures for a "respite from legislation" made it harder to get Directives passed. The creation of the Molitor Group reflected such pressures. The final report drawn up by this group evinced serious misgivings about Community harmonization, and its health and safety proposals totally disregarded the Treaty's social objectives. While the inflammatory rhetoric may have dampened down later on, not least due to the change of government in the United Kingdom, other initiatives like BEST and SLIM were launched which may undermine the coherence of existing directives under the cloak of simplifying them. This situation has taken its toll on the consistency of Community action. The hold-up on the Directive on chemical risks, the deadlock on a Directive covering all physical risks which resulted in the adoption of a common position dealing only with vibrations, the dropping or shelving of a string of Directives for which the Commission had put up proposals or announced plans bear witness to these difficulties. What is now needed is for legislative harmonization to be completed having regard to the following priorities:

A. ensure consistency of Community legislation based on the fundamental principles of the Framework Directive

36. Some areas are still covered by Directives which pre-date the Framework Directive, based on a different approach. Physical risks other than vibrations are a case in point. This is just not on. Noise, in particular, is dealt with in a Directive which was condemned by the ETUC and several Member States as flawed before the ink was dry. It was the product of a political compromise, one element of which was an undertaking to review the Directive's provisions at a fairly early date. The Commission has never put forward proposals for any such revision, arguing that the inconsistencies between the 1986 Noise Directive and the Framework Directive could be addressed by adopting a Directive covering all physical factors.

Noise is the single biggest cause of recognized and compensated occupational diseases in most Community countries. The Dublin Foundation's survey of working conditions reports a slight rise in the number of workers exposed to intense noise for at least a quarter of their working time in the European Union (up from 27% in 1990 to 29% in 2000). We therefore believe that the 1986 Noise Directive must be revised and improved (especially by lowering the exposure limits), and its provisions folded into the Framework Directive (scope, scrapping the "reasonably practicable" clause, etc.). The new directive should reflect the framework directive's overall approach: noise must not be approached just as a possible cause of hearing damage. It is also a major hazard for welfare at work. A particular level of noise which may not be a hearing hazard may still interfere with concentration, communication or other functions.

37. While the 1998 Chemicals Directive was a major step forward, the evidence is that it is not enough to deal effectively with existing risks. Whether or not it is properly applied is very much locked into market rules governing the classification, labelling and packaging of substances and preparations.
Over-dependence on market rules (addressed below) creates serious issues with categories excluded by them (pharmaceutical and cosmetic products, munitions, food additives, etc.). It focuses attention on substances and preparations, and puts obstacles in the path of an approach which allows for combinations of substances and exposures.
The Community's watershed decision in 1988 to focus on adopting Community indicative exposure limits gave rise to two types of problem. One is the length of time and growing backlog in developing these exposure limits. The other is the finding that even where Community exposure limits exist, the Member States look on them as just recommendations and carry on adopting widely divergent national exposure limits. Equal protection for all EU workers is a policy priority for the ETUC. That means bringing all national exposure limits into line at least on the lowest value, and a more concerted effort to give occupational health requirements a central place in the classification of substances and products.

38. The 1983 Asbestos Directive (revised in 1991) is again under review. This is absolutely vital in light of the data on the woefully inadequate protection provided by the existing rules. More specifically, effective ways are needed of ensuring that all demolition or renovation works are carried out by officially-approved firms using properly-trained workers. Here, as with other carcinogen hazards, the Community exposure limit must be at least equal to the lowest statutory exposure limit currently set by one of the fifteen states (0.1 fibre/cm3 in the French legislation as opposed to 0.2 fibres in the Commission proposal). The overhaul should not stop short at revising employers' obligations, but should enable a publicly-accessible database of asbestos-containing buildings to be set up without delay and lay down clear responsibilities for the public authorities. The European Union should also call a halt to exports of asbestos products to countries elsewhere in the world.

39. Other areas are also not being properly addressed, even though national figures show them to be key work-related health issues. The Working Time Directive, for instance, is deficient. It needs revising to cut the maximum weekly working hours from 48 to 44, and to scrap the provision allowing individual derogations other than collectively-agreed ones. Only one EU Member State (the United Kingdom) has used this option, and it has led to countless abuses.

40. Musculoskeletal disorders are an increasing factor. The Manual Handling of Loads Directive covers only some of the contributory factors to these disorders. In particular, it omits controls on repetitive and monotonous work. Also, getting ergonomic requirements onto the agenda of standardization work is an uphill struggle. Whatever headway may be made in this area, standardization alone cannot address the need for a more detailed specification of ergonomic criteria in the workplace. Some states (Sweden is one) already have more suitable regulations on ergonomic requirements. A comprehensive Directive addressing all these issues is needed.

41. Workplace mental health is also a pressing issue. Community legislative activities must be stepped up and programmes of action brought in to address problems like stress and bullying at work. A better work-life balance may often be a key way of addressing workplace mental health problems.

B. Extend Community health at work legislation to all EU workers

42. The very wide scope set by the Framework Directive was a major step forward in many countries. But some workers are still partly or wholly excluded from the scope of Community legislation. We believe that these exclusions must be reviewed, the reasons for them discussed, and proposals drawn up to give proper and effective cover to those excluded categories.

43. There are no good grounds for excluding "domestic servants" from the Community health at work laws. While the nature of domestic work rules out a full application of all the provisions laid down for firms, a blanket exclusion is not the right response. For example, there is no good reason why domestic staff should not have the right to maternity leave or the benefit of health surveillance if they consider it necessary. The precious little data available on paid domestic work suggests that workers may be exposed to significant work-related health risks. Also, most domestic staff are usually un- or semi-educated, and, in some countries, largely migrant, women. They may find themselves cut off from society, which is conducive to different forms of abuse (sexual harassment, denial of compulsory rest periods, etc.). The Framework Directive should be amended by doing away with the exclusion of domestic staff, and making any lawful exceptions to the prevention provisions (e.g., a written risk assessment carried out by each individual employer) the subject of specific provisions.

44. As things stand, self-employed workers are excluded from almost all the Community health at work rules. The ETUC has already made its views on this clear in a consultation exercise held by the Commission. It holds by the precept of the European Social Charter drawn up by the Council of Europe that self-employed workers should be properly covered by health at work rules. It cannot agree with the Commission that self-employed workers are per se excluded from the social policy provisions of the Treaty, especially article 137, since that could completely emasculate the Community rules - it would allow any employer who wanted to get around them free to draft in self-employed workers instead of eliminating the risks.

45. Looking beyond the strict scope of Community rules, all workers must be guaranteed effective access to the preventive system. This does not happen at present inasmuch as conditions related to the size of the undertaking, sector or other considerations effectively deny many European workers the full exercise of their established rights under the Community rules. The vexed issues we wish to stress include:
a) coverage of workers by specific health and safety representatives remains very uneven. The thresholds applied in some countries for setting up representative bodies are too high. These representatives rights to training, information and consultation are not always fully assured. District representation arrangements covering small firms are limited to a handful of countries or sectors. The lack of a system of collective representation makes it enormously difficult for workers to enforce their rights, get adequate information and have a say in prevention policy. So, setting up area- and/or industry-based representation arrangements to make sure all workers in the EU are properly covered is a top priority.
b) coverage of workers by multidisciplinary preventive services is also very uneven. Progress is slow and, in some countries, production system and labour market changes have even reduced the proportion of workers with access to these services. Time and again the ETUC has called for article 7 of the Framework Directive to be properly implemented in line with

the wide scope of prevention set out in article 6. There is evidence from several Community countries that the establishment of multidisciplinary preventive services is beset by many problems, and that the vague wording of article 7 needs to be revised or supplemented by more specific provisions. More specifically, the ETUC calls for ILO Occupational Health Services Convention 161 to be ratified and for its principles and those of the corresponding Recommendation to be incorporated into Community policies. We see the priorities as:

- extending preventive services coverage to all workers;
- developing multidisciplinarity in these services;
- real practical participation by workers and their representatives in running these services;
- the terms of reference of these services to be set by the public authorities so as to secure their preventive role and complete professional independence. In particular, we regard practices like public agency checks on absences, health-based recruitment and pre-employment genetic screening as being at odds with the preventive brief of these services and undermining relations of trust with the workers. We stand firm on the view that the Community must act to outlaw employment-related genetic testing.

c) coverage of workers by labour inspection systems is far from uniform. Community legislation in other areas (marine safety in Community ports, environment) spells out the role of the public authorities and the guidelines for their policing and enforcement activities in much more detail. There is a good case for a similar approach being taken to health at work.

d) in practice, the employer's safety obligation as formulated by the Framework Directive has been found not to address the full range of issues raised by changing patterns of work. The use of independent contractors and employees of service providers, the countless forms of subcontracting arrangements, create situations where effective control over working conditions does not always lie with the direct employer. There is a good case for extending the employer's safety obligations to everyone over whose working conditions he exercises control. Different Member States (notably the United Kingdom) have legislation to this effect. Generally, many situations arise where the linkage between the terms of commercial contracts between two firms (or between a firm and self-employed workers) have a direct and significant impact on working conditions. This should be borne in mind when framing Community law. The Mobile Construction Sites Directive sets a welcome precedent in this respect.

e) the continuing failure to apply health and safety rules to any decent extent to public employees in many Community countries remains cause for concern. The situation is made worse by the difficulty in identifying where liability to provide safe working conditions lies, under-funding due to budget cuts, and other factors besides.

46. A strategy for workplace health must put a special focus on small and medium-sized firms. It would be a dangerous game to draw up different sets of rules for different sized firms. The statutory workplace health protection scheme can only benefit from an internal consistency which enables it to cover all workers. But there are a number of specific issues about applying the existing rules to small and medium-sized firms. A combination of different approaches is needed.

The experience of workplace health issues which workers in these firms have should be turned to account. It is vital to put in place systems for collective representation that cover all SMEs. The positive experience of Sweden's regional safety reps bears this out.

1E) These firms do not operate in a vacuum but are involved in multiple collaborative and subcontracting relationships. A health and safety policy which goes beyond the individual factory gates to act right along the chain of production might be a fitting response. But that raises a range of other issues: introducing health and safety conditions into contractual

relations between firms; creating a work specifier's liability; having employee representative organizations which reflect the real facts of "flow production" work stretching across multiple workplaces.

2E) An area- and sector-based approach to workplace health is practicable. The experiences of the sectoral preventive services in Denmark and the area-based activities of local agencies of the national health service in some Italian regions may provide object lessons of this.

3E) The existence of public underpinnings for socializing experiences and promoting workplace health is even more important than for large firms. It seems more important to provide firms and their workers with means of action than to fund dispersed activities. The experience of working environment funds in various Scandinavian countries can be helpful here. Such public support must be backed up by proper control systems. Putting a bigger focus on workplace health requirements through social/labour clauses in public procurement contracts could help. In public works contracts, especially, safety arrangements should always be costed separately from other cost components so that safety measures do not pick up the cost of competition.

6. For a review of all Community policy instruments

47. Directive-led harmonization may be the main plank of Community action on health at work, but other policy instruments have a role to play, too.

48. The Member States clearly remain central. The focus must be on each State's responsibility for developing an overall national strategy on workplace health. Various national experiences show the value of setting specific objectives to unite the efforts of all players (Denmark, United Kingdom, Netherlands, Spain, in particular). It is obviously paramount for these objectives to be set in line with real needs and for a proper evaluation to be carried out so as to avoid "statistical triumphs" which say little meaningful about real life and in the worst-case scenario may be down to fiddling the figures. Often, the action plans which are drawn up to guide the achievements of the targets are more important than the targets themselves. Inter-state cooperation can be set up focused on preset objectives (e.g., action on reproductive health hazards, or musculoskeletal disorders) or specific industry segments (e.g., hospital work, construction, agriculture, cleaning, road transport, etc.). For this, measures to coordinate national policies on workplace health around common objectives could be considered. Cooperation between Member States to develop indicators for effective monitoring of changes in working conditions and their health impacts would certainly help improve Community policy. A coordinated focus on key objectives for public policy instruments (resourcing and capacities of labour inspectorates, public research agencies into workplace health, support for the development of prevention practice, etc.) is also a possibility.

49. The Social Dialogue can definitely help improve the application of the Directives at both industry and inter-industry level. The ETUC has already made its position clear on the use of the Social Dialogue in the legislative procedures under article 137 of the Treaty. While it is clear that laying down essential guarantees and technical rules is chiefly a matter for Directives, dialogue is a central factor in the different work organization issues which impact health and safety.

50. The European Union could more routinely supplement Directives with general guidance documents drawn up using input from exchanges of experiences. Little use has been made of such policy instruments so far (guide on risk assessment, guidance on the choice of PPE to facilitate the application of Community Directives, guidance on risk assessment for pregnant workers, etc.). The status of such documents would need to be made clear - they should neither be simple opinions which are not binding on the Commission (like the risk assessment document) nor usurp the binding rules laid down in Community legislation.

51. European standardization still plays an important role, which will be looked at in the chapter on work equipment.

52. The roles and interactions of the different Community agencies should also be reviewed to enhance efficiency, effectiveness and the synergies between the Luxembourg Advisory Committee, Bilbao Agency, Dublin Foundation, SLIC, SCOEL, etc. The gradual involvement of applicant countries in their activities should be clarified.
It is clear to see that these various agencies can only play their role to the full if the Commission's ability to give the impetus to overall policy on health at work is restored. We view with concern the watering down of the Commission political and material capabilities in this area.

53. Workplace health is too much of a sideshow in Community research policies. Areas like toxicology, epidemiology and ergonomics tend to be disregarded in Community research policies. Rather than listing areas which deserve a stronger focus, we want to raise issues about the policy approach and method of Community research programmes. The gender dimension, often sidelined, is totally ignored in workplace health. Workers' specific individual and collective knowledge is not made use of in these policies, which tend to focus on partnerships between university research and business. That raises issues about what social needs this research addresses, and how independent it is. It is important to get public agencies and academics working more closely with trade unions and other community-based organizations (environmental groups, women's groups, etc.).

54. An impetus should be given to increase the Community Social Funds' involvement in policies to improve working conditions. More especially, health and safety should be made central to both skills training and gender equality policies.

7. Linkages between health at work and other Community policies

A. Core principles: interaction, individuality and additionality

55. A thoroughgoing discussion on the linkages between health at work and other Community policies is essential. The three distinguishing attributes of these linkages are interaction, individuality and additionality. It would be wrong to leave out any of these factors.

56. Interaction means that health at work requirements must be given more prominence in other Community policies so that their objectives become tied to improvements in the working environment.

57. Individuality means that each policy has its own distinct objectives, is implemented in its own specific way, and that it would be misconceived to weaken health at work by an over-general approach which goes beyond its essential purpose. Recent debates have tried to put the focus on ideas like modernization of business, competitiveness, employment (or, more recently, “employability”) as overall frameworks for health at work policy. We say that health at work policy draws its fundamental legitimacy from reducing health inequalities between workers by eliminating work hazards. Obviously, health at work interacts with many other policies, but it must not be made an adjunct of other objectives, however worthwhile.

58. Additionality means that some health at work issues can be addressed by making rules in other areas to promote the elimination of risks at source. For additionality to work properly, there must be experience feedback mechanisms to check whether the objectives set have been achieved.

B. Market rules and health at work

59. The Community legislation brought in from the latter half of the Eighties is underpinned by two broad sets of rules - one market-related, the other workplace-related. Market rules themselves fall into two groups - one dealing with chemical substances and preparations, the other with work equipment and personal protective equipment. This latter body of rules has been developed out of a set of principles known as the "new approach".

1E) The basics of Community legislation on work equipment

60. Putting market regulations into effective action involves a wide range of different players: standards institutions, notified bodies, designers and manufacturers, importers and marketers, setters and installers, public policing and enforcement agencies (including customs services and the courts), employers, workers and workers' representatives, etc. It is vital that all these players - as well as the public authorities at both national and European level - work together.

61. Community legislation is still not being applied actively enough. The CE mark is often no guarantee that essential safety requirements have been met. A 1995 survey by the Swedish labour inspectorate of 3000 machines put into operation after January 1995 found that a third did not meet Community safety requirements, although some 85% were CE-marked.

The reason why Community legislation is not properly applied may be down to its patchy nature, vagueness and grey areas. It may also be due to lack of cooperation between the players and the failure to connect up workplace experience with market regulation and surveillance machinery. Often enough, it is due to Member States’ own faulty policing and enforcement arrangements. We believe that the public authorities cannot just walk away from their job under the cloak of the "new approach".

62. The machinery of work equipment and personal protective equipment market surveillance differs widely between the Member States. Variability of the institutional players would not be a real problem per se, if their activities were more or less equally effective. Sadly, they hardly ever are. Some States put substantial resources into market surveillance, others pay it scant regard. There is too little cooperation between the public surveillance agencies in the different countries, and even less between these national public authorities and the Community authorities. Even within the Community institutions themselves, cooperation

between the different Commission Directorates General (internal market, social affairs, industry, research and development) is rarely what it should be.

63. Current regulations are in part based on the activities of private players in a competitive market. As the problems of safety at sea show in a different regulatory framework, a competitive market of private policing organizations (broadly defined) is no better than its weakest link. Where there are different levels of enforcement, private players who may have reason to feel that their activities could fall short of requirements may go to more permissive organizations. We say it is vital to harmonize and toughen up the rules on quality criteria and the responsibilities of the notified bodies, and get effective joined-up action going between the Member States, the Community institutions and these organizations in the European Union.

64. Technical standardization is central to the new approach. It allows directives to be kept down to setting essential requirements and is designed to frame the technical rules that address those requirements. The ETUC has always regarded technical standards development as a significant social issue for the trade union movement. Without a trade union input, standards development bodies will never manage to give full weight to workers' needs. The feedback of workface experience is decisive on at least two counts. It shows how far standards address the full complexity of workplace health issues. It should also be a litmus test of the impact of standards on working conditions, to put a check on "unbridled prescription" which might deepen the social divide between "thinkers" and "do-ers". That is why the ETUC set up the Trade Union Technical Bureau, which energizes cooperation on health and safety issues between different trade union organizations, not least by coordinating the European trade union network on technical standardization. It must, however, be emphasized that trade union participation in this work by and large remains vanishingly small. Many EU countries lack any policy to ensure trade union involvement in standards development. Some countries have set up agencies which ensure a modicum of transparency in the standards development process (KAN in Germany, Eurogip in France), but sadly, these are very much isolated experiences.

65. Community legislation may aim to protect the safety and health of equipment users, but current practice is still coloured by a narrow approach to safety. Specifically, standards development takes too little account of ergonomic criteria. Standard EN 1050, which is fairly central in laying down safety risk assessment requirements for machinery designers does not incorporate ergonomic requirements as it should. Its methodology does not properly address ergonomic issues and its reference to B-type standards does not plug the loopholes due to these standards' failings on the ergonomics front.

66. It is our view that market surveillance mechanisms must necessarily take account of all health issues and be properly resourced to do so by collecting data from all sources and steadily developing more consistent occupational health standards.

Setting up information systems on the health impacts of work equipment is a monumental challenge for the coming years. It involves the ongoing collection of data in workplaces on accidents, incidents, ergonomic problems and other health issues (e.g., noise and vibration) with which to pinpoint issues relating to specific equipment. At present, there is no such organized data collection at European level, although some States have a good record on this which could serve as the basis for a Community policy. In most countries, even employment

injury information is under-used. Generally, we know exactly how many accidents occur on each day or hour of the week, or in each industry segment. But information about the equipment involved and exactly how it was being used is much less clear-cut. Accident reports, which in different forms are a compulsory requirement in all EU States, could be a far more effective contributor to the organization of prevention.

Work equipment information systems would also improve the selection of work equipment in line with working environment Directives by giving both employers and workers' representatives access to more comprehensive information than just that provided by equipment vendors. The preventive services set up nationally under article 7 of the framework directive would also have a key role to play, clearing the way for a better multidisciplinary approach.

Such information systems should interface with - so as to improve workplace risk assessment from - worker-generated data on the hazards of different equipment and an ongoing feedback of experience from the workplace to the market and design stage. Workers must be involved in risk assessment, which is still too often seen as a tedious paper formality. The accident and hazard flagging sheets drawn up by workers' representatives in the recent scheme set up jointly by the French public authorities and trade unions are a useful precedent.

Effective information systems would allow public market surveillance agencies to do their job properly as an essential part of the linkage between market rules and workplace experience. A structured approach would be able to pick out which equipment falls short of essential safety requirements because it does not match up to existing standards, and at the other extreme, those which reveal flaws and failings in standards. In this way, workplace realities could inform standardization work on a much more routine basis. More trade union participation in standards development is another basic demand here. The TUTB has for years been pointing out the very low rate of application of the Machinery Directive's participation provisions.

67. Where the Community regulations fall down particularly badly is the lack of rules on the marketing of used equipment. Notwithstanding the size of this market, there is still no Community initiative in sight in this area more than ten years after the Machinery Directive was adopted. The Commission has simply bowed to pressure from the deregulation lobbies here. It is self-deluding to believe that workplace health and safety can be improved without addressing this failing. The whole situation at present turns on a fiction that there is no Community market in second-hand machinery, so that each Member State’s specific legislation is enough to enforce safety standards. Not only that, but the compliance requirements for work equipment in EU workplaces seems to have spurred the export of dangerous second-hand equipment to non-EU countries, especially in central and eastern Europe.

68. The revision of the Machinery Directive affords a major opportunity to learn from the issues summarized here. The problem is that the Commission’s proposed amendment and the Member States' differing positions do not add up to a coherent and effective whole. The explanatory memorandum of the Commission proposal is silent on trade union access to the standardization process. The rules on complex machinery need to be tightened up and clarified. There should be a bigger focus on ergonomics and workers’ experience. The development of an accident-reporting information system should be given priority.

2E) The market in chemical substances and preparations

69. Similar problems arise with the rules on chemical substances.

Community regulations on the market in chemical substances are a three-legged stool:
- Rules on the classification, packaging and labelling of dangerous substances and preparations;
- Rules on restrictions on the marketing and use of certain dangerous substances and preparations;
- Rules on the evaluation of existing and new substances, and drawing up European lists of substances

This body of legislation is supplemented by:
- rules on the major-accident hazards of certain industrial activities.
- rules on international trade in certain dangerous chemicals (Regulations 1734/88, 428/89)

The context may differ to that of the work equipment regulations, but cooperation between a wide range of private and public players is still a prerequisite for effective application of these rules.

70. In practice, Community legislation pays too little heed to some "new" immunological, endocrinological, neural development or reproduction effects. Also, there are failings in public agency scrutiny of the initial risk evaluations made to compile manufacturers' technical files. Manufacturers are putting new substances on the market willy-nilly and not declaring them as dangerous even though they are rightly suspected of being hazardous. Surveys carried out in some industries reveal misclassification in 25% of cases, and mislabelling in 40% of cases. Nor is registration of intermediate substances - i.e., those used only for a short period in a chemical process - wholly certain, as manufacturers are prone to carry out only the minimal tests.

71. Generally, one failing of the system in place is to leave wide discretion to the chemicals industry and information on problems encountered by users is all too rarely fed back as a matter of course into the manufacturer or other notifier's initial evaluation. Systematic feedback of information on workplace health issues must be ensured in the European Union. Amidst other measures, that means forging a stronger link between workplace health surveillance provision, the national and Community risk assessments carried out by independent public agencies and market rules.

72. The interface between market rules and workplace rules must be defined by reference to the overarching objective of health protection. It is good reason for limiting the principle of free trade between the Member States. We believe the ECJ's ToolexAlpha ruling of 11 July 2000 is a clear affirmation of this principle, which must be the basis for the future development of Community policy in this field.

C. Gender equality and health at work

73. The gender division of labour is central to work organization. Work tends not to be mixed across sexual lines. Men and women are not evenly distributed across industries, jobs, levels

of responsibility or type of job. Likewise, the total length of men's and women's working lives and career patterns differ significantly.
Equality and health at work are inseparable issues. Unequal segregation of duties creates risk differentials, unequal access to positions of authority increases the invisibility of women workers' risks. The denial of risks and health damage is also closely tied to the gender-based division of labour. For men's jobs, the glorification of manliness and its associated stereotypes (strength, hardiness, etc.) lead to risks being taken for granted and effective selection between workers in some occupations.
For women's jobs, stereotypes are used both to deny real qualifications (and thereby justify wage gaps and lack of decision-making power) and the health hazards of tasks described as "inherently women's work".
The mass influx of women into the labour force over the last quarter-century has not altered the basic structural inequalities in the labour market. Worse than remaining virtually unchanged, the gender-specific division of work has actually worsened in some cases, most of all in the Scandinavian countries where women's labour force participation rates are highest.
Women have also borne the brunt of the past two decades' worth of austerity policies. In their living conditions, because they carry out most of the work of reproductive labour without adequate socialization infrastructures. In their economic situation, because they are more dependent than men on redistributive mechanisms (unpaid for their reproductive labour, and low-paid for their waged labour). And in their working conditions, by being concentrated in the public or publicly-funded sectors which have borne the brunt of budget cuts (health, social services, education, etc.).
Progress on the gender division of unpaid domestic work is slow. This is probably more due to the crisis in the traditional family - increasingly less the only adult lifestyle choice - than to a redistribution of work and roles within it. The health consequences of domestic work are rarely mentioned. Women whose only role is as a homemaker tend to experience more physical and emotional health problems.
The interaction between unpaid housework and paid work outside the home is key to understanding the gender-specific differential health impact of working conditions. So, flexible working time policies generally make women's jobs more insecure, and in some cases result in mass layoffs. Another interaction lies in the very content of predominantly female paid work, which in some respects is an extension of domestic activities: repetitive tasks, grooming and other personal services, and attitudes: acquiescent, willing, accommodating.
So far, equal opportunities policy and health at work policy have been framed separately without taking full account of the interactions between their respective aims. Almost the only area in which that interaction has entered into the equation is maternity protection. The 1992 Directive reflected a compromise between different approaches. Right from the start, it was clear that it was a makeshift solution and would need revising. The ETUC wants this Directive to be improved to address the issues raised by its application in the different countries. The ETUC supports the European Parliament Resolution of July 2000 on the revision of this Directive. The contents of the directive need to be clarified so as to have a maternity risk assessment carried out in every workplace where a woman is employed. Maternity leave should be increased to 20 weeks. The ETUC wants dismissal on any grounds during pregnancy and during a protected period up to three months after periods of pregnancy-related leave made illegal.

Gender balance in work (across industries, functions and levels of responsibility) as a prerequisite to genuine equality between men and women, on the same footing as a real share-out of unpaid activities and equal representation in policy-making.
A gender-aware approach must be developed in Community health at work policies. That means collecting relevant data, carrying out research into the linkages between different occupational health issues and the gender division of labour, and working out preventive rules in areas where they are missing, with a special focus on women's employment. The criterion of healthy work is conditions which allow both sexes to access it for the normal length of a working life without damage to their health.

D. Employment policies and health at work

74. Over the past two years, the Commission has put a focus on the linkages between employment policies and health at work. Without going into a discussion on the concept of "employability", certain points must be made:

1E) Employment and health at work are two separate Community priorities pursued by different policy instruments. Employment policy does not set out to harmonize existing national legal frameworks while maintaining the improvements made. Its transnational aspects are real but limited. It mostly requires a political framework for convergence.
2E) It is clear that health at work provisions can have an input into employment policy because quality of work is a factor which increases access to and retention in safe and healthy jobs. An improved working environment would certainly reduce exclusion for a number of people with different forms of disabling condition or physical and mental wear-and-tear. In some cases, a linkage exists between long-term unemployment and health problems created by past working conditions. For that reason, Community health at work provisions could stand improvement in certain areas.

- More specifically, the coherence of preventive measures must be assessed over the normal length of a full working life. This means that working conditions are acceptable only if they allow workers to continue working up to retirement age without damage to their health. Such criteria would likely produce tighter (and more effective) prevention policies. As it is, working conditions may be acceptable for the immediate protection they give to a young and healthy person, but unacceptable with regard to their accumulated effect over that same person's entire working life. Employee turnover may be an accurate marker of such medium- or long-term irreconcilability: almost no building workers go right through to normal retirement age, and it is hard to imagine anyone working for long in a call centre. Likewise, night work is known to have a wearing effect on health so that ageing workers find it harder and harder to keep working nights. If mental health and welfare issues are added to the physical health requirements, it is clear to see that employers' obligations are still too vaguely-worded in most national laws and the Community Directives.
- The gender dimension must be given a central place. This has already been dealt with in sufficient detail.
- Integration of people with disabilities into the workplace is another priority so far bypassed by Community legislation! It is a particularly glaring oversight. The only Directive put forward on the matter (transport for disabled workers) has been deadlocked for twelve-odd years in Council. The Commission should put up proposals under new article 137 of the Treaty. A Community policy which stops short at exchanging experiences and promoting good practice is doomed to failure in this area. Protecting the

victims of work accidents or occupational diseases from dismissal (with obligations to adapt jobs or redeploy elsewhere in the firm) should also be high on the agenda.

- Health-based recruitment is an alarming practice, and at odds with the requirement to adapt the work to the individual. Here, too, the Community institutions are manifestly sitting on their hands (where not engaging in reprehensible practices like HIV-testing for recruitment of Community civil servants).

3E) The employment policies should also be audited for their impact on health at work. The spread of non-standard employment contracts and flexible employment policies Europe-wide has led to effective casualization of work, with dire consequences for health. These policies must be critically reappraised and a more focused and tougher legal framework set (especially for temporary work) which fully leverages past experience in health at work.

E. Social security and health at work

75. Since 1962, the European Union has adopted a series of Recommendations intended to harmonize the basis for recognition of occupational diseases. The most recent dates back to 1990 and is coming up for overhaul. But they are not being applied properly in practice, and under-recognition of occupational diseases is common all over Europe. A recent survey by the French organization EUROGIP shows up the glaring inequalities caused by the failure to harmonize systems for the recognition of occupational diseases. So, in 1996, 4 occupational diseases were recognized per 100,000 workers in Greece, compared to 136 in Belgium (in 1997). Other inequalities should be mentioned. Women's occupational diseases get much less recognition than those of their male colleagues. Each country seems to "zero in on" a small number of diseases for no good objective reason in terms of economic activities.

The absurdities produced by deficiencies in systems for the recognition of occupational diseases are well-illustrated by the transitional legislation passed by Italy in 1962 to compensate returning Italian miners who had been working in Belgian mines, where they had contracted silicosis. The Act was intended to be a stopgap measure pending Belgium's recognition of silicosis as an occupational disease. Nearly 40 years on, the Act is still on Italy's statute-book because the conditions set by Belgium for recognizing and compensating silicosis are more restrictive than Italy's. So, the Italian system is continuing to compensate thousand of ex-miners for diseases contracted while working in Belgium.

The mixed system intended to allow recognition of occupational diseases not included on "closed" lists has failed to deliver significant results. For the individual, that means that many victims are denied adequate compensation. Collectively, it means that proactive prevention is being hampered by glossing-over various work-related diseases. For the economy, it means that much of the cost of poor working conditions has been shifted onto the victims or the "health" branch of social protection systems. On the equality front, finally, it is a telling fact that the more restrictive occupational disease recognition systems are, the less accessible they are to women workers.

For all these reasons, questions must be asked about the relevance of a policy based on non-binding instruments when it is now beyond dispute that Directives could be adopted under article 137 of the Treaty.

F. Public health and health at work

76. Community public health policies do not insufficiently recognize working conditions as a social determinant of health. Opportunities in cancer prevention and women's health have been allowed to slip by. The two action areas should be more closely articulated in future in a way which accommodates their differences.

77. Workplace health promotion can be a valuable instrument for public health policies. It should enable an integrated approach to the interactions between work-related and other health factors (effects of unpaid housework, living conditions, whose individual lifestyle expressions are almost always connected with broader economic conditions, etc.). Workplace health promotion involves cooperation by many players: workers and their representatives, employers, workplace health preventive services, public health systems, etc. It must not be individual-centric, and its priorities should reflect two key elements: workers' collective perception of their health needs, and social/occupational epidemiological data stemming from local/regional or Community public health policies. Not under any circumstances must it lead to an authoritarian approach which would undermine the confidence that workers must have in preventive services. Particular care must be taken in ensuring that the approach of workplace drug and alcohol abuse prevention programmes is worker participation-based rather than disciplinarian, based on policing and punitive measures.

G. The environment and health at work

78. The environmental crisis is a sharp reminder of the shortcomings of our economic development model which puts profits before people's needs. Like health at work, it raises issues about establishing machinery for social control of economic activities. Environmental protection and the fight for health at work are linked in many areas. Chemical hazards are a clear case in point: environmental pollution factors are almost always a threat to workers exposed to them. In transport policy, the strong focus put on road transport is tied up with the structural characteristics of the industry which delivers maximum flexibility in goods transport at the expense of the environment and workers' health. Likewise, changes in farming from industrialized methods of agricultural production compound environmental damage with worsening working conditions for many farm workers.

Setting up worker participation machinery through which to give shopfloor health at work reps wider environmental powers is a trade union priority. Some Community countries have gone forward in this direction. Environmental issues have been included to varying degrees in the remits set for workers' health and safety representatives, and have on occasion been included in collective bargaining. The revision of the Seveso Directive should put a bigger focus than has so far been the case on the environmental protection role of workers and their representatives.

8. The international dimensions of Community health at work policy

A. EU enlargement and health at work

79. EU enlargement is a major challenge for health at work. Taking over the *acquis communautaire* (established body of Community laws and regulations) must mean more than just implementing the rules - it must lead to real improvements in national situations. That involves effective cooperation with the Member States and the Community institutions. To imagine that can be done successfully without putting enough money into it is self-deluding.

Time and again, the ETUC has called for a Community Fund for the improvement of the working environment. We believe the context of enlargement gives full relevance to this proposal.

It is an article of faith for the trade union movement that the EU accession countries should apply the workplace health rules properly, and it is no less opposed to a paternalistic approach based on unequal rules. The same transposition and application requirements must obtain in the present and future Member States alike. We are adamantly against the Commission or other institutions applying pressure or controls in the applicant countries which they do not do in the Member States. Properly run labour inspectorate systems, a coherent national policy on workplace health, and a system of effective, deterrent and proportionate penalties are clear prerequisites for the application of the health at work directives, both in the applicant countries and in the Member States. We therefore believe that the Commission must adopt an overall policy on these issues and steer clear of a neocolonialist-type approach that the "right way" followed by the present Member States should be reproduced by the new members. Far from it - our detailed assessment of the application of the directives shows how bad the problems are in the present Member States, and what is needed is an overall strategy to address the needs of the entire enlarged European Union.

The earlier remarks on the interactions between workplace health and other Community policies also apply to the policies connected with EU enlargement. Privatization, retrenchment, the whittling away of certain social and employment rights, and the dismantling of whole swathes of the economy take their toll on workplace health. So, policies must be framed which accommodate all aspects of sustainable human development, including when needed those which go against the interests of European multinationals which have bought into Central and Eastern Europe. Above all, they must check the trend towards a growing division of labour between growth centres and areas of mass poverty, pools of cheap unskilled labour, and low added value production activities with poor working conditions. This is already an issue in the European Union as it is, but is likely to get much worse after enlargement.

B. Relations with international organizations

1E) Needed: more systematic cooperation with the ILO

80. There is no way Community health at work laws can be tightened up without strengthening the international labour standards developed in the ILO. The Commission's determination always to put Community legislation first has at times been a source of conflict. The ECJ has clearly defined the relationship between Community legislation and the ILO Conventions, especially in its ruling of 19 March 1993. The Community Directives and the ILO Conventions alike set minimum requirements, and the labour law principles which all Member States share always allow them to improve on those minimum requirements. This principle allows any conflicts between the two sources of law to be resolved. Whenever an ILO Convention goes beyond a Directive, the State ratifying it must satisfy the minimum level set by the Convention; for any Directive which sets higher standards than an ILO Convention, the minimum level will be that set by the Directive. The low rate of ratification of ILO Conventions by the Member States is cause for concern, however. The Commission's adoption of the Recommendation of 27 May 1998 on ratification of Homework Convention

No. 177 gave a clear political signal. Sadly, the choice of instrument was not up to achieving the end sought. Only Ireland and Finland have so far ratified the Convention.

The debates around the adoption of different Conventions also highlighted the divergences between the lines taken by EU country governments, including in areas covered by Community Directives (maternity protection). In this connection, what the Community institutions need to do is cooperate more closely with the Member States to work out common positions on the adoption of new ILO Conventions. The common policy should also bear on the ratification and application of existing Conventions.

2E) Assessing the potential effects of the WTO Agreements on Community health at work policy

81. The lessons of the asbestos case must be learned. The WTO Appellate Body's report on the specific case of the French decree banning asbestos was positive. But it has just put off the day of reckoning for other issues. Safety and health protection requirements absolutely must be more central to Community policy towards the World Trade Organization than they have been so far. We see the WTO Agreement on Technical Barriers to Trade as a potential threat to the Community system of market controls on work equipment and chemical substances alike. This is because the Agreement's provisions will make it easier for the United States to press for powers to be transferred from the European regulatory bodies to international ones (chiefly the ISO). What is most characteristic of these international agencies is that they reflect, even more than their European counterparts, the purely economic concerns of dominant multinational firms. What the Commission needs to do is clarify the scope of this Agreement, assess any inconsistence with the *acquis communautaire*, and put forward proposals for including more substantial safeguard clauses in favour of health, safety and environmental protection. Any negotiating brief handed by the Council to the Commission should include these factors so that commercial considerations do not outweigh health in future negotiations.

C. Relations with other countries or regional organizations

82. The European Union should make health at work an issue in agreements it concludes with other countries or regional organizations. It should also ensure that EU firms investing in third countries abide by fundamental health at work rules. The European Union also exports new and used work equipment, chemical substances and preparations, and other articles used by workers in other parts of the world. All these items should meet at least the same safety standards as those applying on the Community market (and higher, if the importing countries' national regulations are tougher). The forthcoming enlargement shows that coherence between internal market policy and external trade policy is more essential than ever. The ban on asbestos inside the European Union must be backed up by a policy to ensure that European firms do not just export the risks to other parts of the world.

A NEW IMPETUS FOR COMMUNITY OCCUPATIONAL HEALTH POLICY
(contribution by the Workers' Group of the Luxembourg Advisory Committee for Health and Safety to the framing of the Community action programme on health and safety)