

# **Health and Safety at Work in the European Union**

**Policy responses to changes in work organisation and employment patterns in the  
context of globalisation**

**Paper prepared by Tom Walsh preparatory to the 13<sup>th</sup> EU-Japan Symposium,  
Brussels, 2010**

**Contract ref. No VC/2008/1050**

## Table of contents

	Page
A. INTRODUCTION	
1. Introduction	4
B. THE EU INSTITUTIONAL AND LEGISLATIVE FRAMEWORK	
2. Decision making on safety and health at work in the EU	
2.1 General	5
2.2 The EU institutions	6
2.3 Specialised institutions, Agencies and Committees	6
3. Employer/Worker and Social Partner involvement in safety and health	
3.1 Consultation at the workplace	7
3.2 Social Dialogue	8
3.3 Consultation within the Advisory Committee on Safety and Health at Work	9
4. The development of safety and health in the EU	
4.1 General background	9
4.2 The legal basis	10
4.3 Safety and Health Directives adopted	11
4.4 Other legislative measures influencing safety and health at work	13
4.5 Non legislative measures	13
4.6 Risk Assessment	13
C. DATA AND TRENDS IN SAFETY AND HEALTH AT WORK, WORK ORGANISATION AND EMPLOYMENT PATTERNS, THE CURRENT ECONOMIC SITUATION	
5. Safety and health at work - data, trends and their implications	
5.1 General	14
5.2 First results of Eurostat's EU-27 Labour Force Survey (LFS) 2007 ad hoc module on accidents and work-related health problems of workers aged 15-64 years	
5.2.1 Accidents at work	16
5.2.2 Work-related health problems	16
5.2.3 Exposure to risk factors	17
5.3 Fatal accidents at work	17
5.4 The burden and costs of accidents and ill-health at work	17
5.5 New and Emerging risks	18
5.6 Trends in working conditions – EUROFOUND's Fourth European Working Conditions Survey 2007	20
5.6.1 The employment situation	21
5.6.2 Working time	22
5.6.3 Non-standard working hours	22
5.6.4 Organisation of working time	23
5.6.5 Physical risk factors	23
5.6.6 Violence, harassment and discrimination in the workplace	25

5.6.7	Changes in the nature of work	26
5.6.8	Work organisation, autonomy, intensity, pace of work	27
5.6.9	Impact of work on health	29
5.6.10	Management and communication structures	29
5.6.11	Work-life balance	30
5.6.12	Satisfaction with working conditions	30
5.6.13	Survey conclusions	31
6.	Demographic and related aspects of safety and health at work	31
7.	The current economic challenge	33
8.	The data and trends illustrate the major challenges	34
D. THE STRATEGIC WAY FORWARD		
9.	Strategic approaches to safety and health at work	
9.1	General	35
9.2	The EU Strategy on safety and health at work 2007-2012	37
Annex 1 Member States of the EU		
		39
Annex 11 Safety and Health Directives in place		
		40
Annex 111 First results of Eurostat's EU-27 Labour Force Survey 2007 ad hoc module on accidents at work and work-related health problems of workers aged 15-64		
		43

## **A. INTRODUCTION**

### **1. Introduction**

The aim of this paper is to set out the background, from an EU perspective, against which the broad topics discussed as being appropriate for debate in the Symposium by the Tripartite Working Group meeting in Tokyo on 13<sup>th</sup> March 2009, could be elaborated on at the Symposium. These topics included:

#### Safer Workplaces -

- Effective implementation of Risk assessment
- Involvement of workers
- Education and training for workers
- Role of safety consultation and safety and health committees at company level
- Applying the results of risk assessment on machinery.

#### Healthier Workplaces -

- How to keep workers safe and healthy, taking account of the impact of the changing work environment on workers' health, including mental health
- Improving working environments in order to enable workers to stay longer in the labour market in a healthy condition in the light of the aging workforce and so as to combat newly emerging problems, such as psychosocial problems in the workplace
- The effects on workers' health of the deteriorating labour market as a result of the global financial crisis.

Japan and the European Union (EU), now comprising 27 Member State countries, are both amongst the world's largest industrialised economies. Labour force composition in both is almost identical (services 67%, industry 27%, agriculture 4.4%). The EU has a population of 490 million and a labour force of 223 million people. Japan's population is 127 million, with a labour force of 67 million people. Japan has a long history of development of safety and health at work policies. The EU, building on the work in the Member States, has developed, over the past 30 years, a wide range of policy and legislative measures in safety and health, which over-ride or qualify the actions which take place at the level of the Member States.

Despite progress made, both the EU and Japan face both continuing and new challenges as regards reducing accidents and occupational disease at work.

In 2007, in the EU-27, 3.2% of workers, or 7 million workers, had one, or more, in a small number of cases, accidents at work, 10% of which were road traffic accidents in the course of work. In the same year, 8.6% of workers, or 20 million workers, in the EU-27 experienced work-related health problems, with bone joint or muscle problems, stress, anxiety or depression being most prevalent. These results contrast with the outcome for the EU-15 between 1998 and 1999 of 7.4 million accidents and 7.7 million reported work-related health problems. The figures show that EU safety at

work policies and programmes have yielded good results but that more needs to be done as regards health at work.

These incidents impose a considerable cost on employments and the economy, through lost work days and other costs. They cause suffering to workers and their families.

In Japan, about 130,000 injuries and deaths requiring absence of 4 or more days occur each year, showing a decline since 1979 to a rate per 1,000 workers in 2004 of 2.5 (source: *Present Status of Japanese Industrial Safety and Health, 2006 Edition, Japan Industrial Safety and Health Association*).

This paper charts the development of safety and health at work as an important policy area in the EU. It illustrates the strong role played in this regard by Member States' governments, employer bodies and trade unions in a tripartite setting. It recalls the development of the range of preventive and legislative measures, including through social dialogue, which now influence occupational safety and health in the EU. It looks at the available data. It comments on the strategic approaches adopted in the light of current challenges and at the emphasis placed on risk assessment and on the strategic management of safety and health at work at EU level, in Member States and at company level, aimed at reducing accidents and ill health at work and improving competitiveness and economic well-being.

## **B. THE EU INSTITUTIONAL AND LEGISLATIVE FRAMEWORK**

***Introduction: Democratic and inclusive processes are in place in the EU so that the 27 Governments, the EU institutions, the social partners and other stakeholders can either take or influence policy decisions aimed at improving the safety and health of all EU workers.***

### **2. Decision making on safety and health at work in the EU**

#### **2.1 General**

It is important as regards understanding the positioning of occupational safety and health at work in the EU to have a general appreciation of the decision making, and consultative processes, which lead to EU policy making. Governed by a series of Treaties, dating from 1951, the EU is an intergovernmental and supranational body comprising 27 sovereign member nations (see **Annex 1**), with, currently, 3 applicant countries. Enlargement of the EU took place in several tranches and studies and reports reflect this in their references to either the EU-15 (the first 15 Member States to join) or to the EU-25 and, currently, to the EU-27.

The Member States pool their sovereignty for many of their decision making powers to shared institutions so that decisions on specific matters of joint interest can be made democratically at European level. Formal decisions take the form of Directives, or Decisions, which are legally binding on the Member States, which must transpose them into national law, and EU Regulations which apply directly in the Member

States. There are also social dialogue agreements in the field of social policy, some in the form of binding Directives (the role of European social partners is described in section 3.2). There are Commission Directives which update existing measures in the light of technical progress. Some instruments are in the form of non-binding Council Recommendations.

The individual Member States of the EU, in many cases in cooperation with the social partners at national level, continue to provide national services for safety and health at work and to have strategies and programmes which include inspecting and advising employments and providing national programmes in the areas of risk assessment, safety consultation, education, training and information on safety and health, as well as sharing in EU- based prevention activities.

## **2.2 The EU institutions**

The EU decision-making processes, including the co-decision procedures for legally binding instruments, involve 3 main institutions – the **European Parliament**, which represents the EU's citizens and is directly elected by them, the **Council of the European Union**, which, at Ministerial level, represents the individual Member States, and the **European Commission** which seeks to uphold the interests of the EU as a whole. The Presidency of the Council of Ministers is chaired on a six monthly rotation basis by the Member States. This institutional triangle produces the policies and laws which apply throughout the EU. The European Commission is comprised of a number of Directorates General which are responsible for individual policy areas. Responsibility for safety and health at work within the Commission rests with the **Directorate General for Employment, Social Affairs and Equal Opportunities**.

The **Economic and Social Committee** and the **Committee of the Regions** also influence policy-making.

In principle, it is the Commission which proposes new laws but it is the European Parliament and the Council which adopt them. The Commission and the Member States then implement them and the Commission ensures that laws are properly put into effect.

## **2.3 Specialised institutions, Agencies and Committees**

There are several specialised institutions including, in particular, the **Court of Justice**, which upholds the rule of European law and adjudicates on whether a Member State has correctly transposed EU law. In addition, there are specialised agencies which handle certain technical, scientific or management tasks and three such agencies have an important bearing on safety and health at work – the European Agency for Safety and Health at Work (**EU-OSHA**), based in Bilbao, Spain, the European Foundation for the Improvement of Living and Working Conditions (**EUROFOUND**), based in Dublin, Ireland, and the European Chemicals Agency (**ECHA**), based in Helsinki, Finland.

**EU-OSHA** brings together and shares the EU's vast pool of knowledge and information on safety and health, particularly good prevention practices.

**EUROFOUND** contributes to the planning and establishment of better living and working conditions by providing findings, knowledge and advice from independent and comparative research to governments, employers, trade unions and the European Commission.

**ECHA** ensures consistency in chemicals management across the EU and provides technical and scientific advice, guidance and information on chemicals. It manages the so-called REACH Regulation which regulates chemicals on the European market which originate within the Union or which come from other countries.

The **Committee of Senior Labour Inspectors**, established by the Council, and representative of each Member State, advises the Commission on problems relating to the enforcement of laws on safety and health at work, takes initiatives on cooperation between national labour inspection systems, develops exchanges of experience between the Member States and devises common principles of labour inspection.

The **Advisory Committee for Safety and Health at Work** brings together at EU level representatives of the 27 Governments and the national employer and trade union bodies to advise the Commission on safety and health policy. See point 3.3 for more detail on the Advisory Committee.

The **Scientific Committee for Occupational Exposure Limits (SCOEL)** advises the Commission on limit values for chemicals.

In addition, **CEN** (European Committee for Standardisation) and **CENELEC** (European Committee for Electrotechnical Standards), prepare harmonised technical standards, in support of EU 'single market' Directives, which are not mandatory but which carry a presumption of conformity. These standards contribute to advancing safety and health at work in the EU.

**3. Employer/Worker and Social Partner involvement in safety and health**  
*Introduction: Consultation on safety and health at work in the EU takes place at several levels. Workers are entitled to be consulted at workplace level. The role of worker safety representatives is recognised under the Framework Directive (see Point 4.3). Safety Committees form part of the consultative mechanisms in many Member States. The social partners are deeply involved in policy and decision making on worker safety and health at EU level, including through the social dialogue process and via the Advisory Committee on Safety and Health at Work.*

### **3.1 Consultation at the workplace**

Under EU safety and health Directives (see point 4.3), employers are obliged to consult workers and/or their representatives in good time and allow them to take part in discussions relating to safety and health at work. This includes balanced

participation where national law or practice provides for such. Workplace consultation can take several forms; including dialogue with worker appointed safety representatives, in workplace-based safety committees and through participation arrangements. There is an amount of guidance available by now on safety consultation, both within the Member States and from EU-OSHA.

The **11<sup>th</sup> Industrial Accident Prevention Plan 2008 – 2012** of the Ministry of Health, Labour and Welfare in Japan (the Accident Prevention Plan) highlights the need to enhance the role of the Safety and Health Committee in enterprises.

### **3.2 Social Dialogue**

Recognised under the Treaties (see point **4.2**), a sophisticated system of social dialogue is in place between the employer bodies and trade unions at EU level. Should they wish to do so, the social partners may make contractual relations, including agreements, on social issues, which are implemented either in accordance with employer and trade union procedures and practice or that of the Member State or, at the request of the signatory parties, by a Council Directive on a proposal from the Commission.

The Commission must consult the ‘social partners’ on the possible direction of action by the EU giving them, instead, the opportunity of making an agreement or expressing an opinion.

Over 300 social dialogue joint texts are now in place covering a wide range of work-related subjects, including around 50 on worker safety and health. The latter include autonomous agreements on Telework (2002), Stress (2004) and Harassment and Violence (2007) across industry, and a sectoral agreement on crystalline silica covering 14 employment sectors. Four agreements on working time in some transport sectors have legal force in the form of Directives. The European social partners in the health sector have also asked the Commission to submit their agreement on the prevention of needle stick injuries amongst healthcare workers of July 2009 to the Council for adoption as Directive.

New research from EUROFOUND focussing on several Member States, the results of which will be published shortly, found that social dialogue closely connected to the shop floor level in a strong framework provided by law as well as national and sectoral dialogue is most efficient in improving working conditions. Trade unions play a very important role, as well as sectoral employer organisations, since they organise and articulate interests of company based actors and vice-versa. Social partners and social dialogue play a key role in helping to create better jobs and improve the quality of work and working conditions through influencing policy decisions, negotiating social pacts and collective agreements as well as through participating in particular programmes and policies.

The EUROFOUND findings support the conclusion reached on the social dialogue in the Commission’s **Report on Industrial Relations in Europe 2008** that, when



implementation is treated seriously, social dialogue can go a long way to improving working conditions and competitiveness. That Report noted that European social partners are increasingly prepared to take the responsibility for implementation, particularly of the 'autonomous' agreements.

Social dialogue serves also to reinforce, at the macro level, the good working relationships between the European Union employer bodies and trade unions, building on the social partnership framework which is so common within the Member States.

### **3.3 The Advisory Committee on Safety and Health at Work**

Under a Decision of the Council of Ministers, the Advisory Committee exists at EU level, comprised of 3 full members for each Member State, representing governments, employers and trade unions. Two alternate members may be appointed for each full member. The Committee is chaired by the Commission. The Committee appoints 'ad hoc' Working Parties to consider and propose draft opinions to it on matters which arise. A Standing Working Party is concerned with safety and health in the extractive industries.

The Committee assists the Commission in the preparation, implementation and evaluation of activities in the field of safety and health at work.

The Advisory Committee, both historically and currently, is deeply involved (see point 9.2) in advising the Commission, in the form of opinions, which are reported also to the Council of Ministers and the European Parliament, on all aspects of the development of safety and health at work policies in the EU. These range over strategies adopted, annual action programmes, legislative and other measures. The Committee gives an opinion on the annual work programme of EU-OSHA. Tripartite involvement brings with it a high level of commitment to the legislation and programmes adopted and contributes significantly to the improvement of the state of safety and health at work both in the Member States and at EU level.

## **4. The development of safety and health measures in the EU**

*Introduction: Health and safety at work is, by now, a highly developed policy area within the EU. Successive Treaty amendments have strengthened the policy background, giving ground-breaking recognition to the role of employer bodies and trade unions in framing and implementing policy, particularly through social dialogue.*

### **4.1 General background**

Health and safety at work is now one of the EU's most detailed and important social policy sectors. In 1951, the **European Coal and Steel Community**, the first of the institutions, set about improving the safety of workers in the mining and extractive industries following a significant number of accidents particularly in coalmines. This resulted in the promulgation of many Recommendations which were implemented to

good effect by the industries concerned, albeit that the coal and steel industries no longer play as significant a role in the overall EU economy.

The **Treaty of Rome**, in 1958, extended the concept of safety and health at work to cover all employed persons in all sectors, recognising the need for a dedicated approach at the level of the EU. Since 1978, and the first Programme of Action, the situation has moved from dependence on national legislation to reliance, for the most part, on the competence of the EU to regulate safety and health at work.

Following a period of slow progress in which, due to procedural constraints, a small number of Directives was enacted, the drive to complete the single European market by 1992 emphasised the need for higher standards in the Member States as regards social policies. In order to ensure that competition, productivity and protection of workers were on an equal footing, the single market had to be complemented by minimum requirements for safety and health at work. However, within the enlarged EU, there are new challenges to competition due to the economic conditions from low cost capacity in some Member States. Multi-national companies in a globalised economy are beginning to engage in 'manufacturing migration' both within the EU and also to countries outside the EU.

The production of the single market Directives, relating to the design, manufacture and marketing of products to facilitate achievement of the single market, had to be matched with Directives related to the safe use and maintenance aspects of machinery, equipment etc.

#### **4.2 The legal basis**

Successive amendments of the governing Treaties have enhanced the EU policy approach to worker safety and health and the means of achieving it.

In its social provisions, Articles 117 and 118 of the 1987 "**Single European Act**" Treaty amendment provided that the Member States agreed upon the need to improve working conditions and standards of living for workers and required the Commission to promote close cooperation between Member States on labour law and the prevention of occupational accidents and diseases.

Article 118a of that amendment, under which most of the current Directives were adopted, provided, inter alia, that "Member States shall pay particular attention to encouraging improvements in the working environment as regards the health and safety of workers, and shall set as their objective the harmonisation of conditions in this area, while maintaining the improvements made". To help achieve this, "the Council shall adopt, by means of directives, minimum requirements for gradual implementation, having regard to the conditions and technical rules obtaining in each of the Member States". Directives should avoid imposing administrative, financial and legal constraints on SMEs. Member States could maintain or introduce more stringent measures.

Article 118b provided that “The Commission shall endeavour to develop the dialogue between management and labour at European level which could, if the two sides consider it desirable, lead to relations based on agreement”.

The “**Treaty of Nice**” amendment, signed in 2001, strengthened the social provisions, and, in **Article 136**, recalling the 1989 Community Charter of Fundamental Social Rights of Workers, required the Community and the Member States to promote employment, improved living and working conditions, proper social protection, dialogue between management and labour, and the development of human resources with a view to lasting high employment and the combating of exclusion. Under **Article 137**, the Community supports the Member States as regards improving the working environment to protect workers’ health and safety and may adopt measures and directives to achieve this.

The “**Lisbon Treaty**”, signed in 2007, will, when finally ratified by all 27 Member States, in addition to retaining the safety and health provisions from the earlier Treaties, further reinforce the role of the social partners and social dialogue. **Article 152** states that “The Union recognises and promotes the role of the social partners at its level, taking into account the diversity of national systems. It shall facilitate dialogue between the social partners, respecting their autonomy”. Subsequent Articles reinforce the mechanisms which give effect to the making of social dialogue agreements and their possible recognition, at the request of the social partners, in the form of Directives.

#### **4.3 Safety and Health Directives adopted**

*Introduction: Binding preventive requirements are now in place for all of the most significant workplace risks, high risk sectors, particularly vulnerable workers and for chemical, physical and biological risk at work. There is significant scope for debate and exchange of information and experiences at the Symposium on state of the art approaches to achieving safer workplaces, through effective implementation of risk assessment, involving workers and employers and in educating and training workers.*

An intensive legislative drive, based on Article 118a of the EU Treaties, resulted in the adoption of a considerable number of safety and health Directives (see **Annex 2**) which were transposed into national laws by the Member States. They both complemented the parallel Directives adopted on the free movement of goods and people across Member States’ borders and achieved several significant policy objectives as regards safety and health at work. The Advisory Committee was consulted and gave its opinions on the development of these measures.

The so-called **Framework Directive (No. 89/391)** on the introduction of measures to encourage improvements in the safety and health of workers at work, adopted in 1989, was the first and most important Directive providing for minimum requirements on safety and health. It is at the core of the strategy on which a range of

specific ‘individual’ Directives was built, covering a maximum number of hazards with a minimum number of Directives.

The Framework Directive applies to all sectors of activity with very few exceptions. It lays down general principles of prevention. It imposes duties on the employer to ensure the safety and health of workers in every aspect related to the work, to have an assessment of the risks to safety and health, to consult workers or their representatives and to inform and train workers in safety and health. Workers are obliged to take care of their own safety and health and to make correct use of machinery, dangerous substances and personal equipment.

The provisions of the Framework Directive apply in full to the “individual” Directives. As a result, a written risk assessment must be carried out in respect of the range of hazards covered in the “individual” Directives where they are present in a workplace; workers must be consulted, informed and trained, etc.

The approach in the Framework Directive as regards risk assessment would appear to be very similar to that enshrined in the **Industrial Safety and Health Act (Law No. 57 of 1972)** of Japan.

The philosophical move to a risk assessment approach at EU level brought about a major policy change under which responsibility for risk was placed firmly on persons who created risk, as against an over-reliance prior to that on occasional supervision by enforcement authorities. It laid the foundation for the preventive approach.

Risk assessment is the subject of the EU-OSHA’s current promotional campaign (see point 4.4).

The ‘individual’ Directives and other Directives adopted (see **Annex 11**) cover topics such as work equipment, the use of personal protective and display screen equipment, working situations, such as manual handling, high risk sectors, such as construction, the extractive industries and fishing, particular groups of workers, such as pregnant and nursing mothers, chemical, physical and biological agents at work, carcinogens and mutagens, explosive atmospheres and safety signs at work. The Directives on physical agents apply to vibration, noise, electromagnetic fields and artificial optical radiation. In general, the ‘individual’ Directives are constructed around general duties supplemented by minimum requirements on particular risks which are identified in Annexes.

These Directives, collectively referred to as the *Community acquis* in safety and health, have been transposed into national law by all of the current Member States. It is a condition of joining the Union that prospective Member States must have adopted the *Community acquis* at national level.

Other Directives adopted, including those on temporary workers, young people, medical treatment on board vessels and the organisation of working time, have implications also for safety and health at work.

Due to constitutional constraints as regards legislating for the self-employed, a non-binding Council Resolution, rather than a Directive, applies to agriculture, albeit that in some Member States, the national legislation implementing the Framework and other Directives applies to the self-employed.

#### **4.4 Other legislative measures influencing safety and health at work**

Legislation promoted by other Directorates General of the Commission can have a bearing on safety and health at work and, in particular, those adopted from the perspective of the protection of man and the environment are in this category. These include the Directives on the control of major accident hazards involving dangerous substances, 1996 and 2003, described as the **Seveso Directives**, which were adopted following some major accidents involving dangerous chemicals. Where dangerous chemicals are in place above certain thresholds, a safety case and internal and external emergency plans must be prepared.

Also significant is the 2007 Regulation on the Registration, Evaluation, Authorisation and Restriction of Chemicals (**REACH**), which is mentioned in the Accident Prevention Plan in Japan in the context of chemical management and international cooperation. This Regulation applies directly to Member States and, based on levels of risk, provides for a comprehensive system of managing the placing on the market of chemicals. It is administered at EU level by **ECHA**.

In addition, so-called single market Directives applying to machinery etc have significant implications for worker safety and health.

#### **4.5 Non legislative measures**

With the assistance of the Advisory Committee, a programme of development of Guidelines on Directives for employers and workers was envisaged under the EU Strategies on safety and health at work (see point 9) and forms part of current work programmes. Guidelines have already been published on Work at Height, Noise, Vibrations and Chemicals. Work is in progress on others.

**EU-OSHA** provides and coordinates a range of information and promotional measures at EU level, including, in particular, the annual European Week campaign, which has covered such topics as, musculoskeletal diseases, young people, construction, dangerous substance and stress. Now moving to a two yearly campaign, the current topic is risk assessment.

The autonomous European social partner agreements on stress (2002) and on violence and harassment at work (2004) regulate specific aspects of prevention and protection of workers against psychosocial risk factors. Both of them acknowledge that the

obligations stemming from the Framework Directive also apply to the respective psychosocial risk factors and they provide employers and workers an action oriented framework to identify, prevent and manage the related problems. They are a binding for the members of the signatory parties but they do not cover the whole economy as national means of implementation vary from Member State to Member State according to their industrial relations systems (collective agreements, legislation, guidelines, or practical tools). The European social partners' implementation report in December 2008 indicated that implementation measures for the agreement on stress had been put in place in 21 Member States. Two years after the implementing deadline, the Commission currently reviews the implementation of the stress agreement.

The European social partners in different sectors have agreed on various guidelines and tools that influence the practices of occupational health promotion in the EU Member States to various degrees. Examples are a tools on the "prevention of accidents at sea and the safety of fishermen", the "European agreement on the reduction of workers' exposure to work-related musculoskeletal disorders in agriculture", the "review of good working practices on musculoskeletal disorders in the telecoms", or guidelines on the "use and handling of cosmetic products and their chemical agents in the hairdressing industry".

#### **4.6 Risk Assessment**

***Introduction: Risk assessment is at the heart of the prevention of accidents and ill-health at work and is a critical element in the framework of legislative instruments. By now extensive guidance on risk assessment is in place at EU level and in the Member States. An internet tool on risk assessment has been launched by EU-OSHA.***

The **European Guidance on Risk Assessment**, published in 1996, following consultation of the Advisory Committee, provides detailed guidance on risk assessment, covering methodology, guidance for large and small companies and for particular risks. As part of its Risk Assessment campaign, 2008-2009, **EU-OSHA** refers to the **European Guidance** and provides a stepwise approach to risk assessment, covering 14 steps, and including a five-step approach which would suffice for most companies, especially SMEs, as follows –

*Identifying hazards and those at risk, Evaluating and prioritising risks, Deciding on preventive action, Taking action, Monitoring and Reviewing.*

The approach to risk assessment will depend upon –

*The nature of the workplace ( e.g. whether fixed or transitory)*

*The type of process (e.g. repeated operations, developing/changing operations, work on demand)*

*The task performed ( e.g. repetitive, occasional or high risk) and*

*Technical complexity.*

## C. DATA AND TRENDS IN SAFETY AND HEALTH AT WORK, WORK ORGANISATION AND EMPLOYMENT PATTERNS, THE CURRENT ECONOMIC SITUATION

(Note: Eurostat is to publish a statistical publication analysing all of the available statistical data at EU 27 level on accidents and ill health at work, including the results of the 2007 LFS ad hoc module, ESAW (including Phase 111), EODS and, where applicable, statistics available at the EU-OSHA's risk observatory. If available, this publication will help inform the debate at the Symposium)

### 5. Safety and health at work – data, trends and their implications

*Introduction: The latest data, relating to 2007, shows an improvement across the 27 Member States as regards levels of accidents at work but a deteriorating situation as regards work-related health problems thus making it opportune to debate these trends, and the reasons for them at the Symposium. The health of workers has often been described as the poor relation in the efforts to improve safety and health. It can be difficult to separate lifestyle from workplace issues. Compensation for physical accidents is more easily assessed Questions which arise are – what additional efforts are necessary to further reduce accident at work and are current policies and programmes, at both EU and national levels, fit for purpose and adequate to reverse the deterioration in work- related health. A greater level of engagement with workplace health issues needs to be promoted and encouraged.*

#### 5.1 General

Achieving safe and healthy workplaces in the EU must take account of available information on accidents and ill-health at work, on new and emerging risks, on demographic issues and working conditions which can impact on safety and health.

**Eurostat**, the European body responsible for collecting and publishing statistical data on all aspects of the functioning of the European Union, the European Commission and the Member States have been working to develop harmonised and reliable statistics on accidents and diseases at work. The **Framework Directive** obliges the employer to keep a list of occupational accidents resulting in a worker being unfit for more than 3 working days and to report to the responsible national authority on occupational accidents suffered by workers.

Despite progress made as regards defining the type of data Member States should report, including types of accidents, in which sectors of activity they occurred, the size of company and the gender of the persons injured, there continues to be a problem as regards under-reporting of accidents in the Member States and, consequently, in the reporting of accidents by the member States to Eurostat's database '**European Statistics on Accidents at Work**' (ESAW).

Eurostat also carries out dedicated surveys which have included the inclusion of modules on safety and health at work in the EU- wide Labour Force Survey in 1998 and in 2007. Much work in gathering information is also done by **EU-OSHA**. Data is

also sourced from national insurance systems, both public and private. Analysis of the available data has informed policy debate.

## **5.2 First results Eurostat's EU-27 Labour Force Survey (LFS) 2007 ad hoc module on accidents at work and work-related health problems of workers aged 15-64 years**

*Introduction: The data (see Annex 111) illustrate that Agriculture, Manufacturing and Construction continue to feature as the most high risk sectors for accidents at work, albeit that Fishing and Mining and Quarrying, previously listed as high risk, are not included in the results since the reliability limit for publication is not satisfied. Except that a dedicated legal instrument does not exist at EU level for Agriculture, these high risk sectors continue to feature large in EU legislation, preventive policies and programmes. Young workers remain the most vulnerable but, in the light both of the aging workforce and the changes in demographics which make it desirable that older workers remain in the workforce for as long as possible, the safety and health of older workers should remain in focus.*

*Musculoskeletal problems remain as the most significant work-related health hazard, followed by the psychosocial issues, stress, depression or anxiety. The European Commission is in the process of consulting the EU Advisory Committee on a new legislative initiative in the area Prevention from Work-related Musculo-Skeletal Disorders (WRMSDs), which, if adopted in due course by the European Parliament and Council, will update existing legal provisions in this area.*

*Work-related health problems account for much more time off work than do accidents and the percentage of workers off work for this reason increases with age.*

### **5.2.1 Accidents at work**

The first results indicated that 3.2% of workers had an accident at work during a one year period, which corresponds to almost 7 million workers. Approximately 10% of these accidents were road traffic accidents in the course of work.

The previous LFS Survey, in 1998, revealed a total number of 7.4 million accidents in the EU-11. Thus, as the EU has grown, numbers of accidents at work have not.

Men are more likely to have an accident than women and accidents occur most often in the youngest age groups. In older age groups, the rate of accidents remains rather stable in women but decreases steadily in men as they grow older.

Accidents at work are most prominent in the sectors Agriculture, Manufacturing and Construction. There is a clear gender difference. Among men, the highest risk is found in Construction, Manufacturing and Agriculture, whereas the highest risk for women is in the sectors Health and Social Work and Hotels and Restaurants.



Skilled manual workers are most likely to have an accident at work. Shift work and atypical working hours increase the likelihood of an accident at work.

### ***5.2.2 Work-related health problems***

The first results indicated that 8.6% of workers in the EU-27, with one Member State not included, experienced a work-related health problem in 12 months, which corresponds to 20 million workers. Bone, joint or muscle problems were most prevalent.

The previous LFS Survey, conducted in 1998, revealed that 8 million people at work in the EU-11 were suffering from health disorders, other than accidental injuries, caused or aggravated by their current or past employment. Thus, work-related health problems have grown as the EU has expanded.

In workers with a work-related health problem, back problems (28%), neck, shoulder, arm or hand problems (19%), and stress, depression or anxiety (14%) are most often reported as the most serious health problems. As regards bone, joint and muscle problems, men are more likely to report back problems than women, whereas women are more likely to report shoulder, arm or hand problems.

The proportion of workers with a work-related health problem increases with age. In the younger age groups slightly more work-related health problems are found among women, whereas in the oldest age group slightly more problems are found among men.

Work-related health problems occur most often in the sectors Agriculture, Mining and Quarrying and Health and Social Work. In Agriculture and in Health and Social Work, women are more likely to experience work-related health problems than men. In both those sectors back problems are reported most often as the most serious health problem. In fact, in all employment sectors, musculoskeletal conditions in general (i.e. bone, joint and muscle problems affecting the back, neck, shoulders, arms, hands, hips, legs or feet) are most often described as the most work-related health problem.

Stress, anxiety and depression are also prevalent in several sectors, most notably in Financial intermediation and Education.

Skilled manual workers are more likely to experience work-related health problems, as are older workers, workers with permanent jobs, atypical working hours or shift work.

### ***5.2.3 Exposure to risk factors***

The first results indicated that 41% of workers in the EU-27, i.e. 81 million workers, feel exposed to factors (postures, movements, heavy loads, risk of accident, chemicals, dusts, noise and vibration) that can adversely affect physical health. The

results found that 28% of workers, i.e. 56 million workers, feel exposed to factors that can adversely affect mental well-being (time pressure, harassment, bullying, violence).

### **5.3 Fatal accidents at work**

***Introduction: The numbers of fatal accidents represent the tip of the accident iceberg; near misses must also be borne in mind. While often used as a rough measure of performance, they should not detract attention from the importance of the bottom-up approach to preventing accidents at work and to melting the accident iceberg.***

Every year, 5,720 workers die in the EU-27 from work-related accidents and illnesses at work. Workers in SMEs are particularly exposed to risk; they account for 82% of all occupational injuries and 90% of all fatal accidents.

Underlying the above figures, some progress has been made based on the strategies and national programmes in place. For example, in the period 2000-2004, fatal accidents at work in the EU-15 fell by 17% while the rate of workplace accidents leading to absences of more than three days fell by 20%. It is noted that, under the Industrial Accident Prevention Plan in Japan for the years 2003 to 2007, fatal accidents fell as well as the numbers of industrial accidents.

### **5.4 The burden and costs of accidents and ill-health at work**

***Introduction: In addition to the considerable number of days lost through absence from work arising from accidents and work related health problems, there are huge costs involved which impinge on Member States' health and social insurance costs as well as on costs to employers through lost production, insurance and replacement costs, all of which damage competitiveness in the global economy. There are significant impacts also on workers and their families.***

The 2007 LFS results show that, among workers who suffered an accident, 73% reported lost work days, with 22% reporting time off that lasted at least one month. Hence, due to an accident at work, sick leave for at least one month occurred in 0.7% of all workers in the EU-27.

Among workers with work-related health problems, 22% experienced considerable limitation in normal daily activities. Sickness absence was reported by 62% and absence for at least one month by 27%. Therefore, 1.9% of all workers in the EU-27 were off work at least one month for work-related health problems. The percentage increased with age.

As an illustration of the costs involved, Eurostat's **Statistical Analysis of Socio-Economic Costs of Accidents in the European Union, 2004 edition**, indicated that, for EU-15 in 2000, costs due to accidents alone were estimated at €55 billion, corresponding to 0.64% of the GDP of about €8,500 billion. Non-accidental work-related health problems probably caused even more losses of working time or costs of

health care. Such problems were estimated in surveys to cause 1.6 to 2.2 times more days of temporary incapacity to work than do accidents at work. There were 2.4 times more people reporting long-standing health problems or disability due to work-related diseases than due to accidents at work. Work-related health problems may, therefore, cause at least two times more temporary and permanent incapacity than accidents at work.

In macro-economic terms, the cost of accidents at work and of occupational diseases in EU-15 was estimated to range from 2.6% to 3.8% of gross national product (GNP). According to some studies, the estimated costs of work-related illness per worker are at least three times higher than the costs of prevention.

In 2000, around 500 million working days were lost as a result of accidents at work (150 million days lost) and work-related health problems (350 million days lost) in EU- 15.

### **5.5 New and Emerging Risks**

*Introduction: Research has helped to better identify risks in the workplace, some of long standing such as musculoskeletal disorders, others which arise from newer technologies and new materials, while others arise from the changing nature of work itself, summarised as physical, biological and psychosocial risks. In the past, it was not until much damage was done and workers began to lose their lives that actions were taken, for instance in the case of asbestos. Prevention policy dictates that constant vigilance and research is necessary to protect against avoidable hazards. The current EU Strategy (see point 9.2) and actions on the part of stakeholders, EU-OSHA etc, are contributing to combating such new and emerging risks, which affect both the safety and health of worker.*

EU-OSHA, in response to the EU Strategy for Safety and Health at Work 2002 - 2006, established a **Risk Observatory** to anticipate new and emerging risks which has published three expert forecasts identifying the following –

***Physical risks** – musculoskeletal diseases, noise, vibration, thermal risks, ionising and non-ionising radiations, machinery, work processes and technologies and various ergonomic risks.*

***Biological risks** – occupational risks related to global epidemics, workers' exposure to antimicrobial-resistant pathogens, occupational exposure to endotoxins, moulds in indoor workplaces, biological risks in the management of solid matter and difficult assessment of biological agents in the workplace.*

***Psychosocial risks** – new forms of employment and job security, the risks for the aging workforce, work intensification, high workload and work pressure, high emotional demands at work, including violence and bullying, and poor work-life balance.*

**EU-OSHA** has, in addition, published information on research on emerging risks relating to chemical risks, biological risks, physical risks and organisational, social and human risks as well as national data on specific topics, including absenteeism, hearing loss, noise exposure, the pace of work and working time, and on occupational diseases and dermal exposure.

A recent presentation made to the Government members of the Advisory Committee listed several other emerging issues which could impact on safety and health at work:

- The inter-action between humans and autonomous robots
- Increased workplace monitoring to improve worker performance and avoid accidents
- Growth in the number of micro-tagged workers
- The increased use of drugs to enhance work performance
- The use of bionic limbs to allow older and disabled workers to continue or enter areas of employment currently closed to them
- Growth in synthetically created organisms
- Sustainable chemical production using bacteria
- Increased use of nanomaterials

Account has been taken already, from a policy perspective, of many aspects of the identified new and emerging risks in the legislative and advisory measures taken at EU level. Some topics are, as indicated in point **9.2** below, included for action in the **EU Strategy for Safety and Health at Work 2007 – 2012** and the related current **Action Programme**.

Taken with the available guidance on risk assessment and the Good Practice models published by **EU-OSHA** and in the individual Member States, employers and workers and their representatives have a good foundation on which to base risk assessment and preventive measures.

Several of the issues identified at EU level as being new or emerging risks feature in the Accident Prevention Plan in Japan. As regards physical risks, industrial accidents due to machinery and back injuries are mentioned, in addition to the traditional accidents resulting from slips, trips and falls. Reference is made in the Plan to new communicable diseases, including new strains of influenza and the need for crisis-control structures.

In the context of psychological risks, under the interesting heading “Industrial Health Activities, Health Promotion and Creating Comfortable Worksites”, the effects of overwork leading to high blood pressure, heart disease and other conditions, including stress are referred to. Comfort in this context embraces engineering measures related to the ambient environment and thermal conditions, as well as software issues such as human relations in the workplace, and preventive measures as regards second-hand smoke.

## **5.6 Trends in working conditions – EUROFOUND’s Fourth European Working Conditions Survey 2007**

*Introduction: There is now recognition that the state of workers’ safety and health can be profoundly affected by working conditions, working time, patterns of employment, the organisation of work and of working time, by changes in the nature of work, by the extent to which physical risk factors are present in the workplace and by the increasing incidence of violence, harassment and discrimination in the workplace. Other factors include management and communication structures, work-life balance and levels of satisfaction with working conditions. Trends in these areas have been reported on comprehensively and both negative and positive aspects highlighted. There are regional and sectoral differences within the EU. For instance in the area of autonomy which can reduce stress levels, half of workers in northern EU Member States can choose or adapt working time to their needs while more than 75% of workers elsewhere have no possibility to adapt their work schedules. These are complex matters, all of which would not easily lend themselves to legislative solutions, nevertheless negative aspects need to be taken account of in policies and programmes and in national strategies or at EU level, as appropriate. The social partners will need to play their part.*

The **Fourth European Working Conditions Survey**, published in 2007, carried out by **EUROFOUND**, measured trends in working conditions in the context of promoting employment and improving living and working conditions with the aim of improving quality of work in Europe. In measuring working conditions, it was important to consider a range of different aspects related to job characteristics and employment conditions, safety and health, work organisation, learning and development opportunities and the balance between working and non-working life, as illustrated below. The survey was carried out in 2005 in 31 countries: the EU-25, Bulgaria and Romania, which are now EU Member States; two candidate countries, Croatia and Turkey; and Norway and Switzerland. The survey report contains a great deal of relevant information as regards the challenges to be faced and models for achieving healthier workplaces.

### **5.6.1 The employment situation**

About 235 million people were employed in the 31 countries surveyed. In the EU-27, 50% of workers were concentrated in 5 countries (Germany, the UK, France, Italy and Spain. Nine countries had an unemployment rate of more than 10%, while in nine others it was below 6%. There was a gender employment gap of less than 10% in eight countries and a gap of more than 20% in seven other countries. There were different levels of use of temporary employment contracts as well as divergences in the use of part-time work. In seven countries, more than one in five workers worked part-time; in 13 others, fewer than one in 10 worked part-time. In 12 countries, more than one woman in 3 works part-time, while in 7 countries the figure is less than one in ten.

These differences in the labour market have implications for working conditions. They need to be noted along with legal, social, economic and cultural differences between the various countries.

In the EU-27, more than 66% of workers are employed in the services industry; 29% work in manufacturing and 5% in agriculture. The biggest employers are the manufacturing industries (19%), the wholesale and retail trade (16%) as well as health (10%) and education (7%). The trend since 1991 towards declining employment in manufacturing and agriculture continues as has the corresponding increase in employment in services. Employment in agriculture varies a lot between countries; more than 10% in 4 countries and over 30% in two countries surveyed. Workers in agriculture, 48% of whom are self-employed, are particularly exposed to physical risks and long and non-standard working hours but have more autonomy for decision-making. Manufacturing employs greater numbers in the newer Member States to the east of the EU.

In the EU-27, white-collar jobs account for 62% of workers, while 38% of workers are in blue-collar jobs. In 9 Member States, high-skilled white-collar jobs account for 40% of employment. In Europe, 85% of workers work in SMEs employing less than 250 workers and 15% in large enterprises, with 38% in companies employing up to 9 workers. Nearly 7 out of 10 people are employed in the private sector; 25% work in the public sector. In Europe, 11% of workers are self-employed, with the greatest concentration in agriculture; a further 5% are self-employed with employees. The typical self-employed person is an older male worker who, except for agriculture, is less skilled than the rest of the workforce. The majority of jobs are men's full-time jobs (52%) with women at 32%. Male and female employment is almost equally concentrated in 4 sectors, including manufacturing and wholesale and retail in both cases.

In the EU-27, 17% of all jobs are part-time and are mainly held by women; 29% of women work part-time compared to 7% of men; 25% of fixed-term workers and 37% of temporary agency workers work part-time. Part-time work is less common for skilled workers than unskilled. In the context of work life balance, 57% of part-time workers are satisfied with their working hours. Part-time work for women increases with age while it is more common among young and older male workers. Between 2000 and 2005, 43% of new jobs created were women's part-time jobs, which has helped women in particular to better reconcile work and outside responsibilities.

In EU-27, 78% of workers hold indefinite employment contracts; 12% have fixed-term contracts and only 2% hold temporary-agency contracts, mainly in hotels and restaurants and by unskilled workers. In EU-27, 7% of employees have no employment contract.

The typical European worker is 40 years old, finished full-time education by age 18 and has spent 10 years in the current job but with 25% of employees, mainly

young workers, in hotels and restaurants spending 1 year or less in their job. Just 3% of workers were not citizens of the country in which they worked and were mainly employed in construction and other services. Over half of households (55%) have two wage earners.

### **5.6.2 Working time**

The length, scheduling and organisation of working hours are important as regards the quality of work and balancing work and life. Since 1991, there has been a trend in the EU towards a reduction in paid working hours. There were differences between the 31 countries surveyed, with southern and eastern countries having the longest hours, with implications as regards satisfaction with working conditions, while central and northern countries had the shortest hours. Most workers in most countries worked 40 hours and 5 days a week. In one country with a high proportion of workers in agriculture, 50% of workers worked 7 days a week and 75% worked 6 or 7 days a week. Managers and agriculture workers most often work more than 48 hours.

The proportion of workers complaining that they rarely or never have enough time to get their job done is higher for those working very long hours. They also feel that working long hours may increase health and safety risks. Twice as many workers working more than 48 hours weekly than those not consider their safety and health at risk and that their job affects their health. The greatest negative effect of long working hours is on work-life balance, with 3 times as many such workers than others feeling that working hours conflict with their social and family commitments. However, half of them benefit from being in the top three income categories.

### **5.6.3 Non-standard working hours**

The survey results do not point to any increasing diversification of working hours or a trend towards a 24-hour society. The proportion of workers working outside normal hours has slightly decreased since 1995. Evening work is more widespread than night work, which is low in most countries except the Member States to the east, where 25% of the population are affected. Atypical work schedules are mainly found in hotels, restaurants, agriculture, transport and communication.

### **5.6.4 Organisation of working time**

More than half of all workers work the same number of hours every day, with fixed starting and finishing times and the same number of days every week. There are differences, with more flexibility in northern Member states than in southern.

Shift work is important to companies where there are high fixed costs, such as in manufacturing involving expensive machinery, or where time worked has to match demand, as in services. It has a large impact on individual working conditions. In health, about one third of workers work shifts. In hotels, restaurants, manufacturing and transport, one in every four is a shift worker.

While hours worked are quite standard, shift workers have much less autonomy as regards changing the order of tasks, methods and rate of work. There is a higher feeling of risk at work, a higher level of negative health outcomes and dissatisfaction with working conditions.

As regards autonomy over working time schedules, in northern EU Member States around half of workers can choose or adapt working time to their needs. More than 75% of workers in the other countries have no possibility to adapt their work schedules.

In commenting on working time, the survey took account of the impact of the time spent by workers in the main paid job, where there was more than one paid job, commuting time and unpaid work (such as household duties and caring for children and adults). This showed a huge difference in the working hours of women and men when unpaid work is taken into account. While men work longer hours than women in paid employment, women work more hours than men when paid and unpaid work hours are combined. While part-time work is regarded as family-friendly, male part-time workers spend less time at unpaid work than male full-time workers. Women part-time workers use time saved to carry out unpaid work. Female part-time workers work more hours in total (56) than male full-time workers (54) and the total working hours of women who work full time are the longest, at more than 65 hours per week.

#### **5.6.5 Physical risk factors**

Despite a decline in traditional, physically demanding sectors such as manufacturing and agriculture, some physical risks are still prevalent and changes in levels of exposure to most work-related physical risks tend to be small from one survey to another. Improvements tend to be gradual but with countervailing trends. Trends for most physical risks remained within a narrow range since 1990. The proportion of workers exposed to repetitive hand or arm movements at least one quarter of the time has increased over the last 5 years. This is also the most commonly cited physical risk, with 62% of the working population reporting exposure.

One in five workers continues to be exposed to breathing in smoke, powder or fumes. Nearly one in two workers works at least a quarter of the time in painful or tiring positions. There was a small decrease in exposure to radiation, handling of chemical products or substances and breathing of smoke, fumes, dust or powder. Exposure to vibrations and noise has increased since 2000.

The report states that “While 15 years is a relatively short period in terms of evolving employment structure, it might have been expected that the workplace changes that have take place during this time would generate improved working conditions, especially in terms of a significant decrease in the over all incidence of workplace physical risks”.



New survey questions related to tobacco smoke, infectious materials and standing or walking. One in five workers are exposed to tobacco smoke at least a quarter of the time, dropping to 7% for those exposed all or nearly all of the time. Men are more exposed than women. There were wide variations by Member State with countries which have national legislation restricting or banning smoking in the workplace showing the lowest levels.

Nearly one in 10 workers are exposed to infectious materials such as waste, bodily fluids and laboratory materials at least a quarter of the time, with women more exposed than men, including in health and social work.

While standing or walking are healthy activities, extended periods can predispose a worker to physical risk, including musculoskeletal problems or fatigue. On the other hand, as reported by **EU-OSHA**, sedentary work can lead to increased health risks related to physical inactivity, such as high blood pressure and obesity. Almost 75% of workers work while standing or walking at least a quarter of the time while 43% do so all or nearly all of the time. Workers under 25 years of age do most standing or walking. More women (30%) than men (25%) never, or almost never, stand while working. There are sectoral differences, with 4 out of 5 workers in hotels and restaurants standing or walking all or most of the time.

In general, more men than women are exposed to traditional physical risks, such as noise and vibration. Ergonomic risks are more gender neutral. Female workers are more exposed to certain risks, such as infectious materials and in jobs involving lifting or moving people, reflecting sex segregation in sectors such as health and social work. When combined physical risks are present, men, especially young men, are more exposed than women but exposure diminishes with age.

By occupation, craft and related trade workers, plant and machine operators and skilled agricultural and fishery workers are most exposed. There is a clear differentiation in terms of blue-collar and white-collar workers. The construction sector has the highest level of exposure to each set of risks, followed by agriculture and manufacturing. Workers in hotels and restaurants perceive high levels of ergonomic risk but low levels of biological and chemical risks. Workers in the health sector report high levels of biological and chemical risks but very low levels from noise or temperatures.

The survey reported a correlation between the levels of exposure to the most commonly reported risk – repetitive hand or arm movements – and health problems such as muscular problems in the shoulder, neck or limbs and backache, although the majority of workers exposed all of the time did not report that they suffered from each of these problems. The presence of a ‘healthy worker effect’ may have reduced reporting as workers with a major negative health effect may have left the workforce, something which is often borne out anecdotally.

Workers in the recently joined Member States say they are better informed about workplace risks than in the EU-15 and 15% of EU-15 workers say they are not well informed. Workers in bigger organisations or on indefinite contracts were generally well informed. There was an increase in the proportion of EU-15 workers wearing protective equipment in 2005 (32%) compared to 2000 (28%).

#### **5.6.6 Violence, harassment and discrimination in the workplace**

National working conditions surveys have highlighted a trend towards the increasing incidence of psychological health problems cited as the basis for work-related health problems. Contributing factors may include bullying or harassment, violence or the threat of violence as well as discrimination. These forms of behaviour can have damaging effects, not only on the individual's well-being and performance of the person targeted but also on the collective psychosocial work environment and overall organisational and economic performance.

Subject to the qualification on under-reporting below, the relatively small percentages reported reveal these issues to be the exception rather than the norm. One in 20 workers was exposed to bullying or harassment in the 12 months prior to the survey, with a similar number exposed to violence. Women (6%) are more subject to bullying and harassment than men (4%) and younger women are at greatest risk (8% of those under 30 years old). Workers in establishments employing over 250 workers report the highest levels (8%), with workers in education, health, social work, hotels and restaurants reporting most. There may be under-reporting as it could be that many workers subjected to serious physical or psychological abuse are no longer working or may be out of the workforce suffering ill-health. Only about one in 100 workers experienced discrimination (religion, ethnic origin or sexual orientation) but there could be a much higher incidence in groups potentially affected.

In many sectors where physical risks are high – agriculture, construction and manufacturing - relatively low levels of violence and harassment are reported. The reverse also applies, with workers in the health sector eight times more likely to experience threats of physical violence than in manufacturing. Overall, 6% of public sector workers who have a higher level of interaction with people, report bullying or harassment compared to 4% in the private sector.

Workers affected by violence or harassment report four times higher levels of work-related ill-health, including psychosocial factors such as sleeping problems, anxiety and irritability, than those not affected. They also report physiological symptoms, notably stomach ache, at a higher level, as well as higher levels of stress. Overall, 23% of workers were absent from work due to health problems in the 12 months prior to the survey, with 7% attributing at least a proportion of the absence to work-related causes.. Workers exposed to psychosocial risks were significantly more likely to report absence due to work-related ill-health. They also have longer periods of absence.

Exposure to violence increased from 4% to 6% in the EU-15 from 1995 to 2005. A higher proportion of workers (6%) were exposed to threats of violence than to actual acts of violence. More bullying, harassment and violence was reported in northern Member States than in southern. More workers are affected by violence from people outside the workplace (4%) than from fellow workers (2%). White-collar workers are more exposed than blue-collar to risks related to violence, harassment and discrimination (6% compared to 4%).

Even though the levels of bullying, harassment and violence at work may be lower than those presented by physical risks, their impact on both workers and employments may be greater. The promotion of better human relations in the workplace could help to prevent these phenomena

### **5.6.7 Changes in the nature of work**

The report looked at where work is carried out, the increasing use of information technology at work and at on-the-job-learning.

In EU-27, as may be expected, 60% of workers work all or almost all the time at company premises while 10% work all the time or some of the time (2%) from home. Around one third of workers in education work mainly or significantly from home. There is less variation in the weekly working hours at company premises than in working from home which is much more flexible. Those who work from home are considerably more satisfied with their work-life balance than all other workers. Those who work outside and in other places are least satisfied.

The use of technologies at work has been going through a radical process of change in the past two decades, primarily in the use of information technology (IT) in advanced economies. The survey recorded significant use of IT and the internet amongst 37% of EU workers, compared to 23% of workers who work with machinery and with a further 10% using both IT and machinery. The work of 30% of workers was not significantly determined by either IT or machinery. Countries with a higher proportion of workers using IT are also the countries with less use of machinery and vice versa. Northern Member States score highly for IT use but have little use of machine technology while most eastern and southern Member States are the opposite.

The use of IT is above the EU average in financial intermediation, real estate, public administration, education, health and utilities. In construction, manufacturing and agriculture, work consists largely of the use of machinery. More women than men use IT. Reflecting sectoral composition, men use machine technologies more than women. The use of IT increases with the educational level.

IT work reflects better working conditions; the use of machinery reflects poorer working conditions. Work determined by machinery is traditionally more repetitive and monotonous, with less autonomy and is physically – and sometimes

psychologically - more demanding. This has an impact on the occupational health risk of workers. It results in much higher levels of musculoskeletal disorders and more exposure to workplace risks. The use of machine technology also results in slightly higher levels of stress. Those working with IT are more optimistic about the possibilities for career progression than those working with machines or without IT.

Employability – a key concept in the **Lisbon Strategy** (see point **9.1** below) – depends on a worker continually updating skills, both to progress in the current job and to retain the flexibility to find another job, so as to ensure greater employment security. Access to training for new skills is particularly relevant in the current economic situation in which jobs are being lost by workers. Work which makes cognitive and intellectual demands provides opportunities to develop cognitive and intellectual skills. Looked at by sectors and occupations, some show fairly high cognitive demands and others quite low ones, which often involve monotonous and repetitive work. Higher skilled workers are better placed as regards cognitive demands and professional development than unskilled workers at work.

Less than 30% of workers received any type of training at work in 2005. The levels of training in the EU did not increase in the preceding 10 years. In some northern Member States more than 50% of workers received training at work while in eastern and southern countries fewer than 20% of workers received training. Training is much higher in public administration, finance, education and health but lower in hotels, restaurants, agriculture, construction, retail and manufacturing.

#### **5.6.8 Work organisation, autonomy, intensity, pace of work**

The survey revealed that a high proportion of workers enjoy some control over the work process and can take a break when they wish but just one-third had any influence over the choice of working partners. There are north/south, sectoral and occupation divides in levels of autonomy at work. The use of IT at work is associated with a higher degree of autonomy in comparison with the use of machine technology or no technology.

In the EU-25, 50% of workers rotate their tasks with colleagues and 60% do part or all of their work in teams, reflecting differences between ‘traditional’ and ‘new’ forms of work organisation. However, the levels of autonomy and decentralisation of decision-making in teams is lower than in work organised around task rotation. The health sector displays the greatest prevalence of the advanced forms of work organisation involving functional flexibility and teamwork, with transport and communications showing the least. Professionals, managers and skilled workers benefit most from these forms of work. In construction, the nature of the work entails teamwork and task rotation.

According to 68% of EU workers, the direct demands of people most determine the pace of work – understood as *market* constraints. By contrast, the automatic speed of a machine, an *industrial* constraint, affects only 19% of EU workers – a proportion which decreased over the previous 15 years. Shifts in the economy and the growth in services have brought change. In addition, work done by colleagues and numerical and production targets affect the pace of work, more so now than the control exercised by superiors. There are sector and country differences.

Workers whose pace of work is determined by the automatic speed of machines or by production targets are more likely to have health problems, to see work as more intensive and stressful and to enjoy less autonomy at work. Workers whose pace of work is determined by direct demands from people have higher levels of psychological health effects.

One of the clearest trends over 15 years was the rise in the levels of perceived intensity of work in almost all Member States. Four categories of work organisation were identified as follows and found primarily in the sectors, and in the Member States, indicated, with other countries in marginal positions:

- *active work organisation* (high demands, high control, most conducive to performance and without negative consequences for working conditions) (managers) (Nordic countries),
- *high-strain work organisation* (high demand, low control, job demands causing stress, low levels of autonomy, most negative impact on working conditions) (skilled and semi-skilled industrial occupations and workers in hotels, restaurants and in manufacturing) (Cyprus, Czech Republic, Germany and Greece),
- *low-strain work organisation* (low demands, high control, high productivity levels, indicating that low-strain does not mean low performance) (professionals, financial and public administration) (Belgium, Luxembourg and Netherlands) and
- *passive work organisation* (low demands and low control, most negative implications for performance) (unskilled, service and retail workers) (Bulgaria, Poland, Portugal and Slovakia).

### **5.6.9 Impact of work on health**

Research shows that people at work tend to be in better health than the general population (the ‘healthy worker effect’) but looking at the perceived impact of work on health, 35% was the EU-27 average in response to the question ‘Does your work affect your health?’, with eastern Member States reporting the highest levels of work-related health impact. Agriculture stood out as having a much higher impact, with construction, manufacturing, transport, health and education being higher than average. Self-employed workers perceived higher levels of work-related health problems. The levels of physical and psychological factors were different as between countries, sectors and occupations. Some countries

reported lower than average levels of both physical and psychological health impacts.

The most often quoted symptoms were musculoskeletal disorders (backache and muscular pains), followed by fatigue, stress, headaches, and irritability. Problems with eyesight, hearing, skin and respiratory problems were mentioned by fewer than 10% of workers. The survey indicated that health-related leave is a complex phenomenon dependent on various factors such as working conditions, individuals' health and regulatory systems. A correlation was not found between how work impacts on health and health-related leave.

#### **5.6.10 Management and communication structures**

Employee consultation and participation in decision-making in the workplace is a defining feature of the EU economic and social model. The survey looked at the extent of communication at different levels in workplaces and how it was organised.

In EU-27, one in five workers had discussed work-related problems with employee representatives in the previous 12 months; 30% of whom were in eastern Member States and in Ireland and the United Kingdom compared to 19% in continental and southern Member States. Workers in bigger companies and in public services had more communication with employee representatives.

As regards workers interacting with their superiors, the lowest levels were found in southern Member States with the higher levels of direct contact ranging between 70% and 50% elsewhere. In addition to discussions on performance and work-related problems, consultation took place on changes in work organisation and working conditions, in Scandinavia at a rate of 70% and 40% in southern Member States. Almost 70% of senior managers were consulted, compared to less than 40% in all blue-collar occupations.

#### **5.6.11 Work-life balance**

Four out of five of EU workers were satisfied with how their working time arrangements fitted in with their non-work commitments; 85% in the case of workers working fewer than 30 hours per week, dropping to 40% when working more than 45 hours per week. Dissatisfaction with work-life balance ranged from 11% in some countries to over 40% in a country in which long hours were worked.

While debate has centred around the pressures on working women, including working mothers, men, including fathers, report more dissatisfaction with work-life balance, explained by the high incidence of part-time work among women and the low incidence for men. Men with children work less part-time work than those without. Parenthood for women implies an increased incidence of part-time work. Fathers work longer as parental responsibilities grow. These trends contribute to the growing incidence of 'one-and-a-half' worker households. A

longer working week and changing social expectations regarding the domestic role of fathers may contribute to their relative dissatisfaction with their work-life balance.

Despite more women working, the traditional division of domestic responsibilities remains. On average, men work longer hours in paid jobs but women work longest at paid and unpaid work – in that sense their work and life are ‘balanced’ in particular between ages 25 and 54.

New communication technologies (phone lines, mobile phones, and broadband/internet) are extending working hours by stealth, resulting in negative flexibility; working long hours is associated with higher levels of contactability outside work.

Consistent and regular work schedules and regular flexible working-time arrangements lead to greater satisfaction with work-life balance. Working non-standard hours (evenings, weekends or at night) gives lower levels of satisfaction as do imposed flexibility. Those most empowered to, themselves, determine working hours, including self-employed, expressed most dissatisfaction with work-life balance but this is influenced by the long hours worked rather than the control over working time.

#### **5.6.12 Satisfaction with working conditions**

‘Quality of work’ is a theme in the **European Employment Strategy** but it is more difficult to measure than indicators such as working hours or exposure to risk – and workers are predisposed to report high levels of satisfaction with their job. Workers in EU-15 have reported high levels of satisfaction since 1995. In the 2005 survey, EU-15, except for some southern Members States most reported above EU average. National levels of satisfaction seem to follow standard measures of national wealth, with higher levels in countries with higher GDP.

The minority of workers dissatisfied with work includes younger men, blue-collar and public sector workers, those on fixed-term or agency contracts and those with lower levels of educational attainment. Long or non-standard hours, high levels of work intensity, low levels of job control and exposure to risks to health and safety contribute to dissatisfaction with working conditions.

#### **5.6.13 Survey conclusions**

Point 6 which follows looks in greater detail at demographic issues but the survey already illustrates the ongoing policy challenge presented by the gradual aging of the workforce. It underlines the importance of improving and developing working conditions to enable older workers to remain in the workforce for as long as possible and to facilitate the career progression of younger workers.

Women have increased their participation in the workforce; they are still in a majority in health, education, other services, hotels, restaurants and wholesale and

retail and changes in the working conditions, along with advancing equal opportunities policies, would impact considerably on the quality of work and employment for women. Against the backdrop of an aging population, it will be important to reflect on the duration, times and predictability of work with a view to improving work-life balance both for women and men.

A declining proportion of EU workers consider their safety and health at risk at work but problems persist as regards musculoskeletal disorders, fatigue, stress, headaches and irritability. Work intensity is on the increase. There is increasing use of information technology. Access to training has not improved highlighting a barrier to the policy of encouraging lifelong learning.

## **6. Demographic and related aspects of safety and health at work**

*Introduction: In addition to coping with levels of accidents and ill-health at work, both EU, and Japanese, policy-makers in safety and health at work are faced with common threats, and opportunities, from increasing life expectancy, ageing workforces, falling birth-rates, the increased participation of women in employment, changes in the numbers of workers employed in the various employment sectors, and atypical employment patterns. Falling birth-rates and the ageing workforce, in particular, emphasise the importance of ensuring that older workers remain safe and healthy at work so as to continue to contribute to employment levels. This is to the background philosophy that safety and health is a human right and that work should be such that a worker can both return home each day and, eventually retire in a safe and healthy condition.*

*As illustrated in the LFS Survey for 2007, accident levels tend to decrease with age. For that reason, there is not, at EU level, any specific legal instrument focussing on physical safety for older workers. Instead, the general body of Directives apply as appropriate. The situation is the reverse as regards work-related health problems, which are shown to increase with age, with, for all ages, musculoskeletal problems affecting both men and women the most. As mentioned already, the EU Commission is consulting the Advisory Committee on a proposal for a legislative initiative on ergonomics. The EU Commission, EU-OSHA and EUROFOUND have helped identify the hazards faced by older workers which will inform future policy-making.)*

According to the report on the **Social Situation in the European Union 2005-2006**, published by the European Commission, from 1960 to 2000 the average life expectancy at birth for EU-15 rose from 70 to 78 years (from 65 to 75 for men and from 73 to 81 for women), which was an increase in longevity of 8.2 years. This was the result of improved living conditions and medical progress. The values in the newer Member States are somewhat lower than in the Member States which joined earlier due to economic transition and lifestyle factors.

Given that improvements in living working conditions and in health care have led to increases in average health at any given age, the average capacities of older people



today are larger than those of similarly aged people than, say, 50 years ago. It is important for policy makers to take account of such changes.

For decades Europe benefited from having a large share of its population in the working-age span due to several decades of high fertility, resulting in the large numbers of so-called baby-boomers. The decline in fertility levels, which from the 1960s signalled the end of the baby boom, has by now produced an age pyramid in which the proportion of people of working age is declining fast while the proportion of older people is rising. The next three decades can be expected to be a period of profound and rapid demographic change.

The fertility rate has been in steady decline since the mid-1960s and it is now around 1.7, which is well below the level of 2.1 children per woman required to renew the generations. The fertility rates differ between the Member States reflecting national policies and trends. The driving forces behind ageing in the EU are reflected in a number of common concerns –

- There are fewer marriages and non-marital cohabitation is more common
- Marriages are occurring later
- Couples have children later in life
- Couples are having fewer children
- There are different regional fertility trends and fertility has fallen most in Member States which traditionally had the highest rates
- There are more marital breakdowns
- Births outside marriage continue to increase
- There is an increasing number on one-parent households, which are at risk of poverty and social deprivation.

Family and household patterns are being influenced by changing attitudes and life styles. Young people are staying longer in the parental home. Older people are more likely to live alone. Fertility may be linked to the ability to reconcile careers and family life.

Encouraging increased participation in the labour force is likely to be the best response to the demographic challenge, including of older workers and women.

The question arises as to how female labour force participation may be increased while improving current fertility trends at the same time. A major factor appears to be that of reconciling work and private life but the shift to the two-breadwinner model is not yet fully reflected in the time-use patterns of men and women and the limited contribution to domestic and parental tasks made by men. There are signs in some countries that better educational attainment for women is linked to improvements in fertility and that countries with a higher proportion of women in the labour market can demonstrate higher fertility rates.

In 2001, the **European Council** undertook to raise the average employment rate in the EU for men and women within the 55-64 age groups to 50% by 2010. In addition, in 2002, the **European Council** concluded that a “progressive increase of about five

years in the effective average at which people stop working in the EU should be sought by 2010". The way in which work is organised today, alongside safety and health measures at work, can help to achieve this by ensuring wellbeing at work, maximising the ability of individuals to work and discouraging early withdrawal from the labour market.

The major changes in the population structure and fertility will have important implications in the coming decades and will require concerted and long term policy action in a variety of policy areas, especially in the field of employment and social policies, including social protection, health, immigration, equal opportunities for men and women and education, training and life-long learning. It will, for instance, be important to adapt workplaces and employment patterns to the needs of older workers and people with health impairments who are undergoing rehabilitation to the workforce, in a way which will continue to protect their safety and health at work so as to maximise their contribution to the EU economy.

## **7. The current economic challenge**

***Introduction: Many EU Member States, along with the other major economies, are grappling with economic downturn and financial systems failures, which may prove to be cyclical but which present additional challenges as regards ensuring safety and health at work. EU-OSHA has warned that companies should think carefully before cutting back on their investment in occupational safety and health; there is no point in making short-term gains at the cost of long-term problems. The more safe and healthy workplaces are, the more productive they tend to be.***

A presentation made recently to the Government Interest Group of the Advisory Committee speculated on the possible direct impacts of recession on safety and health at work. Reduced employment could result in fewer injuries and cases of ill-health, but rates may not change. A typical recession (GDP 08% below a boom level) in a cyclical pattern could reduce major injury rates by up to 11%.

The strongest effects could be on the levels of injuries in construction (contributed to by the impact of economic slow-down on housing development), manufacturing, public administration and education. Falling exchange rates could boost manufacturing through increased exports, resulting in smaller reductions in injuries. Recession could also impact on safety and health management, with enterprises cutting costs and giving lower priority to issues not regarded as essential, such as health promotion at work. Employers wishing to remain competitive may be reducing the workforce, putting greater pressures on remaining workers.

On the other hand, public policy responses could include greater financial support particularly for SMEs. In addition, increased regulation of the financial sector could lead to changed attitudes to regulation generally, including the regulation of safety and health at work.

It will be important to try not to lose the gains already made in safety and health in the face of the economic challenge and to maintain levels of competence as regards the prevention of accidents and ill-health at work.

#### **8. The data and trends illustrate the major challenges**

*Introduction: Despite progress made, the numbers of accidents continuing to take place at work are unacceptable from the perspective of workers and their families; they cause immense pain and suffering, threaten livelihoods and result in long-term ill-health for many. The costs involved are unsustainable, especially in the current economic situation. Employers face costs linked to sick pay, loss of productivity and replacement of absent workers, which can have a negative impact on the competitiveness of an enterprise. Just a small proportion of the costs of accidents are insurable and many losses are uninsured. SMEs are particularly affected as they account for 82% of all injuries at work. Key workers cannot be easily or quickly replaced and short-term interruptions of business can lead to loss of clients and contracts.*

*Real challenges continue to exist as regards reducing numbers of accidents, and ill-health, in small enterprises, in the high-risk sectors, amongst young workers and in the face of new and emerging risks. Risk assessment is critical as regards prevention.*

*Changes in demographics, lower birth rates, the end of the baby boom generation, the aging workforce are real challenges for the future.*

*Working conditions impact on safety and health and on work-life balance. There are not 'one size fits all' solutions across all of the Member States because of the differences which exist as between them, yet there is enough common ground on which to base centralised policies. On the other hand, there is more commonality across the Member States as regards the emerging effects of changing demographics, including the aging workforce and lower fertility rates, which will greatly facilitate the adoption of common policies.*

*The framework for making improvements in safety and health at work, including legislation, guidelines, good practice models, is largely in place. Some encouragement can be taken from previous progress. A more focussed and dedicated effort is needed however as regards targeting the achievement of lower levels of accidents and ill-health arising from work, and which involves all of the stakeholders. The strategies and other measures discussed under point 9 illustrate current programmes aimed at achieving this.*

### **D THE STRATEGIC WAY FORWARD**

#### **9. Strategic approaches to safety and health at work**

*Introduction: The safety and health of EU workers remains a key policy area at EU level and is given recognition at levels ranging from the legal base in the Treaties, to the Directives in place, to the Social agenda and its implementing instrument, to the role of the social partners through social dialogue, to the EU Strategy on safety and health at work, overseen through the advisory role of the tripartite Advisory Committee, the annual Action Programmes of the Advisory Committee and the significant contribution of the Member States' national strategies. Policies and programmes deal with the various issues raised at the beginning of this paper under the headings safer workplaces and healthier workplaces. It will be useful to explore the individual subtopics in greater detail in the course of the Symposium.*

## **9.1 General**

There is coherence in the broad EU policy framework to the strategic approach which applies to policy related to safety and health at work. At the highest level, the so-called **Lisbon Strategy** was adopted in March 2000 by the European Council. This embraced a commitment to bring about economic, social and environmental renewal in the EU. It set out a ten-year strategy to make the EU the world's most dynamic and competitive economy. Under the strategy, a stronger economy will drive job creation alongside social and environmental policies that ensure sustainable development and social inclusion. The Lisbon Strategy touches on almost all of the EU's economic, social and environmental activities.

Under the Lisbon Strategy, the Member States have acknowledged, in the review processes in place, the major contribution that guaranteeing quality and productivity at work can play in promoting economic activity. Any lack of protection to ensure safety and health at work will result in absenteeism from accidents and illnesses at work and can lead to permanent disability. This not only has a human dimension but also gives rise to enormous economic costs which have a major impact on the economy. These costs can inhibit economic growth and negatively affect the competitiveness of businesses. A considerable share of these costs falls on social security systems, on national health systems and on public finances.

Under the social pillar of the Lisbon Strategy, the **Social Agenda 2005 – 2010** is aimed at investing in human resources and combating social exclusion in the context of policies on employment and social affairs. Member States are expected to invest in education and training and to conduct an active policy for employment, making it easier to move to a knowledge economy.

In support of the employment and social affairs policies enshrined in the Social Agenda, **PROGRESS 2007 – 2013**, the Community Programme for Employment and Social Solidarity, contributes financially to implementation of the objectives. This includes supporting the improvement of the working environment and working conditions, including safety and health at work and reconciling work and family life. The EU uses the term 'working conditions' to cover a series of important policy areas affecting working life, including –

**labour law** – setting minimum standards for improving working and employment conditions and the information and consultation of workers, including the ‘social dialogue’ as referred to in point 3.2 above,

**restructuring** – equipping people to cope with change, anticipation restructuring and encouraging new enterprise in the face of increased global competition,

**improving working conditions** – focussing on well-being at work and stimulating prevention so as to respond to new risks such as stress, and

**safety and health at work** – supporting the legislation in place, as referred to in point 4.2, with information, guidance, as in the reference to Guides in point 4.4, and promotion activities to highlight healthy working, in cooperation with EU-OSHA and EUROFOUND.

The above sequencing of policy developments led to the adoption of the current EU strategy document on safety and health at work – **Improving quality and productivity at work: Community strategy 2007-2012 on health and safety at work** – succeeding the previous strategy for the years 2002-2006.

The evaluation of the Strategy 2002-2006 concluded that it had succeeded in relaunching prevention policies at national level, presenting coherent and convincing arguments in favour of partnership to achieve common objectives and obliging interested parties in the prevention field to give strategic consideration to how these objectives might be achieved. The strategy had raised public awareness of the importance of safety and health at work by presenting them as integral parts of quality management and as determining features of economic performance and competitiveness.

It was clear that efforts must be continued and stepped up in order to promote health and safety over the next period.

## **9.2 The EU Strategy on safety and health at work 2007-2012**

The goal of the Strategy 2007-2012 continues to be to involve all players in achieving modern, effective and efficient health and safety for Europe, which will reduce the accident and ill-health record and be positive for employability and for business. The Advisory Committee delivered a favourable opinion on the Strategy. The main objective is to obtain a continuous, sustainable and homogeneous reduction of accidents and diseases at work by:

- fostering the development and implementation of coherent national strategies;
- keeping the body of legislation suitable for the changing world of work;
- stimulating commitment and motivation on the part of more employers and workers;
- adopting a new approach to occupational health in the context of demographic trends;

- improving the monitoring of progress.

An overall objective was set in the Strategy of a 25% reduction in the incidence rates of accidents at work and occupational diseases at EU level during the period 2007-2012. If achieved, through downstream measures in the individual Member States, it would save 137.5 million work days which would be otherwise lost through accidents and ill-health at work and reduce costs to employers, workers, insurers, medical and social insurance costs and lost output.

The Accident Prevention Plan in Japan has set targets to:

- reduce fatal accidents by 20% or more between 2007 and 2012;
- reduce injuries by 15% or more in the same period;
- promote measures to ensure workers' health and to stop the increasing trend of workers ill-health.

In preparing the ground for the Strategy, the European Commission argued that, in order to consolidate a culture of risk prevention, it was necessary to combine a variety of policy instruments, such as legislation, social dialogue, progressive measures and best practices, corporate social responsibility, economic incentives and mainstreaming. Member States should develop national strategies and set targets. As comprehensive legislation is in place, action would focus mainly on updating and simplifying existing legislation without lowering standards and producing supportive guidance. Policy should also encourage reintegration of the disabled into the labour market, supporting the contributions of older and young workers and addressing the needs of migrant workers. The aim should be to reduce the direct and indirect costs of accidents and ill-health at work to workers, families, employers and society.

The **Strategy 2007-2012** contains a series of actions at EU and Member State levels in the following main areas:

- improving and simplifying existing legislation and enhancing its implementation in practice through non-binding instruments such as exchange of good practices, awareness-raising campaigns and better information and training
- defining and implementing national strategies adjusted to the specific context of each Member State, targeting the sectors and companies most affected and fixing national targets to reduce accidents and ill-health at work
- mainstreaming health and safety in other national and EU policy areas (education, public health, research) and finding new synergies
- better identifying and assessing potential new risks through more research, exchange of knowledge and practical application of results.

Achievement of the Strategy is progressed through the work of the **European Commission** and the **Advisory Committee** through rolling annual **Action Programmes**, taking account also of the work carried out by **EU-OSHA**, **Eurofound**, the **Committee of Senior Labour Inspectors**, which is representative of all the Member States and possible new agreements by the **European Social**

**Partners.** The **Action Programmes** are organised under appropriate headings as follows:

- exchange of information on national strategies
- strengthening the implementation of the legislation
- simplifying the legislative framework and adapting to change
- promoting good practices and changes in behaviour
- promotion of OSH at international level
- standing coordination with relevant bodies
- ongoing activities

Currently, the activities of the **Advisory Committee** under the **Action Programme 2009**, are organised through eleven active **Working Parties** and include:

- collecting and exchanging information on national strategies
- developing a blue-print to ensure uniformity and quality in Guides and producing new Guides for construction, electromagnetic fields, fisheries, agriculture and forestry
- evaluating the impact of Directives on safety and health at work
- examining possible legislative initiatives on musculoskeletal disorders, revision of carcinogens provisions, additional indicative limit values for chemical agents and revision of the Directive on electromagnetic fields
- preparation of the 6<sup>th</sup> EU-US Joint Conference on OSH and consultation with Japan and China.

Within the **Advisory Committee** structure, the **Government Interest Group** has established a **Scoreboard Group** which is devising a range of voluntary indicators which will help measure the preventive contribution which individual Member States will make towards achieving the targets which underpin the Strategy. The data will cover:

- national statistics
- national strategies
- occupational accidents
- work-related health problems and illnesses
- chemical agents, and
- preventive potential.

The **European Commission**, at a more general level, is conducting a project aimed at reducing administrative burdens in meeting legal obligations in the European Union, including in the area of the working environment and employment relations. One of the issues which have arisen for debate in this context is whether exemptions should be provided for in health and safety Directives from the written risk assessment requirement in the case of low-risk SMEs.

## **Annex 1** **List of EU Member States**

**1951**  
Belgium

France  
Germany  
Italy  
Luxembourg  
Netherlands

**1973**

Denmark  
Ireland  
United Kingdom

**1981**

Greece

**1986**

Spain  
Portugal

**1995**

Austria  
Finland  
Sweden

**2004**

Cyprus  
Czech Republic  
Estonia  
Hungary  
Latvia  
Lithuania  
Malta  
Poland  
Slovakia  
Slovenia

**2007**

Bulgaria  
Romania

**Annex 11**  
**EU Directives on occupational safety and health**  
**The Framework Directive of 1989 and its individual Directives**



1. Council Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work ('Framework' Directive)
2. Council Directive 89/654/EEC concerning the minimum safety and health requirements for the workplace
3. Council Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment, as amended by Council Directives 95/63/EEC and 2001/45/EEC
4. Council Directive 89/656/EEC on the minimum health and safety requirements for the use of personal protective equipment at the workplace
5. Council Directive 90/269/EEC on the minimum requirements for the manual handling of loads where there is a risk particularly of back injury to workers
6. Council Directive 90/270/EEC on the minimum safety and health requirements for work with display screen equipment
7. Directive 2000/54/EC of the European Parliament and of the Council on the protection of workers from risks related to exposure to biological agents at work – Codification of Directive 90/679/EEC
8. Council Directive 92/57/EEC on the implementation of minimum safety and health requirements at temporary or mobile construction sites
9. Council Directive 92/58/EEC on the minimum requirements for the provision of safety and/or health signs at work
10. Council Directive 92/85/EEC on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding
11. Council Directive 92/91/EEC concerning the minimum requirements for improving the safety and health protection of workers in the mineral-extracting industries through drilling
12. Council Directive 92/104/EEC on the minimum requirements for improving the safety and health of workers in surface and underground mineral-extracting industries
13. Council Directive 93/103/EEC concerning the minimum safety and health requirements for work on board fishing vessels
14. Council Directive 98/24/EC on the protection of the safety and health of workers from the risks related to chemical agents at work, supplemented by Commission Directive 2000/39/EC establishing a first list of indicative occupational exposure limit values and Commission Directive 2006/15/EEC establishing a second list of indicative occupational exposure limit values
15. Directive 1999/92/EC of the European Parliament and of the Council on minimum requirements for improving the safety and health protection of workers potentially at risk from explosives atmospheres
16. Directive 2002/44/EC of the European Parliament and of the Council on the minimum requirements regarding the exposure of workers to the risks from physical agents (vibration)

17. Directive 2003/10/EC of the European Parliament and of the Council on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (noise)
18. Directive 2004/37/EC of the European Parliament and of the Council on the protection of workers from the risks related to exposure to carcinogens or mutagens at work (Codification of Directive 90/394/EEC)
19. Corrigendum to Directive 2004/40/EC of the European Parliament and of the Council on the minimum health and safety requirements regarding the exposure of workers to the risks arising from physical agents (electromagnetic fields)
20. Directive 2006/25/EC of the European Parliament and of the Council on the minimum health and safety requirements regarding the exposure of workers to risks arising from physical agents (artificial optical radiation)

#### **“Independent” Directives**

21. Council Directive 91/383 supplementing the measures to encourage improvements in the safety and health of workers with a fixed-duration employment relationship or a temporary employment relationship
22. Council Directive 92/29/EEC on the minimum safety and health requirements for improved medical treatment on board vessels
23. Council Directive 94/33/EC on the protection of young people at work
24. Directive 2003/88/EC of the European Parliament and the Council concerning certain aspects of the organisation of working time
25. Council Directive 1999/63/EC concerning the Agreement on the organisation of working time of seafarers concluded by the European Community Shipowners' Association (ECSA) and the Federation of Transport Workers' Unions in the European Union (FST)
26. Council Directive 2000/79/EC concerning the European Agreement on the Organisation of Working Time of Mobile Workers in Civil Aviation concluded by the Association of European Airlines (AEA), the European Transport Workers' Federation (EFT), The European Cockpit Association (ECA), the European Regions Airline Association (ERA) and the International Air Carrier Association
27. Directive 2002/15/EC of the European Parliament and of the Council on the organisation of the working time of persons performing mobile transport activities
28. Council Directive 2005/47/EC on the Agreement between the Community of European Railways (CER) and the European Transport Workers' Federation (EFT) on certain aspects of the working conditions of mobile workers engaged in interoperable cross-border services in the railway sector

#### **Directives adopted before the Framework Directive of 1989**

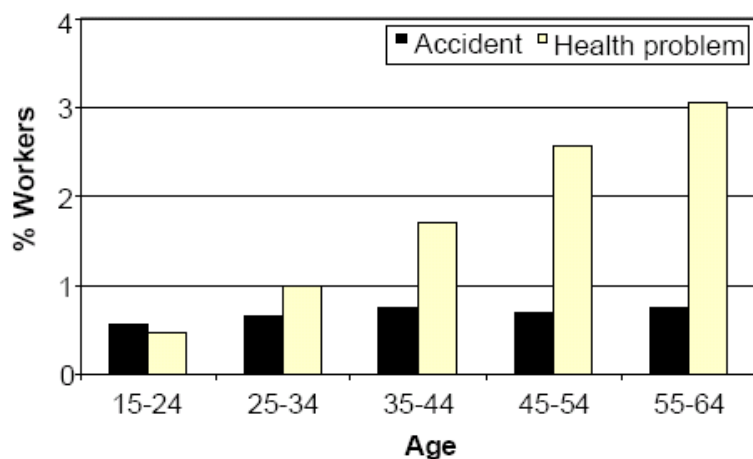
29. Council Directive 83/477/EEC on the protection of workers from the risks related to exposure to asbestos at work, As amended by Council Directive

91/82/EEC and the Directive 2003/18/EC of the European Parliament and of the Council  
**30.** Commission Directive 91/322/EEC on establishing indicative limit values

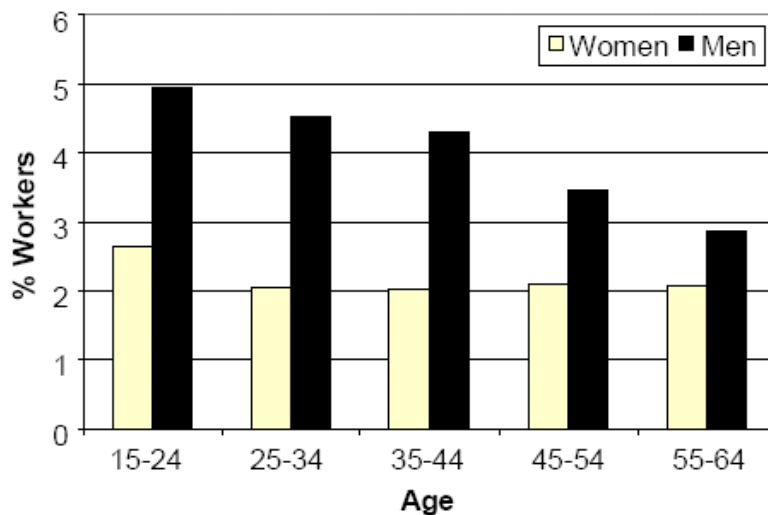
**Annex 111**  
**Accidents and work-related health problems**

**Source: Eurostat, Statistics in focus, 2009, Population and social conditions, Accidents at work, work-related health problems and risk factors, Main results from the Labour Force Survey 2007 ad hoc module.**

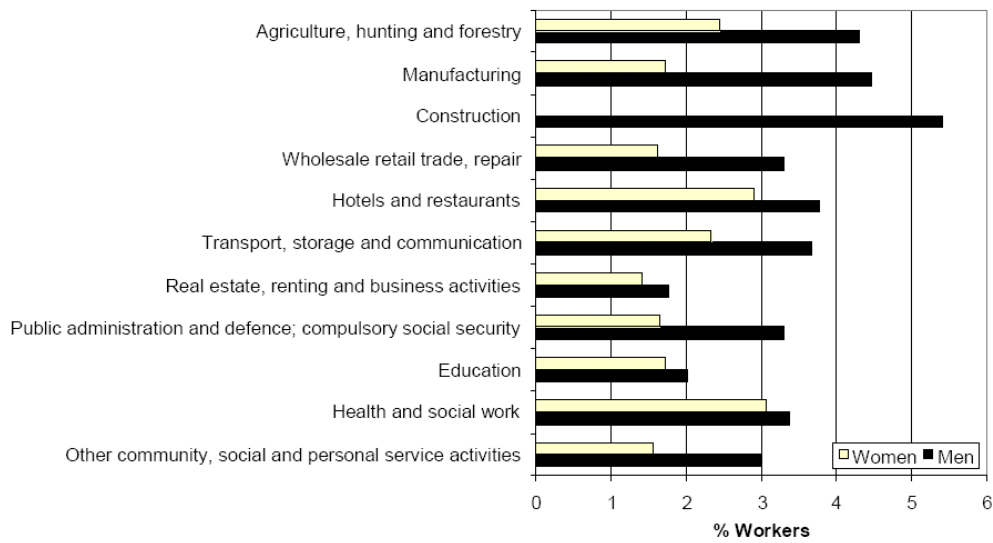
**Figure 1: Workers off work at least 1 month due to accidents at work and work-related health problems in the past 12 months**



**Figure 2: Accidents at work in the past 12 months in different age groups**

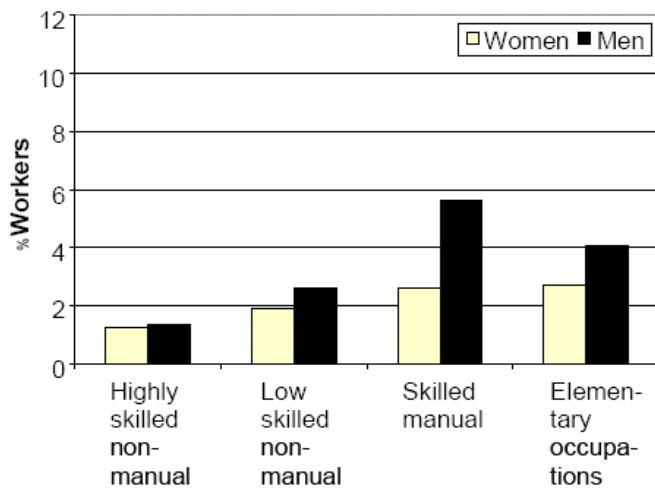


**Figure 3: Workers reporting one or more accidents in the past 12 months in different sectors<sup>1</sup>**



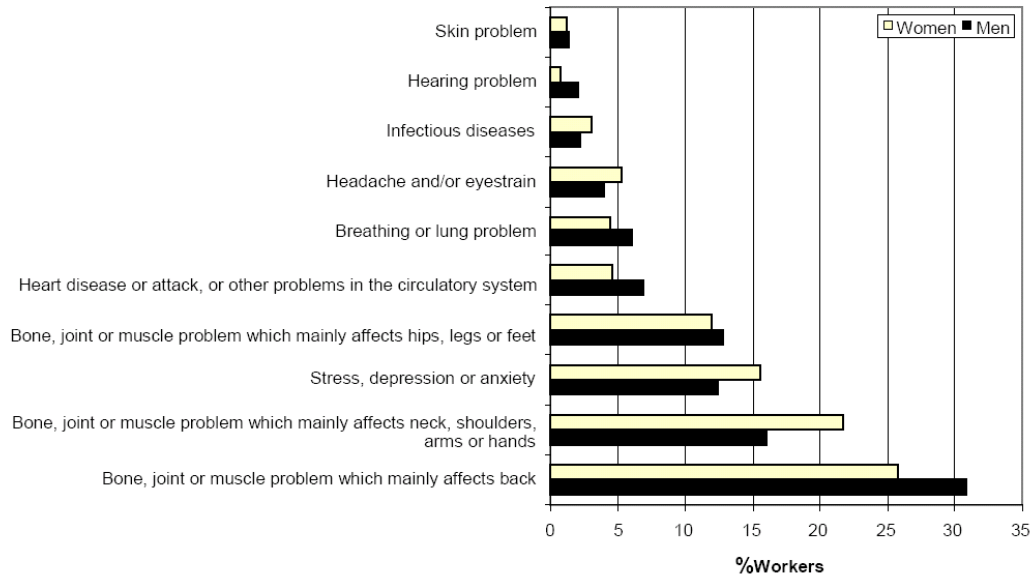
<sup>1</sup> The following sectors are not included in this Figure since the reliability limit for publication is not satisfied: Fishing, Mining and quarrying, Electricity gas and water supply, Construction (women), Financial mediation, Private households with employed persons, Extra-territorial organisations and bodies.

**Figure 4: Accidents at work in the past 12 months among different occupations<sup>1</sup>**



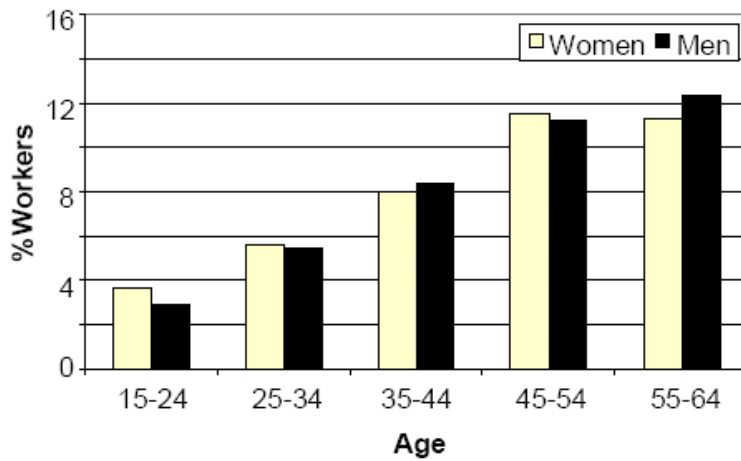
<sup>1</sup> Army was not included in this Figure since the reliability limit for publication is not satisfied

**Figure 5: Work-related health problems experienced in the past 12 months**

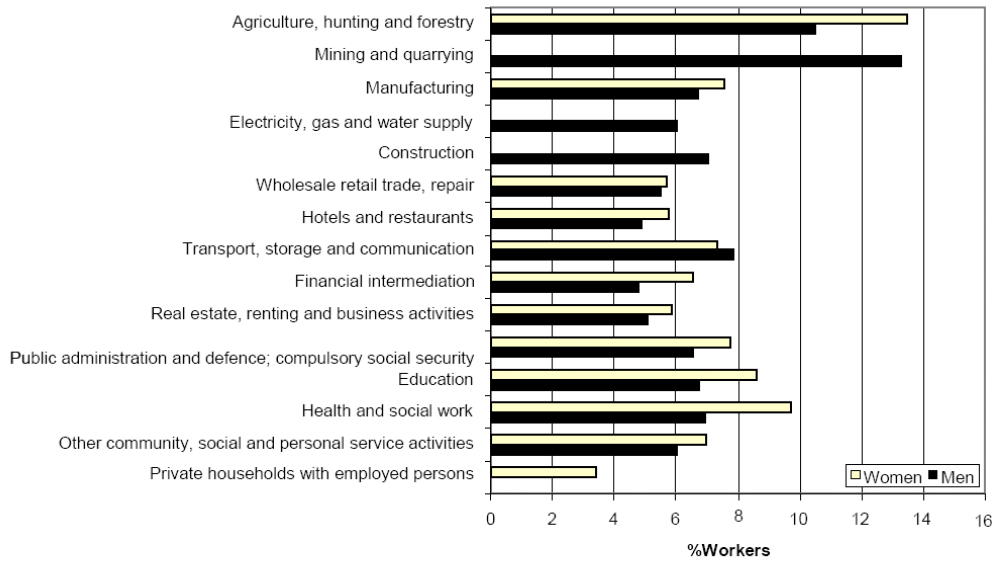


*\*FR not included, EU-27 figures reflect EU-27 without FR (see Methodological Notes)*

**Figure 6: Work-related health problems in the past 12 months in different age groups**

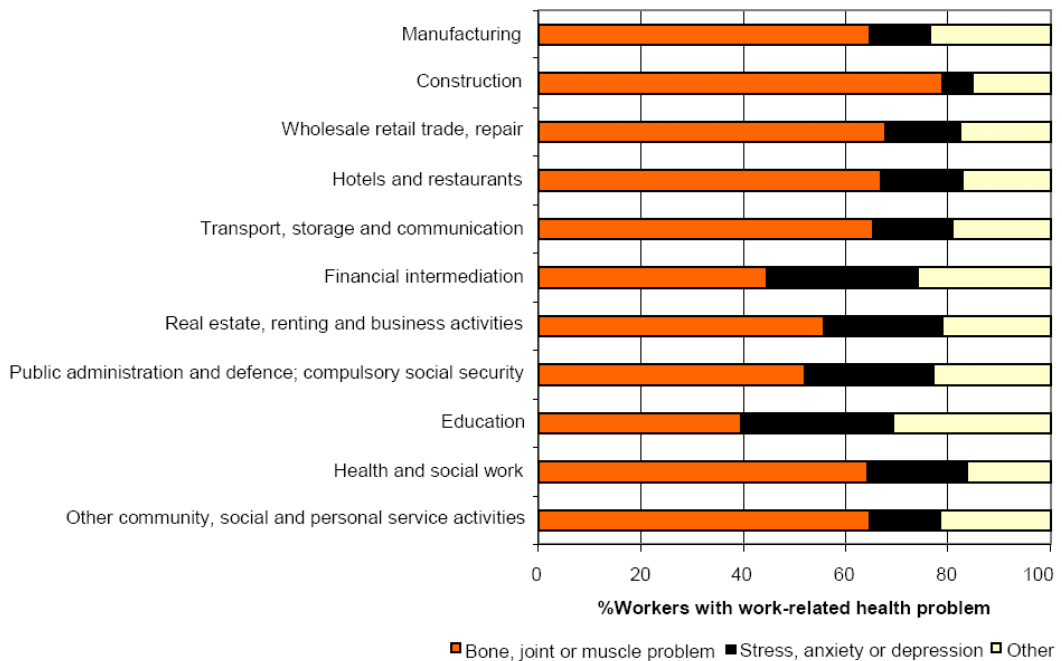


**Figure 7: Work-related health problems in the past 12 months among workers in different sectors<sup>1</sup>**



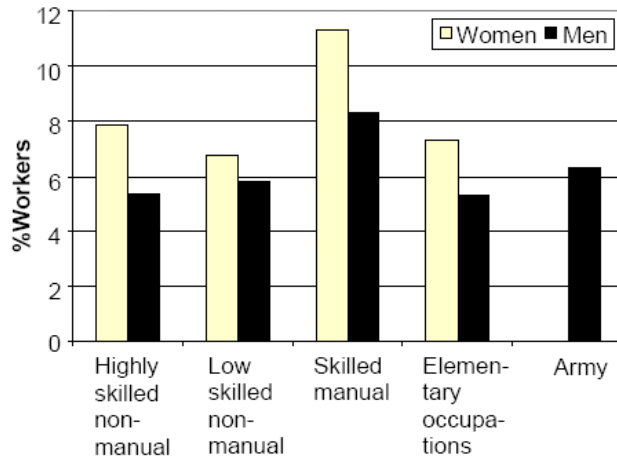
<sup>1</sup> The following sectors are not included in this Figure since the reliability limit for publication is not satisfied: Fishing, Mining and quarrying (women), Electricity gas and water supply (women), Private households (men), and Extra-territorial organisations and bodies

**Figure 8: Type of work-related health problem in the past 12 months in different sectors<sup>1</sup>**



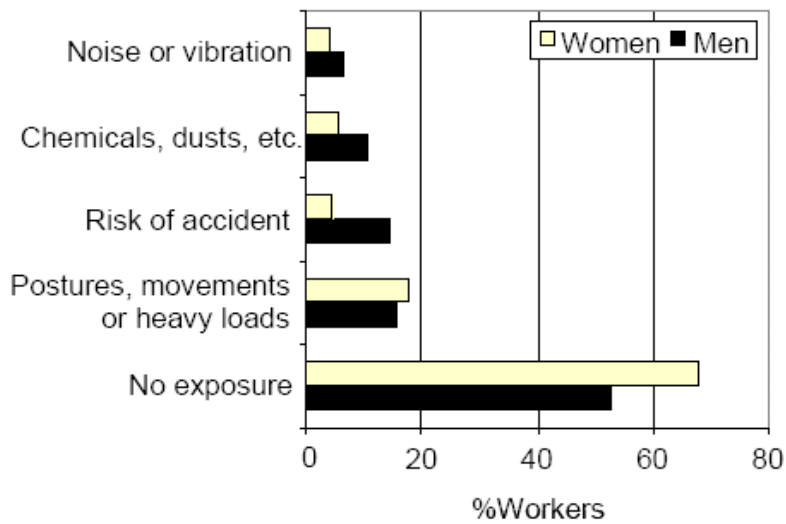
<sup>1</sup> The following sectors are not included in this Figure since the reliability limit for publication is not satisfied: Fishing, Mining and quarrying, Electricity gas and water supply, Private households, and Extra-territorial organisations and bodies

**Figure 9: One or more work-related health problems in the past 12 months in different occupations<sup>2</sup>**



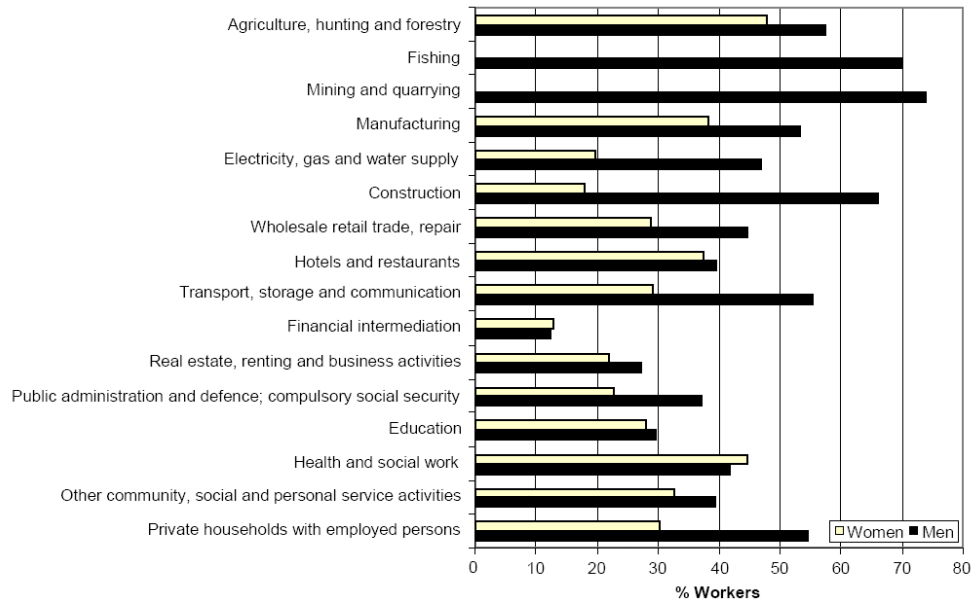
<sup>2</sup>Army (women) was not included in this Figure since the reliability limit for publication is not satisfied

**Figure 10: Main factor adversely affecting physical health<sup>d</sup>**



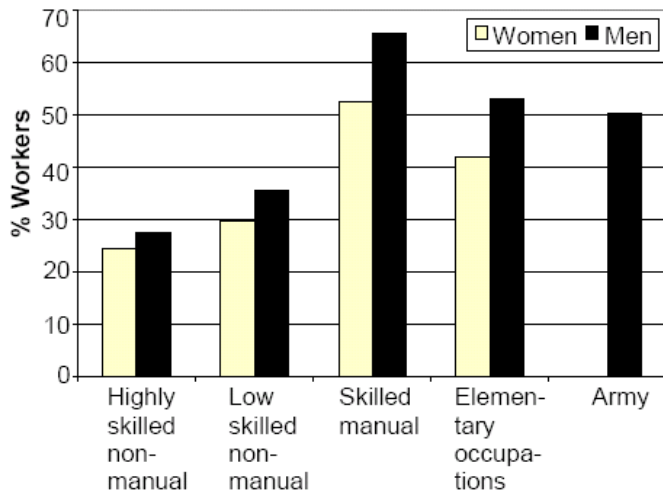


**Figure 11: Workers exposed to one or more factors adversely affecting physical health in different sectors<sup>2</sup>**



<sup>2</sup> The following sectors were not included since the reliability limit for publication is not satisfied: Fishing (women), Mining and quarrying (women), and Extra-territorial organizations and bodies

**Figure 12: Exposure to one or more factors adversely affecting physical health among different occupations<sup>1</sup>**

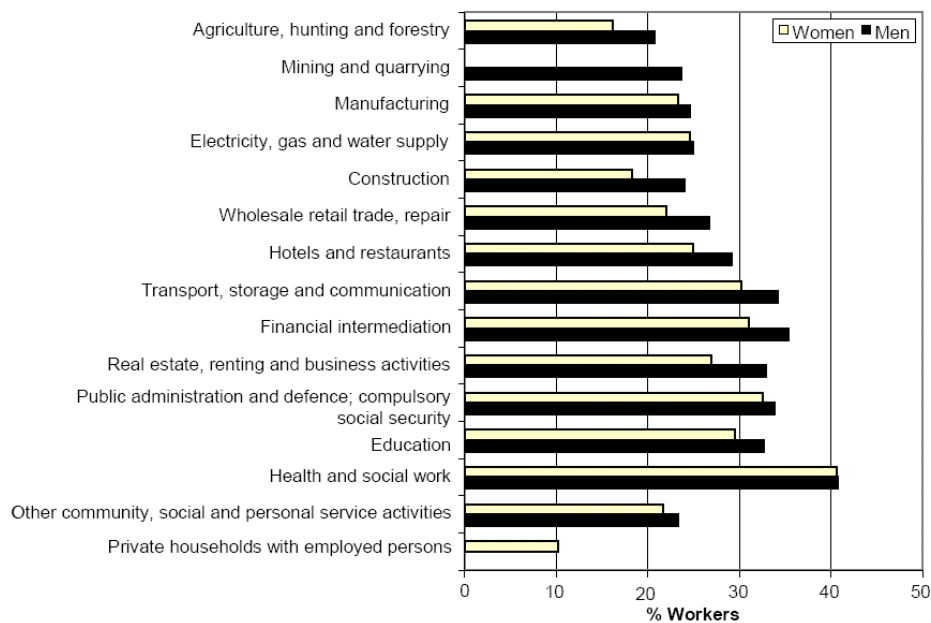


<sup>1</sup> Army (women) was not included in this Figure since the reliability limit for publication is not satisfied

**Figure 13: Main factor adversely affecting mental well-being<sup>e</sup>**



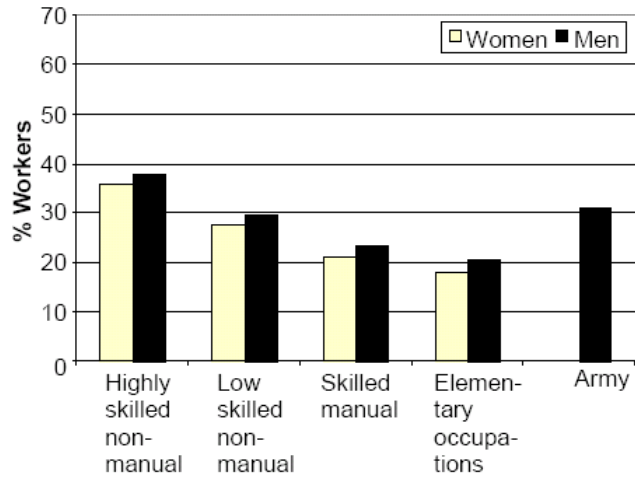
**Figure 14: Workers exposed to one or more factors adversely affecting mental well-being in different sectors<sup>2</sup>**



<sup>2</sup> The following sectors were not included since the reliability limit for publication is not satisfied: Fishing, Mining and quarrying (women), Private households (men), and Extra-territorial organizations and bodies

<sup>e</sup> MT and SI not included (see methodological Notes)

**Figure 15: Exposure to one or more factors adversely affecting mental well-being among different occupations<sup>1</sup>**



<sup>1</sup>Army (women) was not included in this Figure since the reliability limit for publication is not satisfied