A missing link: collectivization of the experience of preventive services

Tens of thousands of prevention specialists are at work in workplaces across the European Union every day - taking complaints from workers, analysing risks, developing preventive solutions. Often enough, they are unable to take preventive action because of decisions taken further up the line in the firm or in society. So their job becomes a damage limitation exercise without addressing the causes. Prevention experts soon come to learn that where occupational health is concerned, not even top-class professional qualifications are enough. They also need a fighting spirit and the ability to form alliances.

Employer pressure often ensures that the experiences of these prevention specialists stay dispersed. If they are to be kept working within the company's objectives, employers need their activities not to be collectivized but contained within a management system where occupational health goals will be accepted only so far as they are consistent with profit-making and the chain of command. There is constant pressure for preventive services, paid for by the firm, to become business services, an adjunct of human resource management and without full professional independence.

The most basic level of collectivization is just having a preventive service. This is nowhere near having happened in many Community countries, where employers bring in specialists, consultants and experts separately for what may be ongoing or purely one-off assignments. But more important than having prevention activities organized into services is getting a systematic exchange going on a bigger scale at sector, area, national and Community level.

Collectivization of prevention activities is a fundamental of any coherent policy on occupational health which enables various objectives to be delivered:

1. Exchanging experiences on problems and solutions gives prevention experts access to practical expertise that is not readily available within a single workplace or preventive service. The experience of networks of prevention specialists on replacing hazardous products by less dangerous ones is a good case in point. Such networks, set up on industry and national lines, then extended to other countries, have been behind the development of databases that have facilitated the substitution of organic solvents in the printing and construction industries - two sectors where the fragmentation of production activities between countless small firms would have prevented effective results being achieved without this pooling of knowledge.

2. Collectively-framed "good practice" is essential to withstand employer pressure. These rules combine scientific and technical validation criteria (best professional practice extracted from an analysis of what professionals do), with political and ethical criteria which let professionals do what they are meant to do - preserve the life and health of workers. The quality of preventive services is the focus of much debate at the moment. In many cases, quality is dictated by internal rules and procedures as well as a blinkered, short-term view of results (e.g., cutting absence or reported accident rates, etc.). The criteria may be even more questionable when they are based on the principle of "keeping the customer satisfied". The collective framing of good practice should not be a pigeonhole exercise for each specialization. Specific practice must be laid down for each profession (occupational medicine, occupational health nursing, ergonomics, industrial hygiene, etc.) but embodied in a set of best practice which is common to the different prevention specialists that also incorporates the insights and priorities of those that occupational health is all about: the workers.

3. Collectivization of the activities of "front-line" prevention experts is an immense resource for occupational health research. Networking the information generated by preventive service activities provides the necessary critical mass that the activity of one service alone will find it hard to develop. Occupational medicine conferences sometimes display an ingenuous enthusiasm for statistical programmes that enable general conclusions to be drawn from an activity confined to a specific workforce. The pooling of knowledge developed by many different preventive services, by contrast, enables properly-designed scientific work to be done. The SUMER survey which collected occupational exposure data for France and the ESTEV survey on ageing in work[1], are cases in point. Neither could have been done without the help of a large number of occupational health doctors. In most EU countries, there is still too wide a divide between occupational health research (whether done in centralized institutions or academic research centres) and prevention specialists. Demand for research may not always reflect the needs and priorities. It may come with priorities other than occupational health from the big institutional customers - the state and work-related risk insurers. Where employers are

[1] F. Derriennic, A. Touranchet, S. Volkoff, *Age, travail, santé : études sur les salariés de 37 à 52 ans : enquête ESTEV 1990*, Paris : INSERM, 1996.

involved in running research institutions, their demands may also be bad for the organization of research. The under-development of public research into hazardous chemicals compared to the state of the market, or the mania for genetic research that would enable a sort of eugenic selection of labour, are particular cases in point.

4. Collectivizing the experiences of prevention specialists is also central to public policy-making and performance assessment of health protection. Some issues cannot be addressed through prevention activities alone - they require policy decisions. Be it banning asbestos, child labour or limitations and controls on agency work and subcontracting, it is clear that prevention is locked into a political and legal framework that sets the ground rules for business. The inability to feed back their experience in order to call the public authorities to account is often a major frustration for occupational health professionals. Hundreds of thousands of risk assessments - of widely varying quality - are done each year in firms. What impact do they have on the setting of prevention priorities? How far do they really shape policy decisions? Health surveillance is carried out on a fairly large scale in EU countries, but there is an acute lack of overall data on occupational health. Most states manage no more than a handful of traditional indicators of dubious significance, like reported work accidents and recognized occupational diseases.

During the 70s and 80s, the collectivization of prevention activities delivered excellent results in the Nordic countries and Italy, but in different political and social contexts.

In Italy, the first moves were made by the trade unions and led to locally-organized public preventive services being set up. The CRD[2], a joint agency of the three trade union confederations, played a central role in collectivizing the practical experiences of workers and prevention experts alike. The waning fortunes of the labour movement in the 80s, epitomized by the defeat of the FIAT workers in 1984, also saw a reversal in collectivization. Nevertheless, there remains a real potential which went ignored by the reforms introduced when transposing the Community directives. These created a two-track system of public health protection services and a private market in company prevention specialists without really addressing the issue of internal consistency within the system as a whole.

Collectivization of experiences in the Nordic countries took place in a less adversarial climate and more socially homogeneous societies, supported by the creation of tripartite-run work environment funds. In Italy and the Nordic countries alike, these experiences have lost momentum but have not run entirely out of steam. The different guides published by the Conference of Regions in Italy are an object lesson in the collectivization of good prevention practice to support the implementation of the Community directives, for example.

Elsewhere, other arrangements have been put in place, many initiated by prevention specialists in a perceived need to get organized in professional associations and speak with a collective voice. Some focus more on framing common policy positions or demands, others on scientific research and exchanging professional experiences. Some initiatives, however, manage to bridge this divide and combine strands of thought from both camps. The French occupational health doctors action group[3] or the more exploratory debates among ergonomists in many countries[4] are cases in point. Some are trade union initiatives, like the Forums on health surveillance and quality in prevention set up in Spain by the ISTAS[5]. A word should be said about a number of schemes at European level, where single issue networks have been set up, like that on substitution of organic solvents in the printing and construction industries. At a more general level, there is also the "European Work Hazards Network"[6] which links together prevention specialists and trade union activists, and draws heavily on the experience of Britain's Hazards Campaigns[7], linking together dozens of grassroots and single-issue groups.

Collectivizing prevention activities means recognizing that preventive services, however they are organized and run, are public services because they bring an external requirement - occupational health - to bear through action in the workplace. To this extent, they are enablers of a public health policy that goes beyond the uncertainties and simplistic approach of promoting individual health through lifestyle changes. If the risk observatory that the Commission has flagged up in its Communication on a strategy for health at work forms part of a collectivization of the experience of preventive services and workers' health and safety reps, it could certainly usefully inform the framing of a Community policy that is responsive to changing realities and that acknowledges occupational health as a central issue of public health. ■

[2] The CRD or *Centro Ricerche Documentazione Rischi e Danni da Lavoro* was set up in 1974 by the three Italian trade union confederations. It published a magazine (*Medicina dei Lavoratori*) as well as a great number of books and brochures. It was wound up in 1985 after the breakdown of the unitary agreement between the three confederations. Its records are one of the most valuable sources of information on the struggle for occupational health in Italy from the late 60s to the early 80s. On the history of the CRD, see A. Grieco P.A. Bertazzi (ed.), *Per una storiografia italiana della prevenzione occupazionale ed ambientale*, Milan : FrancoAngeli, 1997.

[3] See in particular, Association Santé et médecine du travail, *Des médecins du travail prennent la parole. Un métier en débat*, Paris : La Découverte et Syros, 1998.
http://www.a-smt.org/ accueil.html

[4] See in particular the activities of the society of French-speaking ergonomists: Société des Ergonomes de Langue Française, SELF:
http://www.ergonomie-self.org/

[5] http://www.ccoo.es/istas/

[6] http://www.work-hazards.dk/

[7] http://www.hazardscampaign. org.uk/ and http://www.hazards.org/ index.htm