The new EU occupational safety and health strategic framework 2014–2020: objectives and challenges

New technologies, globalization and continuous demographic shifts have produced far-reaching changes in the world of work and new challenges for the health and safety of workers. The European Agency for Safety and Health at Work has reviewed the evolution of new work models and emerging risks in order to adapt the corpus of law and European strategic actions [1]. The resulting European Union (EU) occupational safety and health (OSH) strategic framework for 2014–2020 takes full account of these requirements [2]. As the strategic framework has been in situ for a year, it is timely to look at how it has developed and what contribution it has made to the process of policy modernization currently in progress in OSH.

One of the cornerstones of the 2014–2020 strategy is the EU’s need, in line with the aims of the Regulatory Fitness and Performance Programme (REFIT), to put in motion plans to simplify regulations and eliminate unnecessary administrative obligations. This should ensure greater efficiency and closer conformity with OSH rules throughout member states and enterprises, while at the same time fostering growth and employment [3]. This generates lively debate on these goals in Europe, borne out by some interesting studies and surveys ‘commissioned by’ the European Commission, which have found that legislation on workers’ health and safety is one of the four most burdensome policy areas for small and medium enterprises (SMEs) [4]. This is also evident in the conclusions of the European Survey of Enterprises on New and Emerging Risks (ESENER) that state that European firms have difficulty in correctly fulfilling the requirements of OSH regulations on account of their complexity (in 40% of cases) and the administrative burden (in 29% of cases). In Italy, the same figures are roughly double—67% and 61%, respectively [5].

As regards simplifying the regulations, the member states have recently presented the commission with their reports on implementing the specific OSH directives. The commission is currently analysing these reports and will take them into account in its evaluation of existing OSH legislation and identifying what measures would permit the simplification or reduction of administrative obligations, particularly for SMEs, without jeopardizing safeguards for workers’ health and safety [2]. This becomes even more of a challenge in the light of the implications of the potential Transatlantic Trade and Investment Partnership (TTIP) for safeguarding European workers’ health and safety. The approach to the TTIP relies on ‘recognizing that overly burdensome regulatory standards serve as significant barriers to trade, and that additional growth could follow from addressing such barriers’ [6].

These changes in European OSH policy, while admittedly aimed at cutting administrative and bureaucratic red tape and modernizing the regulations (e.g. Directive 90/269/EEC on the minimum health and safety requirements for the manual handling of loads, and Directive 90/270/EEC on the minimum health and safety requirements for work with display screen equipment), might at the same time involve a risk of deregulation. This could be dangerous in relation to the concept of policy now widely held in Europe, which has achieved valuable results as regards workers’ health and safety. It is worth recalling that the concept of the present regulatory corpus can trace its roots back to the key role Europe has always played in OSH. The first book covering occupational medicine in detail was entitled De Morbis Artificium Diatriba, dated 1700 [7]. The first regulation on work inspection was the Althorp Law (1833), in Great Britain. The first regulations on insurance for accidents at work were introduced in the 19th century in several European countries [8]. These important precedents resulted in the European Community developing OSH policies that now give Europe advanced, detailed legislative systems in this field. The OSH Framework Directive 89/391 EEC on workers’ health and safety marked some fundamentally important improvements in OSH, specifying minimum obligations as regards health and safety throughout Europe. Various subsequent directives focused on specific aspects of OSH.

The growing interest in OSH topics has contributed to the establishment of a network of bodies with specific activities such as EU-OSHA and Eurofound. MODERNET (Monitoring trends in Occupational Diseases and tracing new and Emerging Risks in a NETwork) is a collaboration between academic centres investigating occupational disease and work-related ill-health incidence in a few EU countries [9]. Its aim is to develop a network for the exchange of knowledge that will allow discovery and validation of new OSH risks more quickly. It will also permit the comparative
evaluation and development of new techniques to enhance information on trends in occupational diseases. At the same time, individual countries have set up infrastructures to progress from the concept of prevention to the idea of overall promotion and integration of well-being in the workplace [10]. This has also resulted in a risk management model focused on workers, taking account of their OSH and organization of their work. The model acknowledges the active role of the social parties and assigns importance to promoting the ‘culture’ of prevention; this has contributed to the widespread general growth of skills and a participatory approach to health and safety management. The resulting preventive measures are increasingly effective at the single company and overall levels [11].

The success of this model has led the EU, through its neighbourhood policies (e.g. the Eastern Partnership and Union for the Mediterranean), to take an active part in improving the OSH conditions of workers outside the Union with a view to aligning their practice with the *acquis communautaire* in this field [12]. Even so, although recent European statistics indicate a drop in the numbers of accidents at work, the opposite appears to be true for occupational diseases, particularly in major areas of concern (e.g. musculoskeletal disorders and occupational cancers) [13]. However, this drop might be influenced by some variables: differences in the reporting or monitoring systems among EU countries, job insecurity or reduction in economic activity due to fiscal crisis.

Tackling today’s challenges for workers’ health and safety means aiming for successful models to identify key points that could raise OSH standards in European countries, in line with new production methods. One of these key points is the critical mass of OSH professionals and the importance of healthcare services. The successful model must also be able to identify weak points that threaten OSH levels; these include economic constraints and the administrative burden on firms. SMEs and the informal sector have particular trouble observing OSH regulations without the additional difficulties of OSH policies adapting to globalization, demographic change and innovation. It is therefore essential to focus closely on prevention, which could reduce the costs of occupational accidents and disease estimated at around 3000 billion euros a year in Europe. This figure covers absenteeism, early retirement, loss of productivity, etc. [14].

Another concern in relation to worker health and safety is the inadequate coverage of OSH services, generally considered an important indicator for assessing national OSH levels. The European directives have so far taken little action on this point, despite the indications set out in the Occupational Health Services Recommendation issued by the International Labor Organization (ILO) in 1985, which stated that ‘Each Member should develop progressive occupational health services for all workers, including those in the public sector and the members of production co-operatives, in all branches of economic activity and all undertakings. The provision made should be adequate and appropriate to the specific health risks of the undertakings’ [15].

A survey of a sample of 39 International Commission on Occupational Health (ICOH) member countries from all continents showed that coverage of OSH services as a proportion of the total employed population varied widely between 3% and 97%. On average, 81% of the total working population in the countries surveyed did not have access to services; the global estimate is 85–90%. In the 14 EU surveyed countries, mean OSH coverage was more than 65% with a large variation between Greece (18%) and Belgium (97%), but it was much lower—about 30%—in four surveyed candidate countries for the EU [16].

In summary, it is fundamental to establish policies based on easy-to-adopt, integrated tools that take account of an overall OSH strategy. Starting from the assumption that questions of health, safety and well-being are all interlinked, emphasis must be laid on aspects such as the ‘culture’ of prevention, the creation of skills and a participatory approach. Actions need to be reviewed with respect to research priorities and policy implementation so as to support the OSH social dimension and so foster a broader concept of well-being at work. The challenges relating to global economy and the risk of growing social inequality, including protecting workers’ health, need careful consideration.

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References

PTSD induced by the trauma of subordinates: the Robert Gates syndrome

In July of 2011, Robert Gates resigned as US Secretary of Defense after serving in that position for 4½ years under two Presidents of different political parties. In the Author’s Note to his recently published memoir *Duty* (Vintage, New York, 2014), Gates explains his surprising choice to resign as Defense Secretary, ‘Toward the end of my time in office, I could barely speak to them [soldiers] or about them without being overcome with emotion. Early in my fifth year, I came to believe my determination to protect them … was clouding my judgment and diminishing my usefulness to the president …’ In the book, Gates notes that ‘the hardest part of being secretary for me was visiting the wounded in hospitals … and it got harder each time’. In reflecting on the penultimate page of the book Gates writes, ‘… in my mind’s eye I could see them [injured soldiers] lying awake, alone, in the hours before dawn, confronting their pain and their broken dreams and shattered lives. I would wake in the night, think back to a wounded soldier or Marine I had seen … and in my imagination, I would put myself in his hospital room and I would hold him to my chest, to comfort him … so my answer to the young soldier’s question … about what kept me awake at night: he did’.

That is, Gates has ongoing and longstanding recurrent recollections, dreams and awakenings about the injuries of soldiers under his command. These were so significant as to force him to retire from his job. If these recollections were about trauma he himself had experienced, Gates would meet criteria for post-traumatic stress disorder (PTSD). As best is known, Gates personally did not experience such trauma, so his feelings and emotions are solely induced by trauma sustained by his subordinates. Loved ones or caregivers for patients who have undergone trauma can experience PTSD symptoms [1]. But this situation is different because PTSD is being experienced by the person who ordered the traumatized individuals into the situation that induced the trauma. PTSD induced by trauma of subordinates likely occurred to others in the past either in the pure form as here or a mixed form induced also by personally experienced trauma and is likely an important workplace hazard for civilian and military war commanders.

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Reference