

Occupational health regulations and health workers: protection or vulnerability?

by

Jane Lethbridge

j.lethbridge@gre.ac.uk

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PSIRU, Business School, University of Greenwich, Park Row, London SE10 9LS, U.K.

Website: www.psiru.org Email: psiru@psiru.org Tel: +44-(0)208-331-9933 Fax: +44 (0)208-331-8665

Researchers: Prof. Stephen Thomas, David Hall (Director), Jane Lethbridge, Emanuele Lobina, Vladimir Popov, Violeta Corral
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Occupational health regulations and health workers: protection or vulnerability?

Occupational health and safety is a key issue for health workers. Changes in the delivery of public health care services raises concerns about whether occupational health and safety standards will be adhered to by different providers. Increased violence experienced by health workers poses a new and growing occupational health problem. With changing occupational health and safety risks, legislation and standards need to be reviewed regularly, especially in relation to trade agreements that set international standards for companies operating in national environments.

The role of trade unions in occupational safety and health is crucial. The “*strength of unions remains essential for integral worker health*”(Partanen *et al*, 2005:313). An OECD study found that there was a negative correlation between fatal accident rate and union strength (Rueda, 2004). The recognition of the right to freedom of association and collective bargaining has an impact on the health of workers.

This paper was commissioned by Public Services International (PSI) to:

- Explore the extent to which national and international occupational health legislation is changing in both positive and negative ways;
- Analyse the implications of specific international trade agreements for occupational health;
- Identify specific examples of how the implementation of occupational health standards has changed

The paper is structured as follows:

1. Changes in international and national occupational health and safety policies;
2. Implications of trade agreements for occupational health and safety;
3. Implementation of occupational health policies;
4. Conclusions and recommendations

1. Changes in international and national occupational health and safety policies

This section discusses some of the changes taking place in international and national occupational health policies. The role of the International Labour Organization (ILO) is discussed in relation to the formulation of global occupational health and safety policies. It is more limited in its control over occupational safety and health policy implementation. There are also several policy issues that influence the implementation of OSH at national level.

International Labour Organization

The International Labour Organisation (ILO) plays a central role in providing recommendations and guidance for national occupational safety and health (OSH) policies. Although ILO publishes instruments, which outline varying levels of obligations for member countries, ILO members still have to ratify each instrument before implementation takes place. Ratification does not guarantee implementation. The recommendations are for national governments to implement and use in an advisory capacity.

Occupational health has been a major concern of the International Labour Organization since its founding, in 1919. There are 17 Conventions, 1 Protocol, 23 Recommendations and 37 Codes of Practice, which cover occupational health and safety. These fall into three groups:

- Occupational safety and health policies and the provision of occupational health services;
- Labour inspection and systems for recording and notification of occupational health diseases;
- Specific hazards, which cover biological to psycho-social hazards provide further

Table 1: ILO conventions/ recommendations - occupational safety and health principle/policies

Convention	Brief description	Date	Ratification No. of countries
C155 Occupational health and Safety Convention	Sets objectives and basic principles of a national policy	1981	50
R164(OSH)	Further details and additional practical guidance on provisions in C155		
Code of Practice (OSHMS)	Management systems approach to OSH - for use at national and enterprise?? Level		
C161 Occupational Health Services Convention, 1985	Policy instrument - provision of occupational health services	1985	26
R 171 OHS	Further guidance on implementing C161 Occupational health services	1985	
Code of Practice (Workers' Data)		1997	
Code of Practice 1998	Technical & ethical guidelines for workers health surveillance	1998	
C187 Promotional Framework for Occupational Safety and Health Convention, 2006		2006	1 (Japan)

Source: ILO www.ilo.org/lex

Since 1981, there have been several ILO Conventions, which are directly related to the formulation and implementation of national occupational safety and health policies. The (1981) Convention C.155 (OSH) sets out objectives and defines the basic principles of a national policy. It is a policy instrument and does not set out specific legal obligations. It sets out the requirements for Member states, in collaboration with stakeholders, to formulate, implement and review a national occupational health policy, setting out rules on actions to be taken at national level. It has been ratified by 50 countries.

The (1985) Convention C.161 (Health Services) covers the provision of occupational health services. Member states should be committed to developing occupational health services, although only 26 countries have ratified this convention, so far. A Code of Practice (1998) also sets out technical and ethical guidelines for workers' health surveillance. There are other instruments which deal with the protection of workers' health, welfare facilities and workers' housing (R.97 (Workers' Health), R.102 (Welfare Facilities) and R.115 (Workers' Housing Recommendations)).

The Protocol of 2002 to the Occupational Safety and Health Convention 1981 (P.155) and the List of Occupational Diseases Recommendation 2002 (R.194) both complement the procedures for recording and notification of occupational accidents and diseases in C.155 (OSH). They set out the details for establishing a system for recording and notifying occupational accidents and diseases as well as procedures for recording and notification.

Table 2: ILO conventions/ recommendations - Labour inspection / Recording and notification

Convention	Brief description	Date	Ratification No. of Countries
C81 Labour Inspection Convention, 1947	Sets out the rules governing labour inspectorates - obligatory for industrial establishments and optional for commercial and non-commercial services sector	1947	137
R81 Recommendation (Labour Inspection)	Details on preventive duties of labour inspectorates and collaboration of employers and workers in relation to H&S and annual reporting on inspection	1947	
P81 Protocol to the Labour Inspection Convention, 1947	Extends the application of C81 to non-commercial services sector	1995	10
Protocol of 2002 to the OSH Convention 1981	Establishment of systems for recording & notification and requirements / procedures for recording & notification of occupational accidents & diseases	2002	
R194 (Recording & Notification)	Recommends national list of occupational diseases	1995	
Code of Practice (CoP) (Recording & Notification)	Further practice guidance	1995	

Source: ILO

The (1947) Labour Inspection Convention (C.81) sets out the rules governing labour inspectorates. This is obligatory for industrial establishments and optional for commercial establishments, although this was revised to include the non-commercial services sector. C81 has been ratified by 137 countries. Other ILO instruments cover specific industries, such as commerce, construction, mines and agriculture and more specific workplace hazards, for example, chemical, biological, physical, mechanical, ergonomic, and psycho-social hazards.

ILO is committed to promoting and supporting labour inspection. ILO strategies for labour inspection work to strengthen the implementation of national policies and systems for labour inspection, through the provision of technical assistance and international collaboration. In many countries, labour inspection is under threat due to lack of resources, the privatisation of state services, and a lack of recognition and support (Albracht, 2004).

Table 3: ILO Conventions/ Recommendations on hazards

Convention	Brief description	Date	Ratification No. of countries
<u>Biological</u> Anthrax Prevention Recommendation	Asks member states to make arrangements for the disinfection of wool infected	1919	

	with anthrax spore		
HIV/AIDS and world of work		2001	
<u>Physical hazards</u> C115 Radiation Protection Convention No 115	Basic requirements for protection of workers against risks associated with exposure to ionising radiations - regulate employers and workers responsibilities - provides system for regular updating of exposure limits	1960	47
R114 Radiation Protection Recommendation	Provides that levels for doses should be fixed considering relevant values recommended by International Commission on Radiological Protection	1960	
C139 Occupational Cancer Convention	Carcinogenic substances and agents in all workplaces	1974	36
R147 Occupational Cancer Recommendation	Clarification of supervision of workers health and measures for information & education	1974	
C148 Working Environment (Air Pollution, Noise and Vibration) Convention		1977	41
R156 Working Environment (Air Pollution, Noise and Vibration) Convention		1977	
C127 Maximum Weight Convention	Manual lifting, lowering and moving of heavy material and work items	1967	25
R128 Maximum Weight Recommendation	Specifies max weight limit for men and time limits for women & young workers (less than for adult men workers)	1967	
Code of Practice Management of alcohol & drug related issues in the workplace		1996	

Source: ILO

There are signs that there has been renewed interest and action by ILO in OSH in the last 5 years. Occupational health plays an important part in the ILO 'Decent Work' strategy. A 'Global Strategy on Occupational Safety and Health' was adopted in 2003, which aims to build a national preventative occupational health and safety culture and introduce a 'systems approach' to occupational health management, using the 2001 ILO Guidelines on Occupational Safety and Health Management Systems. The development of new instruments to cover ergonomics and biological hazards were identified as a priority (ILO, 2003)

In 2006, there was a review of the existing Occupational Safety and Health Convention, 1981 (C. 155), and the Occupational Safety and Health Recommendation, 1981 (R. 164), as well as and other instruments of the International Labour Organization, relevant to the promotional framework for occupational safety and health. In the light of the review, it was decided to draw up a new international convention, the Promotional Framework for Occupational Safety and Health Convention, which was agreed in 2006 (ILO. 2006). So far, Japan is the only country to have ratified this new Convention.

Public sector

As well as OSH policies, there are specific provisions for different sectors and types of workers. The term '*economic activity*' is often assumed to cover workers in the public sector, although more recent instruments have made specific reference to the public sector.

Table 4: Specific provision for public sector workers

Title	Specific clauses for public sector workers	Date
C.161 (Health Services) (Article 3)	“Each Member undertakes to develop progressively occupational health services for all workers, including <u>those in the public sector</u> and the members of production co-operatives, in all branches of economic activity and all undertakings. The provision made should be adequate and appropriate to the specific risks of the undertakings”	1985
R.171 Occupational Health Services Recommendation, 1985 (No. 171 Para 2.1	“Each Member should develop progressively occupational health services for all workers, <u>including those in the public sector</u> and the members of production co-operatives, in all branches of economic activity and all undertakings. The provision made should be adequate and appropriate to the specific health risks of the undertakings”	1985
The Convention C.170 Chemicals convention Art 2(d)	the term branches of economic activity means all branches in which workers are employed, <u>including the public service</u> ;	1990
Recommendation R.102 Welfare facilities (1956) Paras 1-2	1. This Recommendation applies to manual and non-manual workers employed in <u>public</u> or private undertakings, excluding workers in agriculture and sea transport. 2. In any case in which it is doubtful whether an undertaking is one to which this Recommendation applies, the question should be settled either by the competent authority after consultation with the organisations of employers and workers concerned, or in accordance with the law or practice of the country.	1956
R.164 Occupational Safety and Health Recommendation (1981) Para 3(a)	3. As appropriate for <u>different branches of economic activity and different types of work</u> and taking into account the principle of giving priority to eliminating hazards at their source, measures should be taken in pursuance of the policy referred to in Article 4 of the Convention, in particular in the following fields: (a) design, siting, structural features, installation, maintenance, repair and alteration of workplaces and means of access thereto and egress there from;	1981
C149 Nursing Personnel Convention -(1977) is a specific convention for nurses		1977

Sources: <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C161>
<http://www.ilo.org/ilolex/cgi-lex/convde.pl?R171>
<http://www.oit.org/ilolex/cgi-lex/convde.pl?R164>

Although there has been a gradual development of measures that include health workers and workers in the public sector, a recent ILO survey shows that there are 32 countries that do not have any special OSH provision for workers in the public sector. In these countries, existing OSH legislation has to be assumed to cover the public sector. This may be significant in the development of collective bargaining agreements for public sector providers. The countries are set out below (Table 5):

Table 5: Countries with no special OHS provision for workers in the public sector

Region	Countries
Africa	Algeria Benin, Botswana, Burkina Faso, Burundi, Kenya, Mauritius, Niger, Tanzania, Togo, Zambia
Asia	Cambodia, Nepal, Singapore
Europe	Azerbaijan, Belarus, Cyprus, Denmark, Estonia, Iceland, Netherlands, Poland, Romania, Switzerland, United Kingdom
Americas	Argentina, Canada, Ecuador, Guatemala, Jamaica, Peru, Venezuela

Source: ILO, 2003

Apart from the C81 Labour Inspection Convention (1947), which was ratified by 137 countries, all other major occupational health and safety conventions have been ratified by 50 or fewer countries. This gives an indication of some of the limitations of ILO Conventions. Although ILO draws up OSH policies, it can only make Conventions, which require national ratification, and Recommendations, which are “*non-binding instruments*”. Although they are agreed by the ILO General Assembly, which consists of member countries, they still have to be ratified by individual countries. Conventions require political will at national level for policies to be implemented fully.

ILO has attempted to assess its effectiveness in the field of OSH (ILO, 2003). Although it acknowledged that the number of ratifications is relatively low, it argued that ILO conventions also provide models for national OSH policies, even if they are not formally ratified. ILO uses the growing demand for information on ILO standards as evidence of its wider impact of its work on OSH.

ILO works closely with the World Health Organization on occupational safety and health issues. In 1996, WHO published a ‘*Global Strategy for Occupational Health for All*’. The European Office of WHO published a Declaration on Workers Health in 2006 and this was followed by ‘*Workers’ health: global plan of action*’ at the World Health Assembly in 2007 (WHO, 2007). This provides an important international OSH policy framework for health workers.

There are several issues that affect the way in which OSH policies are implemented at national level. A fundamental organisational problem can be the separation of responsibilities for OSH between Ministries of Health and Ministries of Labour. Related to this, are new developments in public health policies that encompass occupational health but, by their breadth, may leave OSH issues lacking resources and political will.

Ministries of Labour and Health

Occupational health and the monitoring of health and safety standards has traditionally been the responsibility of national government departments of Labour or Work. The department of health has been responsible for broader public health policies, which may include the health of workers. Increasingly these two approaches to occupational health are being combined. The department of labour perspective, which has focused on occupational health of workers, is combined with the work of the Ministry of Health, which is responsible for wider public health policies. This results in broader health strategies, which may include maintaining the health of the workforce through ‘health at work’ strategies.

Vanhoorne, Vanachter De Ridder (2006) argue that OSH needs a combination of the labour and health approaches. The labour approach remains important. The share of work on the burden of disease (attributable risk) is estimated to be 2.2% of deaths globally and for some occupational groups this will be higher. However work also contributes to some common diseases, e.g. airway cancer, asthma, deafness, low back pain.

The health approach includes a wider view of 'health at work' because it includes all aspects of life influencing health e.g. lifestyle, family. The nature of work is changing, with the identification of new risk factors, for example psycho-social and musculo-skeletal problems. Life-long employment with one employer is becoming less common. Part time, short term contracts and self employment are becoming more widely used forms of employment. A growing number of health problems, called '*work related diseases*', are influenced by conditions at work and other areas of life, for example, coronary heart disease. An ageing population also presents new health at work issues. The pressure to remain in the workforce for as long as possible will involve looking at ways of modifying the work environment to accommodate people with long term chronic conditions.

'*Workplace health promotion*' is another term that brings together OSH policies with a wider health strategy. Workplace health promotion in Latin America (Partanen et al 2005) may cover "*Workplace hazards, hazard and health surveillance, work organization, professional competence of workers and/or early detection of diseases and/or problematic lifestyles*" (Partanen et al, 2005:315)

'*Workplace health promotion*' may be incorporated into a wider health promotion programme, for example, Karelia, Finland. Occupational health services need to have a strong preventive element.

Only 15% of the global workforce has access to any occupational health services. Certain groups of workers, including health care workers, are more exposed to occupational health risks. Eijkemans (2004) considers that in order to make the provision of a safe work environment a basic right, public funding will be required. Navarro (2004) argues that the important issue is not so much the level of resources as who has control over resources for workers health.

In Russia, a new Federal program '*Health of the working population in Russia 2004-2015*' is building on the integration of Ministry of Public Health and Social Development, the Ministry of Labour, the compulsory medical insurance fund, and the social insurance fund. The Russian National Centre of Occupational health operates under the Ministry of Public Health and Social Development and the Russian Academy of Medical Sciences (Izmerov, 2005).

In Belgium, a draft decree was drawn up by Vanhoorne, Vanachter, De Ridder (2006) which aimed to incorporate both a labour and health approach. It incorporates several elements:

- All workers, in all sectors, are included
- Health is not just focused on work related aspects
- The concept of incapacity at work is rejected
- Work should be adapted to the individual
- Health and workplace surveillance to be combined
- Collection and analysis of data
- Increase of resources

Although there are several advantages to combining labour and health approaches to OSH, the implications of moving from, what could be considered, a more collective OSH approach to an individual health approach, should be considered, carefully.

Local occupational health services

The discussion of how to merge the labour and health approaches to OSH, also raises questions about whether health services and occupational health services should co-exist or be integrated. In Russia, plans for a new occupational health policy and programme are recommending the creation of a network of local occupational health centres, financially independent from employers, in large and small enterprises (Izmerov, 2005).

In South Africa, the 2003 National Health Act (Act 61 of 2003) set out the rights and duties of health care providers, health care workers, health establishment and users. It also gave

provincial departments of health the responsibility for occupational health services. In reality, the quality of occupational health services at provincial level is variable because of a lack of resources and training. The lack of a health information system makes it difficult to evaluate the provincial services (Adams, Morar, Kolbe-Alexander, Jeebhay, 2007).

Non-decision making in developing countries

The majority of developing countries do not have adequate OSH policies. Kamuzora (2006) identified a series of mechanisms that have contributed to a lack of implementation. A lack of resources or underfunding for OSH initiatives effectively limits any action. In Tanzania, less than 1% of the Labour Department was allocated to OSH (Kumuzora, 2006:66). This can result in shortages of equipment required for risk management, failures to recruit OSH workers, which weakens legislation enforcement, inspection and surveillance and, lack of investment in research and training.

Lack of political will is the most damaging for OSH policy implementation. OSH agreements may be drawn up with trade unions, at national or sector level, but never implemented. The weakness of trade unions is another factor that affects the implementation of OSH because it impacts on the willingness of workers to take risks in raising OSH issues. Centralised decision making also makes it more difficult to implement OSH agreements if there is no political will. The prevailing ideologies of economic neoliberalism and the focus on economic growth, also work against the take-up of OSH policies, particularly the focus on economic growth (Kumuzora, 2006).

Emergence of new occupational issues

The emergence of violence at work as an occupational health issue has intensified in the last decade. The responses to this, in the health sector, have brought together international agencies, for example ILO and WHO, with PSI and the International Council of Nurses. In 2000, the group launched a joint programme to develop policies and practical approaches for the prevention and elimination of violence in the health sector. This alliance has commissioned research, developed guidelines and training manuals as well as raised awareness. The first international conference on violence at work in the health sector will take place in 2008.

The increased violence that public sector workers, especially health workers, are experiencing during their work has raised the profile of this occupational hazard in many countries. In Scotland, there have been recent changes to legislation, entitled the Emergency Workers Act, which were approved recently by the Scottish Parliament's Justice Committee (Scottish Parliament, 2008). The Act will provide protection to NHS staff and this will be extended to GPs, other doctors, nurses and midwives working in the community.

ILO and national policies conclusion

ILO has played an important role in setting standards and models of OSH policies. Loewenson (2001) emphasizes the role of ILO in promoting policy convergence. However, the ratification process by individual countries has been slow. The weakness of the ratification process can lead to a political reluctance to review or improve existing OSH legislation. This has some impact on the negotiation of trade agreements which will be discussed in the next section.

The extent to which OSH is a labour or health department issues is one issue that is still influencing national implementation. The trend is towards occupational safety and health being incorporated into health strategies. This is conceptually sound but may provide competition for limited resources in the health sector.

2. Occupational health and trade treaties

An examination of how trade treaties have the potential to affect occupational health requires an analysis at several levels. The immediate focus is whether the treaty includes specific provision for occupational health and safety standards. As important as whether a trade treaty includes OSH standards is the extent of the sanctions that countries will be subject if they do not adhere to the OSH standards.

Occupational health and safety standards are also a form of regulation. Trade treaties that aim to reduce regulation in order to stimulate competition may put occupational health and safety regulations in conflict with measures to open national markets.

The Trade Treaties that have been considered in this paper are:

- The General Agreement on Trade and Services (GATS)
- The North American Free Trade Agreement (NAFTA)
- The Central American Free Trade Agreement (CAFTA)
- Central American Common Market (CARICOM)
- ASEAN
- European Union (EU)

General Agreement on Trade and Services (GATS)

There are two specific clauses in the General Agreement on Trade and Services (GATS) that refer to occupational health.

Article XIV lit. b) GATS “Measures that are necessary to protect human, animal and plant life or health can be based on this clause. The fact that this clause also includes most regulation for OH&S can be proven without difficulty. Should this not be provable directly,

Article XIV lit. c) “GATS can be consulted to support the requirement of occupational safety. Here actions by government of the member states, which hinder international services transactions (measures), are permitted if they are necessary to ensure compliance with laws and other regulations and are not in contradiction with the GATS”.

Although these two specific GATS clauses cover OSH, the complexity of the GATS mechanisms has to be considered before any assessment can be made about their effectiveness. There is an indication of this in the Article XIV lit c) “to ensure compliance with laws and other regulations and are not in contradiction with the GATS”. National sovereignty and the most favoured nation (MFN) are two of the main GATS principles that could potentially overrule the provision for OSH. Sexton (2003) argues that many occupational and workplace health and safety regulations, aimed at preventing accidents at work could possibly be challenged if, in practice, they created a barrier to a company outside the country providing a service.

Another area of concern is the classification of environmental services. If environmental services are considered as services that are subject to competition, this could also affect OSH. The privatization and commercialization of environmental services under the GATS, which cover sanitation, refuse and waste disposal, will decrease the responsibility of national governments to protect the environment and the occupational safety and health of workers (IUF, 2004). This could also affect the functions of local government, which often have responsibilities for environmental services and OSH.

There is also extensive debate about how to maintain OSH standards in the working of the GATS. There are some suggestions that OSH standards could be included within requirements for workers, if seen as part of wider service standards and impacting on the quality of service.

However, standards within contracts should not be seen as a substitute for OSH policies and regulations.

NAFTA

The North American Free Trade Agreement (NAFTA) included OSH in a '*labour side agreement*' entitled the North American Agreement on Labor Cooperation (NAALC). (Brown, 2005). The NAALC set up structures to monitor labour issues and to address complaints about non-enforcement of labour laws. (NAALC,2008).

There have been many criticisms of the NAALC. Many of these views emerged in public comments, submitted as part of a review of the NAALC agreement, in 1999. The AFL-CIO raised several issues in relation to the effectiveness of NAALC. It "*contains no agreement on adherence to internationally recognized worker rights*" and only commits each nation to "*effectively enforce*" its domestic labour laws. NAALC does not have the power to improve or strengthen labour laws, at any level (NAALC, 1999).

Occupational health and safety is one of three areas where NAALC has power to enforce sanctions, when a country has failed to enforce a labour law. However, the non-enforcement must involve mutually recognized labor laws and be trade-related. The remedies are also ineffective (Appendix B). Canada opted out of the enforcement provisions of NAALC (NAALC, 1999).

"*Compensation in cases of work accidents or occupational diseases*" is one of five areas subject to ministerial consultations and review by a committee of independent experts. However, this group has only to produce a report. There is no requirement for any further action (NAALC, 1999).

AFL-CIO recommended that labour rights should be given the same weight and importance as intellectual and investment rights within NAFTA. NAALC should be given responsibility for improving a country's labour laws if these are inadequate (NAALC, 1999). The OSH arrangements in the NAFTA show some of the limitations of having a separate agreement for labour issues, as well as the weakness of the system of sanctions.

Central American Free Trade Association (CAFTA)

The CAFTA agreement has been considered weaker than the NAFTA agreement because it only enforces existing national labour laws. Whereas there was some special recognition for OSH issues within the NAALC side agreement, there is no such provision within CAFTA. This means that it weakens the enforcement of OSH standards. It also undermines ILO pressures to improve labour standards more generally. CAFTA does not encompass any right to organise and there is no enforcement under the Free Trade Agreements dispute rules (Shaffer, Brenner 2005).

Several free trade groups, such as CARICOM, ASEA and MERCOSUR have all attempted to take OSH initiatives. Although facing extensive barriers to improving OSH issues because of lack of resources and limited capacity, these initiatives can be seen as evidence that OSH issues are of concern to countries, working together in free trade or common market arrangements.

CARICOM The Central American Common Market

In 1996, Ministers of Labour from the CARICOM countries formulated a model based on ILO recommendations for the recording and notification of occupational accidents and diseases and the recording of best practices from the legislations of the member countries. Some countries (OECS and Suriname) are upgrading their legislation to meet the CARICOM model.

Several constraints for improving OSH standards were identified. There was a lack of financial resources, trained staff, and a consistent public education programme (except for Suriname).

There was no technical equipment or national/ regional databases. A lack of opportunities for tertiary education made the development of training programmes difficult (CERSSO, 2004)

ASEAN

In 2000, Asean countries developed a Memorandum of Understanding to establish a ASEA OSH Network. The Network aims to promote cooperation and solidarity among national occupational safety and health (OSH) centres, enhance the capability of these centres in OSH promotion, training and research in ASEAN countries. It also aims to facilitate and promote the exchange of the relevant OSH information and the sharing of training expertise. A longer term aim is to promote the development and harmonisation of the ASEAN OSH standards and guidelines.

MERCOSUR has made similar agreements.

European Union (EU)

The European Union is an older and more established common market. An analysis of how OSH has been addressed illustrates many of the opportunities and the barriers to improving OSH standards that emerge in free trade agreements.

Occupational accidents and diseases in fishing, agriculture, construction and health and social services sectors were still 30% above average (ILO,2003:35). The EU is facing changes in the work place as a result of moving towards a knowledge based economy with increased numbers of short term, temporary, non-standard working times, increasing feminisation and ageing of the population.

OSH has been an area of health policy that has been the responsibility of the European Union, in contrast to other areas of health care policy, which have been technically subject to the subsidiarity principle and so the responsibility of member states. The EU Occupational Health and Safety at Work Agency (EU-OSHA) was set up in 1996. It operates in a tri-partite arrangement with governments, employers and worker representatives. It commissions, collects and publishes new scientific research, makes information available and identifies new occupational health risks.

EU Strategy 2002-6

A four year European Community occupational health policy was introduced in 2002. TUTB provided an evaluation of its progress in 2004, which illustrates some of the issues facing occupational safety and health (OSH) in Europe.

An overall criticism was that the text of the strategy was too general and the recommendations for implementation were not specific enough. This vagueness was attributed to the hostility of employers and anti-union governments (TUTB, 2004). The political environment has been hostile to OSH. This can be seen in the attacks by Prime Ministers Aznar- Blair-Berlusconi on the concept of a 'social Europe' and the proposed Bolkenstein Directive. The 2004 Dutch presidency called for the '*simplification*' of the Directive on occupational safety and health. The Council of Ministers warned about the threats that more OSH legislation placed on European competitiveness. The evaluation concluded that national governments need to develop more preventive strategies and tighten up labour inspectorate enforcement (TUTB, 2004). TUTB also emphasized the important role that trade unions can play in improving the identification of OSH needs.

There have been some successes in the 2002-2004 period. TUTB highlighted the advances made in areas such as asbestos, physical agents, the implementation of new legislation in new Members states and a European collective agreement on stress. However, in several areas, there are serious concern about commitment to formulating and implementing preventive strategies (TUTB, 2004). There has not been any progress in mainstreaming gender dimensions

across occupational health measures. Links between equality and occupational health have been ignored. The implementation of the Working Time directive has been '*flexible*' and been governed by employer concerns. There are also examples of a weak political will towards OSH issues at an EU and member level.

A new EU strategy, *Improving Quality and Productivity at Work*, has been developed for the period 2007-2012. It aims to promote a culture of risk prevention through "*legislation, social dialogue, progressive measures and best practices, corporate social responsibility and economic incentives*". There is a strong emphasis on the role of social dialogue to implement the strategy. The overall aim is to support an increasingly older workforce.

However, the practicalities of implementing *Improving Quality and Productivity at Work* are shown in a study of Lithuania and the new EU strategy. Woolfson (2007) questions whether there is still a social dimension to the '*European project*' in terms of balancing social justice and economic development. He illustrates this argument by examining Lithuania, a county with a fatal accident rate of 113/100,000 as compared to the EU rate of 78/100,000.

In many of the new EU member states in Central and Eastern Europe, new legal frameworks and institutional structures have been set up. The former labour systems have been replaced by standards, based on ILO and EU standards. New employer organisations are becoming involved in social partnerships for occupational health and safety (ILO, 2003: 36). Yet in Lithuania, management is hostile to workplace representation, essential to monitoring OSH issues, because it is seen as part of the '*old*' system. Increasingly issues which would have been addressed through collective bargaining are being negotiated through individual contracts (Woolfson, 2007). This suggests that effective implementation of a European OSH has to address wider issues of representation.

Working Time Directive

The EU Working Time Directive illustrates some of the difficulties in implementing OSH policies and standards in the EU and some of the political compromises that undermine OSH policies and practice. It has affected health workers directly.

The 1993 Working Time Directive was an attempt to address some of the OSH issues caused by long working hours. The main objective was to promote health and safety at work, in the light of evidence that occupational accidents increase the longer the number of hours worked (Hanecke, 1998). There main provisions covered:

- Maximum weekly working time of 48 hours average, including overtime
- At least 4 weeks paid annual leave
- A minimum rest period of 11 hours in each 24, and one day in each week
- A rest break is the working day is longer than 6 hours
- A maximum of 8 hours night work, on average, in each 24 hours.

There were several exclusions, which reduced the impact of the Directive. Doctors in training were one of the excluded groups. The average working week could be calculated over a longer "*reference period*" of up to four months or 12 months by collective agreement. EU member states were given leeway to define terms such as "*rest period*" and "*night work*". In 2000, an Amendment Directive 2000/34/EC was published, which covered non-mobile working in previously excluded areas.

In 2004, a survey of the implementation of the Working Time Agreement, found that the majority of member states were contravening at least two parts of the agreement. Four member states had opted out altogether.

Table 6: EU member States contravening the Working Time Directive

Country	Contravene	Countries
19 countries	On-call time	Austria, Belgium, Cyprus, Czech Republic, Germany, Denmark, Estonia, Greece, Spain, Finland, France, Hungary, Ireland, the Netherlands, Poland, Sweden, Slovenia, Slovakia and the United Kingdom
21 countries	Compensatory rest	Austria, Belgium, Cyprus, Czech Republic, Germany, Denmark, Estonia, Greece, Spain, Finland, France, Hungary, Ireland, Lithuania, Latvia, the Netherlands, Poland, Sweden, Slovenia, Slovakia and the United Kingdom
4 countries	Reference period	Germany, Lithuania, Malta, Poland
4 countries	Individual opt out	Spain, France, Hungary, United Kingdom

Source: Gros-Verheyde, 2007

In 2000 and 2003 there were two significant rulings by the European Court of Justice which ruled that *“all time spent on-call should be classified as working time”*. The ECJ found that *“on-call”* duty for doctors, when required to be present, forms part of working time (Vogel, 2004). However, the revised directive stated that *“time spent on-call that is not worked would not be counted as working time, with compensatory rest granted within 72 hours”*. This still did not incorporate the ECJ rulings. This has particular impact on the health care sector, through provisions for junior doctors. There has been a failure to agree on this revised Directive.

Trade agreements conclusion

The weakness of trade agreements in relation to OSH standards is that OSH issues, along with wider labour and social issues, have not been incorporated into the main body of the agreements. Labour and social clauses have not been given the same weight as investment or intellectual property rights. For example, the 1996 WTO Trade Ministers meeting endorsed international labour standards but ILO was considered the appropriate forum to deal with these labour issues, rather than WTO.

In the case of the NAFTA, some OSH issues featured in the labour side-agreement NAALC. The weakness of the agreement was that the sanctions took a long time to activate and were not powerful enough to change practice. Although trade agreements acknowledge the need for OSH policies, their commitment to opening up national markets dominates their implementation. The CAFTA did not even have the limited OSH clauses attached to the NAFTA *‘labour side’* agreement, NAALC.

Regional free trade agreements have often used the opportunity of working more closely together to draw up memoranda of agreements on OSH. This suggests that OSH issues are considered important but the political will is not strong enough to create an environment that will provide rigorous systems of enforcement and sanctions. The EU illustrates some of the problems that result from a lack of political commitment to OSH issues as well as the potential for regional OSH agreements.

3. Implementation of occupational health policies

This section will examine some of the issues that influence the implementation of OSH policies.

Gender

There are significant national variations in the recognition and reporting of occupational diseases. Women are less likely to be recognised as having an occupational disease, although a EU labour force survey found that work related conditions are more prevalent in women. The

under-recognition of occupational diseases means that the scope of prevention policy in relation to diseases, which are more common for women are more limited in scope (Dupre, 2002).

Women are more often employed in health care where occupational problems such as infection (including needle stick injuries), violence, musculo-skeletal diseases, and burnout (WHO, 2002). A study of sexual harassment, as experienced by nurses in Turkish hospitals, found that the shame and guilt caused by this led to anxiety, tension, irritability, depression, sleeplessness, fatigue and headaches (Wilson 1995). These conditions may lead to absenteeism, sick leave and reduced efficiency at work. Women are often in low paid and insecure employment in the health and social care, which contributes to high levels of stress and insecurity.

Gender conditions the type of exposure that women experience to occupational hazards (Messing *et al.*, 1994; Kennedy and Koehoorn, 2003). The organisation and design of many workplaces have been designed for men. This is reflected in the design of tools. It can be seen in the timetabling of working hours, which only in some countries, show an awareness of caring responsibilities. The toxicological data from men is used to determine 'safe' exposure levels for men and women. There is little knowledge available on the sex differences in the metabolism of toxins (Wizemann and Purdue, 2001). Occupational health research has been criticised for its gender bias. WHO (2006) argued that gender-specific patterns of occupational health problems may be the result of gender differences in exposure to risk factors and psychology combined with sex differences in biology (Messing & Ostlin, 2006). Work-related fatigue, repetitive strain injury, infections and mental health problems are more common among women than among men (Östlin, 2002), yet these are often the most contested occupational health problems.

There may be equality in law but the way in which OSH legislation is implemented may be different for men and women. Men and women are offered different rehabilitation measures for the same OSH problem. For example, men are more often offered training or help at home. Women receive rehabilitation benefits for a short length of time and have more difficulty in accessing compensation for OSH problems. Compensation benefits for psycho-social and musculo-skeletal problems, which are more common in women, are scrutinised more than for accidents at work, which are more common in men (Messing & Ostlin, 2006). For example, in Sweden, a larger percentage of work related diseases reported by women were not approved, by social insurance offices, than those reported by men (Messing & Ostlin, 2006).

There is a global underestimation of burden of occupational injuries and disease but for women it is even greater than for men. OSH research tools have been developed for work with men's jobs but they often fail to cover dimensions of women's jobs, or differentiate between women's jobs. There is a need to collect more sex disaggregated data. Women work-related health must also consider gender roles and work in domestic setting (Doyal, 1995) as well as socioeconomic class, race and ethnicity.

Classification of diseases

The nature of work is changing in many countries and so occupational health risks are also changing. Hence, the revision of diseases considered occupational in origin is a significant process for the development of a culture of risk prevention. There is currently extensive debate about whether musculo-skeletal conditions and psycho-social conditions should be included in lists of recognised occupational diseases. This is relevant to health workers, especially women, because women suffer from these conditions more than men.

In the EU, the 1990 Recommendation on occupational diseases was replaced by the 2003 Recommendation (19 September 2003). This consists of two schedules:

1) Occupational diseases which should be recognised by all member states. These included three musculo-skeletal diseases (carpal tunnel syndrome and three categories of bursitis).

2) A list of diseases that are suspected of being occupational in origin which should be subject to notification. This list may be included in the first schedule in future.

Musculo-skeletal diseases are an area of contention within OSH, globally. In 2004, there was an initial consultation for an EU directive on musculo-skeletal diseases.

Although three musculo-skeletal diseases were included in the EU list of recognised occupational diseases, disc-related diseases of the lumbar vertebral column, caused by repeated carrying of heavy loads were left out (p.23). There had been no progress in the recognition of spinal column problems caused by carrying heavy loads, even though there is an EU Manual Handling of Loads Directive (Appendix 3).

Voluntary standards

The extent to which OSH regulations are considered a form of regulation has also led to the development of the concept of 'soft' and 'voluntary' measures which would allow employers to regulate themselves. The administrative 'costs' of OSH regulation to employers are used by de-regulators to argue against OSH measures. These pressures can be found in North America and the European Union, where there are already OSH regulations.

An example of the weakness of voluntary agreements can be seen in the '*Stress Autonomous Framework*', which is a voluntary agreement between social partners. It was signed by on 8 October 2004, by the ETUCE, UNICE/UEAPME and CEEP and has to be implemented by all member organisations of the signatory bodies before 8 October 2007 (ETUCE, 2004). There is no definition of stress. Four factors are defined as causing stress in the workplace: work organisation, work environment, work content and communication issues (Gauthy, 2004). Prevention issues are addressed but there are no measures to eliminate risk factors.

The pressure to establish 'voluntary' standards can also affect the way in which regulations are drawn up. In 2001, the Workers' Compensation Board of British Columbia was asked by the provincial government to "*reduce its regulatory burden and establish a more appropriate balance of performance and prescriptive regulations*" (Begelow *et al*, 2004:434). This would involve the elimination of occupational exposure limits (OELs), and their replacement with threshold limit values (THVs). OELs are used throughout the world and require extensive research, at local level. THVs, developed by the American Conference of Governmental Industrial Hygienists, are health-based standards but developed without economic, technical or political considerations. They are not developed locally.

The OSH Agency for Healthcare in British Columbia, which represents health workers, decided to review the health implications of these changes. The review examined different chemicals used in the health care sector and the changes in risk exposure, which might result from moving from occupational exposure limits (OELs) to threshold limit values (THVs). The review concluded that although the changes would not result in any major health effects to healthcare workers, there might be increased morbidity in the short term, which might increase the risk of serious health effects (Bigelow *et al*, 2004). The review also concluded that any decrease in local capacity could be problematic in future. Although the existing OELs were replaced by TLVs, there were policy changes to establish exemptions in future.

Data and scientific evidence

The increasing commercialisation of research has implications for gathering scientific evidence for use in identifying the extent of occupational health problems. Huff (2007) analyses some of the recent changes that US government health agencies have undergone in the ways in which they work with industrial interests, which challenge their independence and integrity. The growing influence of commercial interests on academic institutions and university research programmes, make it more difficult to commission independent scientific research.

Commercial interests also lobby governments to change and weaken existing protective OSH legislation (Huff, 2007). Civil servants are often unable to assess the scientific evidence that is presented to them. Consequently, they are unable to argue against suggested changes that commercial interests are lobbying for.

Professional organisations are also subject to pressure from commercial interests. The International Commission on Occupational Health (ICOH) is a front for industry (Huff, 2007). The ICOH is presented as an organisation that aims to protect workers' health. Most members do not admit to their links with industry. In some cases, members also have links with WHO and the ILO, which help to provide legitimacy, for example the Centre for Pesticide Safety (Huff, 2007). Continued caution is needed to identify the growing influence of commercial interests in public health agencies.

Culture of risk prevention or blame?

Although ILO and EU strategies promote the development of a culture of risk prevention, there is evidence that in many workplaces, a '*blame*' culture exists. This may be caused by uncertainties about public sector reforms, increased competition for contracts, and the impact of targets, which contribute to greater socio-economic insecurity for workers.

An example of the effects of a '*blame*' culture can be seen in a report by Quality Improvement Scotland, an agency responsible for improving healthcare quality, in Scotland. In recent research, it found that some National Health Service staff had not reported accidents involving patients or colleagues for fear of the consequences of admitting a mistake. Accidents were defined as "*unintended or unexpected events leading to patient or staff harm, as well as near misses*". Workers felt that there was a '*blame*' culture which made workers reluctant to report accidents. Although Quality Improvement Scotland had found that the NHS was better than some industries, there is still a need for a change in attitude to accident reporting. Managers found reporting easier than clinical staff (Quality Improvement Scotland, 200).

Training and capacity building

For effective implementation of OSH policies, training and capacity building for workers, including health workers is needed. There are a wide range of initiatives taking place globally, even though resources are limited.

In Ghana, poor OSH conditions are considered to be one of the factors that contribute to health workers leaving the country in the search of better pay and working conditions. The Ghana Health Service has developed a curriculum of in-service training on OSH for health workers. This is in conjunction with the development of a several policies: OSH, HIV/AIDs and health care waste management. A health surveillance system for staff is also being put in place (Clarke, Sutherland, 2007).

Implementation conclusion

Improved implementation in OSH would require action in several areas. The influence of commercial interests in research and in the lobbying of international agencies is one of the most serious threats to the continued improvement of OSH.

OSH research and practice has to address the needs of women more effectively. This will involve a more rigorous gender analysis of many OSH trends and issues.

The creation of a supportive 'culture' for OSH risks to be addressed is often threatened by the changes taking place in many sectors as a result of public sector reforms.

4. Conclusions and recommendations

Conclusions

Increasingly, occupational health and safety is recognised as an issue that can impact on economic growth and the effective functioning of different sectors. This is reflected in several trade agreements that have specific OSH clauses. It is also reflected in international OSH policies which, if fully implemented, would provide standards, systems and procedures that could create working environments that reflect the occupational health needs of workers.

However, there are many barriers to the implementation of existing OSH policies at international, national and sector levels. The most fundamental barrier is the lack of political will. This manifests itself in many ways. It can be seen in the low level of ratifications of ILO Conventions that address OSH. A more pernicious form is the criticism of existing OSH measures for being a hindrance to competition. The linking of OSH and regulation illustrates a view that although there is some acknowledgement of the need for OSH measures, their implementation should not threaten free trade and the opening of new markets. It is evident in the lack of resources allocated to OSH measures, whether through lack of investment in inspection, capacity building or monitoring.

One of the goals of the ILO OSH strategy is to create a culture of good OSH practice, globally. It is worth considering what a “*culture*” of good practice would require. It would be based on a sense of trust between workers and management that occupational safety and health problems could be addressed openly. Workers would feel that they had a right to work in an environment that was not threatening and did not pose any specific occupational risk. If new risks were identified, then there would be a shared effort to find ways of alleviating them. Research would be commissioned that was independent of commercial interests. Workers would have access to adequate training and capacity building. OSH issues would be given priority over the interests of the sector or industry. Workers would not be afraid to report OSH problems. The pressure on public and private sectors to compete creates a working environment which is often the opposite to one in which OSH issues are dealt with openly.

The mechanisms that can be used as sanctions for existing legislation are often weak. In trade agreements, such as NAFTA, there is no pressure to improve national legislation that is weak or limited. The implementation of the EU working time directive shows that even when there are valid attempts to improve the working environment, many countries will be powerful enough to ignore or be exempt from any sanctions. These are often part of a wider agenda that is anti-worker and anti-union. The process of social dialogue will not solve these conflicts.

Recommendations

Trade unions have a central role to play in the promotion of OSH. There are several areas where trade unions have to improve their practice, if they are to be effective in promoting and supporting improved implementation of existing OSH policies. Some suggested recommendations are:

1. Define a ‘*culture*’ which creates good OSH practices
2. Be more active in identifying good practice and integrate initiatives into a more ‘*whole*’ systems approach to OSH
3. Commission research that involves workers in identifying OSH problems and ways of addressing them

4. Commission or lobby for research that identifies new hazards or looks at existing hazards in new ways, particularly being more aware of gender issues
5. Review existing OSH standards using a gender lens
6. Identify good practice in incorporating OSH into contracts for public services
7. Continue to raise awareness of OSH and develop capacity building programmes to prepare members for taking on OSH issues in the workplace
8. Recognise that raising the profile of OSH is part of the process of challenging neo-liberal policies and protecting workers within economic globalization

Jane Lethbridge
j.lethbridge@gre.ac.uk

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Appendix A: Methodology

Although focusing on health workers, this paper examines general trends in occupational health and safety as well as more specific trends, in relation to public sector workers.

TO BE ADDED

Appendix B: NAFTA remedies for non-enforcement

“If the case involves one of the three labor standards that can proceed to remedy, following the findings of the independent panel of experts, two of the three labor ministers must vote to convene an arbitration panel. If the arbitration report also finds non-enforcement of a country's labor laws, the guilty government would be given 60 days to begin an agreed-upon plan of enforcement. If the country does not comply, the arbitration panel can levy a fine of up to .007 percent of the total trade in goods between the three countries. The fine is paid by the offending country to itself into a fund dedicated to improving enforcement of its own labor laws.

The offending government will be given six months to begin enforcement and pay any fines. If it refuses to comply, penalties can be assessed by imposing duties, quotas or investment limits based on the amount of the fine if the case is against Mexico or the U.S. If the case is against Canada, the Labor Commission created by the NAALC must file suit in the Federal Court of Canada”.

<http://new.naalc.org/index.cfm?page=256>

Appendix 3: EU Directive Manual handling of loads involving risk

The object of this Directive is to ensure that workers are protected against the risks involved in the manual handling of heavy loads.

1.1 ACT

Council Directive [90/269/EEC](#) of 29 May 1990 on the minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers (fourth individual Directive within the meaning of Article 16(1) of Directive [89/391/EEC](#)) [Official Journal L 156 of 21.6.90].

1.2 SUMMARY

Definition of the term "manual handling of loads": any transporting or supporting of a load which, by reason of its characteristics or of unfavourable ergonomic conditions, involves a risk to workers.

In applying this Directive, employers must:

- use the appropriate means to avoid the need for manual handling of loads by workers, or, where this cannot be avoided, to take the appropriate organisational measures to reduce the risk involved, having regard to Annex I;
- ensure that workers receive adequate information on the weight of a load and the centre of gravity or the heaviest side when a package is eccentrically loaded, and to ensure proper training and precise information on how to handle loads correctly, and the risks involved in incorrect handling, having regard to Annexes I and II;
- guarantee that consultation and participation of workers takes place in accordance with the framework Directive on matters covered by this Directive.

<http://europa.eu/scadplus/leg/en/cha/c11118.htm>