

Hospitals and Occupational Health in the European Union

The Standing Committee of the Hospitals of the European Union (HOPE) is a non-governmental European Association, which was created in 1966 and since 1995 has been an international association for social gain. It includes national hospital associations as well as representatives from the national health systems of the 15 Member States of the European Union plus Bulgaria, Cyprus, Malta, Romania and Switzerland as observers.

With limited means, the Standing Committee is carrying out its associative mission by means of information, representation, exchange, study and education. Through the actions of its Sub-Committees on Co-ordination and on Economics and Planning, HOPE is showing the European dimension of health care.

This leaflet presents briefly, for the 15 health systems of the Member States of the European Union, the topic 'Occupational Health & Safety and Hospitals'. It has been prepared by the Sub-Committee on Co-ordination and is preceded by a description of the theme 'Occupational Health & Safety' within Europe.

In the 1990s considerable conceptual, political, legislative and practical progress in occupational health has been observed in many European countries. The ILO Occupational Safety and Health Convention (No. 155, 1981), ILO Occupational Health Services Convention (No. 161, 1985), European Community framework Directive (89/391/EEC) and the WHO Global Strategy for Occupational Health for All (1996) have guided recent changes in legislation on occupational health practice in many European countries. All of them strengthen the concept of using multidisciplinary occupational health services and active participation of employees to improve working environment and workers' health.

The very interesting national descriptions show some revealing orientations: A recently renewed and innovating general legislation exists in many European countries.

There is almost no specific legislation for the hospital sector.

We can observe an interesting evolution in terminology. The term 'occupational medicine' is more and more being replaced by 'occupational health.' In French, 'médecine du travail' is replaced by 'santé (ou bien-être) au travail'.

The scope of application is expanding too: health and hygiene are more and more linked to safety. It is not only about safety within the undertaking, but also about safety in relation to the environment.

There is almost no link between occupational health in hospitals and occupational health in undertakings. Occupational health in hospitals could, however, serve as an example to other undertakings. The more general role of hospitals to promote health (health promoting hospitals) would be applied here!

At European level, occupational health and public health are in fact within the EU competencies (especially by art. 152 of the EC Treaty), but there are too few links between them. With this leaflet HOPE wants to draw the attention of Europe to the obvious need of building a bridge between both fields.

Finally a last observation on the health professions in Europe can be added here. The turbulence of the reforms (and of the budgetary restrictions) for the healthcare sector in all EU countries also has considerable consequences for the hospital staff who are not always the best paid nor the least stressed in our society: dismissal because hospitals are closed down; the – less visible – increase of the workload in the remaining institutions and beds; the stronger selection of patients and the sparingly calculated number of staff per patient (staff ratio). The growing psychological pressure caused by the care of often very old chronic patients, whose numbers increase rapidly in the palliative care units shouldn't be forgotten either. These phenomena, which can clearly be observed in hospitals, are also on the increase in nursing homes and in home care, whose budgets are likewise being restrained.

The new model of occupational health practice integrates various occupational health professions, and possibly other specialists, into multidisciplinary preventive services capable of detecting and controlling the occupational, non-occupational and environmental risks. They aim at improving working capacity, the health and well-being of employees, and their working or general environments. Sufficient access to preventive services is necessary to increase equity in health and well-being within and between nations. It is also a prerequisite for establishing socially fair and sustainable trade competition.

Hope, 1 May 2000

Occupational health & safety in Europe

Work is essential for development, which brings benefits to nations and to individuals. However, activities, processes and operations required for industrialisation and development are often associated with exposure to harmful agents or conditions. In the last decade, globalisation of the economy, as well as political and socio-economic changes created new realities with emerging new problems for health care systems, especially for occupational health, which is a public health service requiring a multidisciplinary approach, with integration of knowledge and expertise of those concerned.

The available historical evidence suggests that safety at work has been of importance from the time that human beings first began to use implements or tools for their work. Even at the dawn of mankind, attempts were made to take into account the concept of 'integrated safety'. Occupational health and safety at work is by no means a new issue for the EU, it has been given priority ever since the birth of the European Community. The efforts of the EU in this area have led to important improvements in working practices because of the existing desire to ensure the safety and comfort of workers.

In our previous leaflet 'Social Dialogue in the Hospital Sector in the EU Member States' we have already mentioned that the social partners play an important role in the organisation of labour relationships between employers and employees. All Member States had a solid tradition of social consultation related to labour law and social security. This guide is intended to provide a brief introduction to the topic 'Occupational Health & Hospitals' in Europe. It should be pointed out that little information or literature is available concerning this topic in particular for the healthcare institutions.

Occupational health: Focal point of international organisations

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly in 1948, recognised the right of all people to just and favourable working conditions. Unfortunately, hundred millions of people around the world are employed in conditions that deprive them of dignity and value. It has been estimated in 1998 that workers suffer 250 million accidents every year, with 330,000 fatalities. Further avoidable suffering is caused by 160 million cases of occupational diseases and an even higher number of threats to workers' physical and mental well being. The world of work will continue to undergo dramatic changes. Technology transfer is one of the major factors behind the economic development in both the industrialised and developing countries. Therefore there is a need world-wide for an integrated approach to improve working conditions since the concern for total health of workers is growing in all countries.

Since its inception in 1948, WHO (World Health Organisation) in Geneva has recognised the utmost importance of improving the health status of working populations and has been developing international collaboration in this area. In order to attain 'Health for All', the health of workers must be protected and promoted through the development of adequate multidisciplinary occupational health programmes and services. In 1996 the Network of the WHO Collaborating Centres on

Occupational Health implemented a Global Strategy on Occupational Health for All which had been adopted by the World Health Assembly. It is based on prevention of disease and promotion of health. The objective of the strategy was to encourage countries with guidance and support from WHO to establish national policies and programmes with the required infrastructures and resources for occupational health.

The following summary of major workplace hazards has been extracted from the Global Strategy on Occupational Health for All.

- (a) Mechanical hazards, unshielded machinery, unsafe structures in the workplace and dangerous tools.
- (b) Heavy physical workload or ergonomically poor working conditions are the main cause of short-term and permanent work disability and lead to economic losses.
- (c) Biological agents: Hepatitis B and hepatitis C viruses and tuberculosis infections, asthma and chronic parasitic diseases are the most common occupational diseases. Blood-borne diseases such as HIV/AIDS and hepatitis B are now major occupational hazards for healthcare workers.
- (d) Physical factors such as noise, vibration, ionising and non-ionising radiation and microclimatic conditions can all affect health adversely.
- (e) Reproductive hazards in the workplace known to be mutagenic or carcinogenic.
- (f) Occupational carcinogens include chemical substances, physical hazards (UVR and ionising radiation) and biological hazards (viruses).
- (g) Allergic agents. Allergic skin diseases and respiratory diseases (asthma) should therefore be the focus of any occupational health programme.
- (h) Psychological stress, caused by time and work pressures, is associated with sleep disturbances, burn-out syndromes and depression. Monotonous work, work that requires constant concentration, irregular working hours, shift-work, etc. can also have adverse psychological effects.
- (i) Social conditions of work such as distribution and segregation of jobs and equality in the workplace, and relationships between managers and employees, raise concerns about stress in the workplace.

In addition to the specific workplace hazards discussed above, working conditions, type of work, vocational and professional status, and geographical location of the workplace and employment also have a profound impact on the social status and social well being of workers. WHO's Occupational Health Programme also addresses groups of workers with special needs. These include women and workers in small undertakings or in the informal sector, who are usually not covered by legislation and do not have access to occupational health services.

WHO has paid special attention to co-operation and co-ordination of its work with the ILO (International Labour Organisation) to protect the workforce and to ensure safety and health at work. The ILO was created in 1919 primarily for the purpose of adopting international standards to cope with problems of labour conditions involving 'injustice, hardship and privation'. With the incorporation of the Declaration of Philadelphia into its Constitution in 1944, the organisation was broadened to include more general, but related, social policy, human and civil rights matters. One of the key functions of the ILO from its inception has been the establishment of international standards on labour and social matters in the form of Conventions and Recommendations. The ILO

Occupational Health Services Convention (No. 161, 1985) and its Recommendation (No. 171) were milestones for the establishment of occupational health services. The concept of using multidisciplinary occupational health services and active participation of employees to improve working environment and workers' health have been strengthened.

Since 1950 the ILO and WHO have had a common definition of occupational health. The Twelfth Session of the Joint ILO/WHO Committee on Occupational Health held in 1995 revised this definition to focus on three different objectives:

- (a) The maintenance and promotion of workers' health and working capacity;
- (b) The improvement of the working environment and work to become conducive to safety and health;
- (c) The development of work organisation and working culture in a direction which supports health and safety at work and in doing so also promotes a positive social climate and smooth operation which may enhance productivity of an undertaking. The concept of working culture is intended, in this context, to mean a reflection of the essential value systems adopted by the undertaking concerned. Such a culture is reflected in practice in the managerial systems, personnel policies, principles for participation, training, policies and quality management of the undertaking.

Besides the ILO, WHO also collaborates actively with:

- (a) ICOH (International Commission of Occupational Health)

As the largest international non-governmental organisation in occupational health, the ICOH plays an important role in developing and disseminating WHO's policies with regard to occupational health. Its objectives can be summarised as fostering the scientific progress, knowledge and development of occupational health, in all its aspects, on an international basis.

- (b) IOHA (International Occupational Hygiene Association)

The principles of IOHA are:

- to promote and develop occupational hygiene throughout the world;
- to promote the exchange of occupational hygiene information among organisations and individuals;
- to encourage the further development of occupational hygiene at a professional level;
- to maintain and to promote a high standard of ethical practice in occupational hygiene.

- (c) IEA (International Ergonomics Association)

The goal of the IEA is to promote the knowledge and practice of ergonomics by initiating and supporting international activities and co-operation. Their objectives include the advancements of knowledge, information exchange and technology transfer.

WHO's European Region, which stretches from Greenland to the Pacific shores of the Russian Federation, is a complex national and international matrix of social, economic and political concerns. In the 1990s, many European countries have made considerable conceptual, political, legislative and practical progress in occupational health. The awareness has been growing that reorienting occupational health services can help greatly in achieving the objectives of national health and environmental

strategies. The health of the workforce is a result of all occupational and non-occupational health determinants.

In 1991 WHO's European Health for All Strategy recommended promoting healthy life styles such as healthy nutrition, physical exercise and non-smoking as some of the effective measures to reach Target 25 – Health of People at Work. A number of environmental and health issues were highlighted at the Second European Conference on Environment and Health, in Helsinki in 1994. The Helsinki Declaration on Action for Environment and Health in Europe recognised that the serious consequences for health and well being of a large number of people within the European Region were resulting from unsatisfactory living, working and recreational environments.

The European Social Charter, whose text was agreed by Member States of the Council of Europe, is the counterpart in the social and economic field to the European Convention on Human Rights which covers rights in the civil and political sphere. It was opened for signature in Turin on 18 October 1961 and a new version was implemented in Strasbourg on 3 May 1996. The Charter pays special attention to the topic Protection of employment, which includes the following themes:

- (a) the right to work;
- (b) the right to safe working conditions;
- (c) the right to just conditions of work, fair remuneration and non-discrimination;
- (d) the rights of workers to organise, bargain collectively, receive information, and be consulted;
- (e) protection of certain categories of workers: children and young persons, women, disabled persons, and migrant workers.

Under Article 3 The right to safe and healthy working conditions the Contracting Parties undertake:

- (a) to issue safety and health regulations;
- (b) to provide for the enforcement of such regulations by measures of supervision;
- (c) to consult, as appropriate, employers' and workers' organisations on measures intended to improve industrial safety and health.

In 1972 HOPE obtained consultative status with the Council of Europe and is since then represented in the Liaison Committee of the Non-Governmental Organisations of the Council and its Health Group. Early 1998 Hope has been accepted on the list of international NGOs entitled to submit collective complaints in relation to the European Social Charter.

Occupational health in the EU:
historical perspective

Within the framework of the European Coal and Steel Community (ECSC), created by the Treaty of Paris in 1951, various research programmes have been carried out in the field of health and safety. The ECSC has initiated efforts to reduce the significant number of explosions and fires that mainly have occurred in coalmines in Europe during the past 50 years, causing the death of over 1,000 people. In subsequent years, the activities were extended to other extractive industries. In 1957, the Safety and Health Commission for the Mining and Other Extractive Industries was set up to

assist the Commission in the preparation of legislative initiatives to prevent the occurrence of major accidents in this sector. The protection of workers in this sector has long been followed attentively by the Commission because of the high accident rate and the frequent occurrence of respiratory diseases and hearing impairing diseases.

The need for a global approach to the health and safety of workers became more and more evident with the establishment of the European Economic Community (EEC) on 25 March 1957 by the Treaty of Rome. Authorities became aware that because of the wide differences in the measures taken by the Member States, occupational health and safety protection should receive Community attention. Improvement and equality in this area have subsequently been major objectives of Community initiatives. From 1962 till 1966, the recommendations of the Commission were the first steps towards the development of a Community policy concerning the protection of the health and safety of workers.

These recommendations concerned:

- (a) occupational medicine;
- (b) the adoption of a European list of occupational diseases;
- (c) the health surveillance of workers exposed to specific risks;
- (d) the compensation of victims of occupational diseases;
- (e) the protection of young people at work.

The ever-growing awareness by the EEC of the importance of safety and health at work took a decisive step forward when the Advisory Committee for Safety, Hygiene and Health Protection at Work was set up in 1974 (Council Decision 74/325/EEC of 27 June 1974). This Committee was created in order to assist the Commission in the preparation and implementation of activities in the field of health and safety at work and to facilitate co-operation between national administrations, trade unions and employers' organisations. It covers all sectors of the economy (except the extractive industries) as well as the protection of worker's health against the dangers arising from ionising radiation. A major role was played by this Advisory Committee in drawing up the first action programme in 1978, which covered 14 major areas including:

- (a) incorporation of safety aspects into design, production and operation of machinery, equipment and plant;
- (b) determination of safe exposure limits for workers;
- (c) monitoring of health and safety;
- (d) study of accidents and diseases;
- (e) co-ordination and promotion of research;
- (f) development of health and safety consciousness through education and training.

A second action programme, covering the period 1982-86, continued the measures begun under the first programme within the aim of the EEC to improve quality of life and standards of living across Europe. Within the framework of the first two programmes, the Council adopted the following directives:

- (a) Directive 78/610/EEC of 29 June 1978 on the approximation of the laws, regulations and administrative provisions of the Member States on the protection of the health of workers exposed to vinyl chloride monomer.
- (b) Directive 80/1107/EEC of 27 November 1980 on the protection of workers against risks related to exposure to chemical, physical and biological agents at work.
- (c) Directive 82/605/EEC of 28 July 1982 on the protection of workers from the risks related to exposure to metallic lead and its ionic compounds at work.
- (d) Directive 83/447/EEC of 19 September 1983 on the protection of workers from the risks related to exposure to asbestos at work.
- (e) Directive 86/188/EEC of 12 May 1986 on the protection of workers from the risks related to exposure to noise at work.

A considerable speeding-up of Community directives was made possible by the adoption in 1987 of the Single European Act, which was the beginning of a second phase in the period between 1957 and the signature of the Maastricht Treaty (1991). An intensification of the role of the Advisory Committee on Safety, Hygiene and Health Protection at Work has become more important since the implementation of the new Article 118A of the EEC Treaty of Rome which provides both the legal basis and sets out a general principle:

Member States shall pay particular attention to encouraging improvements, especially 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.

The effect has been to accelerate further the development and introduction of Community legislation in the health and safety field. In order to help to achieve the above objective, the Council adopted by means of Directives, minimum requirements for gradual implementation in each of the Member States. The Commission also made it clear that the minimum requirements as set out in Article 118A of the Act must not be interpreted as 'minimalist' or the 'lowest common denominator' of existing law. Indeed the provisions adopted pursuant to this Article do not prevent each Member State from introducing more stringent measures for the protection of working conditions compatible with the Treaty.

On the other hand, Article 100A - the objective of which is to remove all barriers to trade in the single market and to allow the free movement of goods across borders - is also relevant for health and safety at work. Directives under Article 100A are intended to ensure the placing on the market of safe products including machines and personal protective equipment the professional use of which is addressed by Directives based on Article 118A. In principle, Article 100A does not permit Member States to set higher requirements for their products than those laid down by the directives.

It is important to mention that all Member States except the United Kingdom adopted the Charter of the Fundamental Social Rights of Workers, commonly known as the Social Charter, in December 1989 in the form of a declaration, which was added to the Maastricht Treaty as a protocol in December 1991. It is seen as a political instrument containing 'moral obligation', whose object is to guarantee that certain

social rights are respected in the countries concerned. The preamble of this Charter, which has no binding force, affirms that 'the same importance must be attached to the social aspects as to the economic aspects' of the single market. In a specific reference this Charter underlined the importance of the protection of health and safety at the workplace. In June 1997 the protocol was integrated in the Amsterdam Treaty, which entered into force on 1 May 1999 and is binding for the UK.

Since 1978, the Commission has implemented three action programmes on safety and health at work, which were all subjects of Council resolutions. The third action programme, which was an essential complement to the social aspects of the development of the internal market, was based on three fundamental concepts:

- (a) the need to push on improving the safety and health protection of workers on a broad front;
- (b) the obligation to ensure that workers have adequate protection from the risks of work accidents and occupational diseases;
- (c) the need to ensure that the competitive pressures of the single market did not jeopardise the safety and health protection of workers.

With these three objectives in mind, the programme was strongly focused on legislation. In consequence of the third action programme on 12 June 1989 the first and probably the most important Directive was adopted under Article 118A: Framework Directive 89/391/EEC, which provided minimum requirements concerning health and safety at work. It was the core of the Commission's strategy on health and safety directives to have a Framework Directive on which all subsequent directives have been built. This Framework, which has been implemented by each Member State on 31 December 1992, included the following main provisions:

- (a) applies to all sectors of work activity;
- (b) assigns primary responsibility for health and safety of employees to their employer;
- (c) sets out general principles for employers to follow in protecting health and safety, including: (1) assessing workplace risks and introducing appropriate preventive measures, (2) developing a coherent overall prevention policy, (3) co-operation between employers;
- (d) requires employers to designate competent personnel to take charge of health and safety activities, or use competent outside services;
- (e) provides for first-aids, fire precautions and emergency arrangements;
- (f) requires employers to provide information and training for employees and to consult Workers' representatives on health and safety measures;
- (g) requires employees to take care of their own and others' safety and to co-operate with their employers.

Next to the actions of general nature, there are also a number of individual (or more specific) Directives submitted by the Commission and adopted by Parliament and the Council within the framework of Article 118A.

A. Protection of Specific Groups of Workers

1) Pregnant Workers

Council Directive 92/85/EEC was adopted on 19 October 1992 and has been implemented in the Member States by 19 October 1994. It identifies pregnant workers and workers who have recently given birth or are breastfeeding as a group of workers who face specific risks in the workplace:

(a) It has ensured that the public and private sectors are covered, as well as women on both indefinite and fixed term contracts.

(b) It provides that an assessment must be made of the workplace and the job. If the assessment reveals a risk to health and safety, all reasonable steps must be taken to ensure that the risk is avoided.

(c) There must be the possibility to transfer to daytime work if a risk is identified for pregnant workers in working at night.

The Directives prohibit the dismissal of a pregnant woman or a woman on maternity leave, unless it is for reasons unconnected with the pregnancy. The minimum length of maternity leave permitted under the Directive is 14 weeks, which must be paid.

2) Temporary Workers

Council Directive 91/383/EEC of 25 June 1991 supplementing the measures to encourage improvements in the safety and health at work with fixed-duration employment relationship or a temporary employment relationship:

(a) The purpose is to ensure that temporary workers, as regards safety and health at work, have the same level of protection as that of other workers in the user undertaking and/or establishment.

(b) The existence of an employment relationship shall not justify different treatment with respect to working conditions, especially as regards access to personal protective equipment.

3) Young People

Council Directive 94/33/EEC of 22 June 1994 on the protection of young people at work:

(a) The necessary measures will be taken to prohibit work by children. They shall ensure that the minimum working or employment age is not lower than the minimum age at which compulsory full-time schooling as imposed by national law ends or 15 years in any event.

(b) They will ensure that work by adolescents is strictly regulated and protected.

(c) Member States shall ensure in general that employers guarantee that young people have working conditions which suit their age. They shall ensure that young people are protected against economic exploitation and against any work likely to harm their safety, health or physical, mental, moral or social development or to jeopardise their education.

B. Safety

1) Manual Handling

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. Manual handling of loads means any transporting or supporting of a load by one or more workers (including lifting, putting down, pushing, pulling, carrying or moving of a load), which, by reason of its characteristics or of unfavourable ergonomic conditions, involves a risk particularly of back injury to workers.

(a) The employer shall take appropriate organisational measures, or shall use the appropriate means, in particular mechanical equipment.

(b) Wherever the need for manual handling of loads by workers cannot be avoided, the employer shall use appropriate means to reduce the risk and he shall organise workstations in such a way to make such handling safe and healthy.

2) Work Equipment

a) Electrical equipment for use in potentially explosive atmospheres in mines susceptible to firedamp (Council Directive 82/130/EEC of 15 February 1982).

b) Work Equipment

Council Directive 95/63/EEC of 5 December 1995 amending Directive 89/655/EEC concerning the minimum safety and health requirements for the use of work equipment by workers at work.

(a) The employer shall take the measures necessary to ensure that the work equipment made available to workers is suitable for the work to be carried out or properly adapted for that purpose and may be used by workers without impairment to their safety and health.

(b) In selecting the work equipment, the employer shall pay attention to the specific working conditions and characteristics and to the hazards that exist in the undertaking and/or establishment.

(c) Ergonomics and occupational health: The working posture and position of workers while using work equipment and ergonomic principles must be taken fully into account by the employer when applying minimum health and safety requirements.

c) Personal Protective Equipment (PPE)

Council Directive 89/656/EEC of 30 November 1989: the minimum health and safety requirements for the use of personal protective equipment at the workplace.

Personal protective equipment shall mean all equipment designed to be worn or held by the worker to protect him against one or more hazards likely to endanger his safety and health at work.

(a) PPE must comply with the relevant Community provisions on design and manufacture with respect to safety and health.

- (b) The conditions of use of PPE, in particular the period for which it is worn, shall be determined on the basis of the seriousness of the risk, the frequency of exposure to the risk, the characteristics of the workstation of each worker and the performance of the personal protective equipment.
- (c) Adequate information on each item of PPE shall be provided.
- (d) PPE shall be provided free of charge by the employer, who shall ensure its good working order and satisfactory hygienic condition by means of the necessary maintenance, repair and replacements.
- (e) The employer shall inform the worker of the risks and he shall arrange training sessions and demonstrations in the wearing of PPE.

d) Display Screen Equipment

Council Directive 90/270/EEC of 29 May 1990 on the minimum safety and health requirements for work with display screen equipment.

- (a) Employers shall be obliged to perform an analysis of workstations in order to evaluate the safety and health conditions to which they give rise for their workers, particularly as regards possible risks to eyesight, physical problems and problems of mental stress.
- (b) The employer must plan the workers' activities in such a way that daily work on a display screen is periodically interrupted by breaks or changes of activity reducing the workload at the display screen.
- (c) Protection of workers' eyes and eyesight: Workers shall be entitled to an appropriate eye and eyesight test carried out by a person with the necessary capabilities.
- (d) Special requirements are included for the (1) equipment, (2) environment, (3) operator/computer interface.

3) Safety Signs

Council Directive 92/58/EEC of 24 June 1992 on the minimum requirements for the provision of safety and/or health signs at work.

- (a) Employers shall provide safety and/or health signs as laid down where hazards cannot be avoided or adequately reduced by techniques for collective protection or measures, methods or procedures used in the organisation of work, or ensure that such signs are in place.

C. Different Workplaces

- 1) Workplaces (Council Directive 89/654/EEC of 30 November 1989).
- 2) Temporary or mobile construction sites (Council Directive 92/57/EEC of 24 June 1992).
- 3) Mineral-extracting industries (Council Directive 92/91/EEC of 3 November 1992) (Council Directive 92/104/EEC of 3 December 1992).
- 4) Fishing vessels (Council Directive 93/103/EC of 23 November 1993).
- 5) Medical treatment on board vessels (Council Directive 92/29/EEC of 31 March 1992).

D. Chemical, Physical and Biological Agents

1) Chemical Agents

- (a) Vinyl chloride monomer
(Council Directive 78/610/EEC of 29 June 1978).
- (b) Exposure to chemical agents
(Council Directive 80/1107/EEC of 27 November 1980).
- (c) Metallic lead (Council Directive 82/605/EEC of 28 July 1982).
- (d) Asbestos (Council Directive 83/447/EEC of 19 September 1983).
- (e) Banning (Council Directive 88/364/EEC of 9 June 1988).
- (f) Carcinogens agents
(Council Directive 90/394/EEC of 28 June 1990).
- (g) Protection of workers (Council Directive 98/24/EC of 7 April 1998).

2) Physical Agents

- (a) Exposure of workers
(Council Directive 80/1107/EEC of 27 November 1980).
- (b) Noise (Council Directive 86/188/EEC of 12 May 1986).

3) Biological Agents

- (a) Exposure of workers
(Council Directive 80/1107/EEC of 27 November 1980).
- (b) Protection of workers
(Council Directive 90/679/EEC of 26 November 1990).

E. Working Time

The Council of Ministers adopted Directive 93/104/EC on certain aspects of the organisation of working time on 23 November 1993. The essential aims are to ensure that workers are protected against adverse effects on their health and safety caused by working excessively long hours, having inadequate rest or disruptive working patterns.

The Directive provides in particular for:

- (a) a minimum daily rest period of 11 consecutive hours a day;
- (b) a rest break where the working day is longer than 6 hours;
- (c) a minimum rest period of 1 day a week;
- (d) a maximum working week of 48 hours on average including overtime;

- (e) 4 weeks' annual paid holiday; and that
- (f) night workers must not work more than 8 hours in 24 on average.

The Directive contains a number of further provisions relating to the protection of the health and safety of night workers and shift workers. It also requires measures to be taken so that the work organisation can adapt work to the worker.

Employed doctors 'not in training' are covered by the 1993 Working Time Directive. The original exclusion refers to 'doctors in training': persons who have completed their basic medical training and are preparing themselves to acquire a higher medical qualification. The employment status of doctors in training is not clear. In some countries they have a special status, which is neither self-employed, employee nor trainee. But in the vast majority of countries, they are considered to be 'employees' for the purpose of the employment law. A specific feature of the employment of doctors in training relates to 'on-call' duty.

The long working hours of juniors has been a long-standing source of resentment. In November 1998, the European Commission outlined proposals, as part of an extension to the coverage of the EU's 1993 Working Time Directive, to reduce the working hours of doctors in training to an average of 48 hours. The Commission proposed a transition period of seven years to bring junior doctors in line with the 48-hour working week. As a response to Member States' concerns that such a large reduction in hours would require a longer adjustment period, in May 1999 the Council of Ministers decided to extend this transition period to nine years. In April 2000 a discussion between the Council, proposing thirteen years of transition, and its Parliament, accepting only four years, was still going on.

European institutions for health
and safety

1. European Foundation for the Improvement of Living and Working Conditions

The European Foundation for the Improvement of Living and Working Conditions (Wyattville Road, Loughlinstown, Dublin - Phone ++353/1/2043100 - Fax ++353/1/2826456/2824209 - E-mail: postmaster@eurofound.ie - Internet: <http://www.eurofound.ie/html/health.html>) in Dublin was established by a Regulation of the Council of Ministers (EEC) on 26 May 1975. The aim of the Foundation, which covers now 15 Member States, is to contribute to the planning and establishment of better living and working conditions through action designed to increase and disseminate knowledge likely to assist this development.

The transformations in work and society, which are central to the Foundation's work, have profound influences on the health and well being of Europe's citizens. Poorer health results in increased costs at the workplace and for the society in general. An integrated approach is essential because of the blurring boundaries between life at work and life outside work.

As regards the improvements of living and working conditions, the Foundation deals more specifically with the following issues:

- (a) man at work;
- (b) organisation of work and particularly job design;
- (c) problems peculiar to certain categories of workers;
- (d) long-term aspects of improvement of the environment;
- (e) distribution of human activities in space and in time.

2. European Agency for Health and Safety at Work

The European Agency for Safety and Health at Work, as a complex network organisation made up of, and working with, various groups and bodies, started work on 15 September 1996. It is based in Bilbao (Gran Via 33, E-48009 - Phone +349 4 - 479 43 60 - Fax +349 4 - 479 43 83 - E-mail: information@eu-osh.es - <http://www.eu-osh.es>), Spain. The objective of the Agency as set out in two Council Regulations - 2062/94 and 1643/95 - is:

in order to encourage improvements in the working environment, the Agency shall provide the Community bodies, the Member States and those involved in health and safety at work with the technical, scientific and economic information of use in the field of safety and health at work.

For the year 2000 the European Agency for Safety and Health at Work will work, among other priorities, on a project to develop information on health and safety best practice in healthcare services. The Agency will even organise a European Week to raise awareness about and prevent muscular/skeletal disorders and back pain at work, which is one of the most alarming health and safety risks in the EU at present.

Health and safety at work:
committees

In addition to the Committees (The Safety and Health Commission for the Mining and Other Extractive Industries & the Advisory Committee for Safety, Hygiene and Health Protection at Work) already mentioned (see Occupational Health in the EU: Historical Perspective), two other Committees were set up by the Commission.

1. Occupation Exposure Limits (OELs)

In 1990, at the request of the Council, the European Commission set up an informal group of scientists, known as the Scientific Expert Group (SEG), to work on the scientific evaluation of the risks at the workplace related to chemical substances. The Committee reflects the full range of expertise that is necessary to complete its

mandate, including, in particular chemistry, toxicology, epidemiology, occupational medicine, industrial hygiene, and general competence in setting OELs.

2. Senior Labour Inspectors Committee

The Commission Decision 95/319/EC of 12 July 1995 set up a Committee of Senior Labour Inspectors:

...whereas the 'Committee of Senior Labour Inspectors', by virtue of its long experience, constitutes an appropriate framework for monitoring, on the basis of close co-operation between its members and the Commission, the effective and equivalent enforcement of secondary Community law on health and safety at work, and for the rigorous analysis of the practical questions involved in monitoring the enforcement of legislation in this field;...

In many Member States, in addition to health and safety at work, labour inspectorates are also responsible for a whole range of areas comprising social benefits, pay, leave and working hours, employment relationships, environmental protection, and the management of employment and vocational training policies.

Accidents at work in the European Union

To determine work safety trends at European level, it is essential to have comparable data on accidents at work. Until 1990, the variables and classifications used by the Member States to record accidents at work were not comparable and national data could not be used to study risk levels on a Europe-wide basis. The European Commission tackled this problem by launching a scheme to harmonise data on health and safety at work, known as ESAW (European Statistics on Accidents at Work). In 1992, the Commission adopted an approach involving the introduction of harmonised definitions, variables and coding systems which the Member States started to use in 1993. ESAW statistics cover accidents causing absences from work of more than three days and accidents leading to the death of the victim. In 1998, figures were collected for 1996 on the size of the undertaking, the occupational status of the victim (employee, self-employed, etc.) and the number of days lost through absence from work. Subsequently account was taken of the causes and circumstances of the accident as well as the victim's job and working environment when the accident occurred. A pilot project for European Statistics on Occupational Diseases known as EODS concerning 31 diseases on the European list of occupational diseases is currently underway.

Conclusion

The ultimate objective of occupational health is a safe and satisfactory work environment and a healthy, active and productive worker. A person who is free from both occupational and non-occupational diseases and capable and motivated to carry

out his or her daily job by experiencing job satisfaction and developing as a worker and as an individual.

Select bibliography

Belcher, P.J. (1999). The role of the European Union in Healthcare. Overview produced at the request of the Council for Health and Social Service on behalf of the Advice Europa en de Gezondheidszorg, Zoetermeer.

Commission of the European Communities, Directorate-General for Employment, Industrial Relations and Social Affairs (2/90). Health and Safety at Work in the European Community, pp. 241.

Europese Commissie, Directoraat-Generaal werkgelegenheid, industriële betrekkingen en sociale zaken (3/93). Europa voor veiligheid en gezondheid op het werk, pp. 344.

European Commission (1995). Health and Safety at Work - Community Programme 1996-2000.

Health & Safety Commission Newsletter (1992). A Short Guide to European Directives on Health & Safety at Work, 81, p. 5-16.

Kenny T. (1998). Securing Social Rights across Europe. How NGOs can make use of the European Social Charter, Human Rights Information Service Council of Europe, France.

Macdonald E., Baranski B. & J. Wilford (1999). Occupational Medicine in Europe: Scope and Competencies, Report in press.

Masschelein R. (1992). Arbeidsgeneeskunde in de Ban van Europa 1992: De arbeidsgeneeskunde in Vlaanderen in de Ban van Europa 1992, 26e Vlaamse Universitaire Studiedagen voor Arbeidsgeneeskunde, Antwerpen, 14-15 mei, p. 46-56.

WHO - Geneva (1995). Global Strategy on Occupational Health for All - The Way to Health at Work, Recommendation of the Second Meeting of the WHO Collaborating Centres on Occupational Health, Beijing, China.

AUSTRIA

GENERAL INFORMATION AND DEFINITION

By law, the protection of employees in Austria is regulated by the Federal Safety and Health Protection Law, which came into force on 1 January 1995. The general regulation is fully applicable to the hospital sector.

The regulations on employee protection are monitored partly by legally specified internal arrangements within organisations and partly by external arrangements, especially through the Labour Inspectorates. The Labour Inspectorates are independent administrative authorities, which are directly responsible to the Federal Ministry of Employment, Health and Social Affairs. They are essentially responsible for ensuring that employers and employees observe their obligations regarding employee protection, and for providing support and advice; if necessary, they may enforce the observance of regulations.

The starting point for the revision of the law was Austria's membership of the EU and the associated adaptation to EU employee protection regulations.

The new law stipulated an expanded responsibility for employers including, for example, the obligation to carry out an assessment and evaluation of risks and to provide appropriate measures for the prevention of risks in all places of employment.

Until 1995, the provision of occupational medical care was obligatory in Austria only for organisations with 250 employees or more.

Since 1995, organisations have been included in the expanded programme of health protection at work on the basis of a graduated plan according to the number of employees. At present, occupational medical staff and safety specialists must be employed in organisations that regularly employ more than 50 people.

From 1 January 2000, every organisation with one or more employees must ensure the provision of occupational medical care and safety at work.

At present, the Preventive Services provide care for around 500,000 employees (a total of around 2.5 million employees fall within the scope of responsibility of the Labour Inspectorate).

OCCUPATIONAL MEDICAL CARE

In appointing the Preventive Services, which include safety specialists and occupational medical staff, there are always the following options:

- to employ in-house safety specialists and occupational medical staff
- to call in external services (such as local medical practitioners)
- or to conclude a contract for work with an occupational medical centre or specialist safety organisation.

These Preventive Services are responsible for advising employers and employees in the fields of health protection, promotion of health and human rights in the work

place; they are also required to support employers in the fulfilment of their obligations. Furthermore, they must ensure that all employees can arrange to have a regular medical examination if they wish to do so. Employees and employers must be informed appropriately in case of any danger, and, if the measures taken by the employer are inadequate, the Labour Inspectorate may be notified.

TRAINING / QUALIFICATIONS

Since 1994, university courses have been available leading to qualification as a specialist occupational physician. The duration of the course is 6 years. In addition to this, a 12-week post-graduate course in occupational medicine is available for doctors already qualified. This course is currently run at two training centres. Specialist safety personnel require a basic technical training with an additional, 8-week specialist training-course.

WORKING HOURS

Minimum working hours are specified for the Preventive Services. These are specified with reference to the number of employees per calendar year. On average, the working hours per employee are approximately one hour for specialist safety personnel and approximately 40 minutes for occupational medical staff. Records of hours worked must also be kept.

OCCUPATIONAL DISEASES

The procedure for acknowledgement of occupational diseases is regulated by the General Social Insurance Law (ASVG). At present 52 disorders are recognised as occupational diseases.

In recent years, a decline has been recorded in the number of acknowledged occupational diseases (approximately 1, 1 00 cases in 1997). With reference to the frequency of occurrence of occupational diseases, skin disorders are most frequent, followed by hearing impairment caused by noise.

REFORMS / DEVELOPMENT

The following changes have come into force since the Amendment to the Employee Protection Law, adopted on 01. 01.1999:

- * Special rulings for work places with less than 50 employees (more flexible models of care tailor-made for the needs of small to medium sized organisations and the creation of "Prevention Centres" [accident insurance providers], which offer qualitative consultation services). The new option of making use of Prevention Centres free of charge is available to the majority of Austrian employers (a total of approximately 205,000 jobs).

- * Expansion of the so-called "organisational model" (employees can fulfil the responsibilities of the safety specialists if they can provide evidence of "adequate knowledge").

Amendment of the approval of occupational medical centres and centres for industrial safety (a centre can be operated after fulfilling the legal requirements).

* More flexible ruling on the use of safety provisions and occupational medical care for work places with more than 50 employees.

At a future stage, quality criteria will be prepared for occupational medical care in order to raise the quality of occupational medical care to a unified level.

Austria is a founding member of the European Network of Societies for Occupational Medicine (ENSOP - European Network of Societies of Occupational Physicians).

Bundesministerium für Soziale Sicherheit und Generationen
Sektion VII,
Radetzkystrasse 2
A-1030 Wien
Austria

BELGIUM

GENERAL INFORMATION AND DEFINITION

Occupational medicine, nowadays called occupational health (OH) in Belgium is regulated by the 'Law on the well-being of employees at work' (4 August 1996), which covers all employers and employees in Belgium, both in the private and public sectors. This framework law will contain all the specific regulations on safety, health and well-being at work until now collected in the former 'General Regulations on Labour Protection' (1952) and will also incorporate present and future European regulations in this field, such as the European Directive 89/391/EEG of 12 June 1989 concerning measures aimed at improving the safety and health of employees at work. The Belgian law covers three main areas: occupational safety, occupational medicine (stricto sensu) and occupational hygiene in the work place, with a growing focus on prevention and multidisciplinary in all three areas. The general regulation is fully applicable to the hospital sector.

OBJECTIVES

In general well being is aimed at through the improvement at work by measures of safety, health prevention, ergonomics and hygiene. The prevention policy of the employer should be based on the principles of continuous risk assessment in the work place, medical surveillance of workers and health education and promotion.

ORGANISATION

On the national level the Federal Ministry of Labour holds responsibility for the regulation and control of occupational health. The government policy is implemented and controlled by the administration of occupational hygiene and health. The medical inspection service specifically supervises the occupational health service; the technical inspection service supervises the safety services. The High Council for Prevention and Protection, consisting of representatives of employers and employees advises the Minister on legislation. Responsibility for the implementation of the measures for the well being of workers in the work place is laid on all the employers. There are two organisational schemes to fulfil these obligations. The employer can establish his own internal service for prevention and protection, equipped with the necessary medical and technical professionals in occupational health and safety (prevention advisors). As an alternative the employer can affiliate with an external service for prevention and protection for the specific tasks he wishes or may not wish to perform in his own internal service. The external service for prevention and protection is set up as an independent multidisciplinary service, which provides both specialised technical and medical service to affiliated employers, in fulfilment of their legal obligations in the fields of safety, health and the well-being of workers.

ACCREDITATION

Both the internal and external service have to be accredited by a governmental accreditation commission within the Federal Ministry of Labour. The occupational health section within these services should have additional accreditation from the regional ministries of health. The accreditation must be renewed every five years.

SUPERVISION

Supervision is carried out on the national level by medical and technical inspectors. On the plant level the internal and the external services for prevention of accidents and protection are supervised by the joint committee of the social partners, which is compulsory in every organisation with more than 50 employees. A specific national supervising committee will control the accreditation of all the external services for prevention and protection.

FINANCING

The costs of the legal obligations for the well being of workers must be borne entirely by the employer. The basis of the financing system until now is the amount of time per worker needed for health surveillance and related tasks. This amount of time differs according to the degree of work-related health and safety risks of workers. For the workers at higher risk a one-hour yearly service equivalent is calculated, the cost of which is set by the government at 75 ECU. Special health examinations or biological and environmental measurements are charged separately.

SERVICES FOR PREVENTION AND PROTECTION

Both the internal and external services for prevention and protection should assist the employer in establishing a prevention policy within the company and in executing the necessary and legally required actions. The service for prevention and protection has to perform continuous risk assessment in the work place, including the inventory of dangers, assessment of exposure and risk evaluation. Risk assessment provides the starting point for preventive measures for risk elimination or reduction and for a programme of workers' protection. The occupational health service provides medical health surveillance of workers, especially for workers with a higher, work-related risk profile (e.g. exposed to known risks for occupational diseases, safety functions...). Medical surveillance includes a pre-employment examination, periodical medical examinations, vaccinations, examinations after a four-week sickness leave. For all workers medical first aid in emergencies and the possibility of a free consultation is provided. The occupational health physician has the legal obligation to declare each case of (suspected) occupational disease to the medical inspectorate and to the national fund for occupational diseases. He has specific duties towards special groups of workers at risk (pregnant women, handicapped workers). He must not control absenteeism of workers. Together with the other prevention advisors the occupational health physician has to provide information and training for employers and employees and has to participate in the plants' joint committee for prevention and protection.

FACTS AND FIGURES

In 1995 there were 220,000 undertakings and 2,400,000 workers in Belgium. 38% of workers worked in undertakings with less than 50 employees (97%). 62% of workers worked in undertakings with more than 50 employees (3%). At present there are 235 occupational health services (OHS) covering 300 undertakings with 400,000 employees and 55 interoccupational health services (IOHS), covering 219,700 undertakings with 2,000,000 employees. With the new law of 1996 the aim is to integrate the OHS and the IOHS respectively in the internal services and the external services for prevention and protection. As for the occupational health physicians in 1995 there were 940 OH physicians or +- 600 FTE: 30% in OHS, 70% in IOHS (60% in Flanders and 40% in French-speaking Belgium).

Association Belge des Hôpitaux
Vereniging van Openbare Verzorgingsinstellingen
Consisting of:

Association des Etablissements Publics de Soins
Vereniging van Openbare Verzorgingsinstellingen
Gildenstraat / rue des Guildes 9
B-1040 Brussels
Belgium

and

Association Belge des Hôpitaux
Belgische Vereniging van Ziekenhuizen
Lennikbaan / route de Lennik 808
B-1070 Brussels
Belgium

Belgische Federatie van Caritas Ziekenhuizen
Fédération Belge des Hôpitaux de Caritas
Consisting of

Fédération des Institutions Hospitalières de Wallonie
Chaussée de Marche, 604
B-5101 Erpent
Belgium

and

Verbond van Verzorgingsinstellingen
Guimardstraat 1
B-1040 Brussels
Belgium

GERMANY

GENERAL INFORMATION AND DEFINITION

Occupational Health in Germany was created by the Accident Insurance Act of 6 July 1884. Previously, compensation for an industrial accident or an occupational disease had to be sought directly from the company itself. With the new regulation compensation for an industrial accident or an occupational disease could be claimed from the professional association, who assumed liability in the place of the individual companies. The tasks of the German accident insurance system are:

- accident prevention,
- restoration of health and fitness to work (rehabilitation)
- and payment of benefits (e.g. pensions).

The special feature of the German system is that these tasks are taken care of by one agency - the professional associations ("Berufsgenossenschaften"). They are the representatives of accident insurance.

Since 1884 the system of occupational health has seen fewer changes than other parts of social security. In 1963 a new ruling was established. It mainly laid down that once a company has reached the size of 20 employees it must appoint staff qualified in occupational safety and that the Federal Government has to publish an annual report on accident prevention ("Unfallverhütungsbericht"). Every four years this report includes a broad overview of the development of industrial accidents and diseases, their costs and measures for security and health at work. The system is fully applicable to the hospital sector.

Other changes in the system have broadened the type of persons included in the system (e.g. since 1971 the accident insurance system is also responsible for students).

AGREEMENTS ON HEALTH AND SAFETY

An array of compulsory rules governing occupational safety and health protection is contained in:

- laws and statutory ordinances of the government
- and Accident Prevention Regulations of the professional associations ("Unfallverhütungsvorschriften").

Some of the Accident Prevention Regulations apply to all branches of industry and others apply solely to particular machines, facilities or sectors of industry. The Accident Prevention Programmes also serve the implementation of national laws with the same legal status as statutory ordinances.

The government regulations set the Work protection standard in Germany across the board for all areas of work.

PROFESSIONAL ASSOCIATIONS ("BERUFSGENOSSENSCHAFTEN")

The professional associations are statutory accident insurance companies. They are organised on the basis of industrial sectors. By law, every employer is a member of them. The employer must register with the professional association within one week of founding a company. Membership of the professional associations must not be replaced by private insurance. They are funded exclusively by contributions from member companies and must be non-profit. Therefore they only collect contributions to cover the costs of their statutory duties.

The professional associations are public-law bodies, carrying out the legally assigned tasks of accident prevention and insurance under autonomous administration based on equal representation of the interests of members (employers) and those insured (employees). The government is responsible for legal supervision. Every six years, "social elections" take place in which employers and employees elect their members of the representatives' assembly.

INDUSTRY-WIDE OCCUPATIONAL SAFETY

The industry-wide occupational safety organisation has two pillars:

- the Technical Inspectorates of the professional associations ("Technischer Aufsichtsdienst")
- the public factory inspectorates ("Gewerbeaufsichtsämter").

The Technical Inspectorates have certain tasks. The most important is to monitor company compliance with the Accident Prevention Regulations and work place protection standards. To fulfil this task more than 500,000 companies are inspected every year. Infringements can be punished with a fine up to 20,000 DM.

Technical Inspectorates also advise companies on all matters of occupational safety and health protection, and they are involved in safety checks on appliance and equipment.

Public factory inspectorates are regionally structured. They monitor all companies in their district, no matter what branch of industry they belong to. They ensure that the laws on occupational safety are respected. Nearly 300,000 companies are inspected every year.

OCCUPATIONAL SAFETY AT THE WORK PLACE

Responsibility for the health and safety of staff at work lies with the employer. A company is obliged to organise occupational safety and health protection in such a way that all senior staff are aware of their responsibilities in this field. The employer must create the facilities, issue the instructions and take the measures necessary to ensure that the work is safe and healthy.

The staff must operate plant and equipment in accordance with instructions, use the required personal protection equipment and observe the rules on accident prevention. Once a company has reached a size of 20 employees it must appoint staff qualified in occupational safety. The task of this staff is to give the employer advice on all matters relating to this field. The so-called "Sicherheitsbeauftragter" is supported by safety delegates. Increasing importance is being given to occupational preventive medicine and medical care services at the work place. Companies of a certain size (Regulation of size varies from one area to another) are obliged to have their own physicians. These doctors are specially trained in occupational medicine. Some professional associations have set up their own occupational medical services so that companies not wishing or unable to employ their own doctors can still provide comprehensive medical care for their workers.

OBLIGATIONS OF THE ACCIDENT INSURANCE SYSTEM

The professional associations are responsible for

- industrial accidents
- commuting accidents
- occupational diseases

They provide the insurance cover for these accidents and diseases.

If employees have accidents or contract occupational diseases, they will get help in the form of medical care, nursing where patients are unable to take care of themselves, occupational/social rehabilitation and pensions.

Deutsche Krankenhausgesellschaft
(Postfach 300252 - D-40402 Düsseldorf)
Tersteegenstrasse 9
D-40474 Düsseldorf
Germany

DENMARK

THE DANISH MODEL

The Danish Working Environment Act has the following preamble:

"The provisions of this Act shall have effect with a view to creating

- 1) a safe and healthy working environment at all times adapted to the technical and social developments of society;
and
- 2) a basis which enables undertakings themselves to resolve questions regarding health and safety under the guidance of the social partners and, guidance and control by the Danish Working Environment Service."

The Danish Working Environment Act (1975) represents the foundation of a modern working environment system, based on the principles of consensus and three-party government. It is fully applicable to the hospital sector.

The aim of the Danish Working Environment Act is to create a safe and healthy working environment, free from any effects of work that in the long term may be physically or psychologically injurious to health without directly causing accidents or immediate illness. Emphasis is placed on prevention of occupational diseases and on forestalling effects injurious to health, which may cause rapid exhaustion of employees with premature departure from working life as a result.

The Danish Working Environment Act is a framework act containing only few detailed regulations. Within this overall framework, detailed rules are formulated by way of administrative regulations, issued by the Minister of Labour or the Directorate of the Working Environment Service (WES).

WES does its utmost to turn advances made by research, both in Denmark and internationally, into improvements in the work place. This is partly achieved through amendments to the rules laid down by virtue of the Working Environment Act. The Danish rules are also being amended regularly so as to comply with the various regulations and directives adopted by the EU.

THE WORKING ENVIRONMENT SYSTEM

The Working Environment Act has given Denmark a system in which the social partners have a substantial influence on developments in working environment matters.

At the superior level the social partners have influence on the efforts to improve the working environment through the Working Environment Council. The Council participates among other things in the drafting of new rules.

At the industrial level, influence is exerted through the Sector Safety Councils (12 in all), and at the enterprise level the social partners take part in Safety Organisation.

The Ministry of Labour is Denmark's supreme administrative authority in the field of health and safety at work. Subordinate to the Ministry of Labour is the Working

Environment Service consisting of the Directorate of the Working Environment Service, 14 Regional Inspectorates and the Institute of Occupational Health.

THE INTERNAL SAFETY ORGANISATION

All undertakings with 5 or more employees have a statutory duty to establish an Internal Safety Organisation.

The core of the Internal Safety Organisation is the Safety Group, which consists of the foreman/supervisor and the employees' safety representatives. A Safety Group is set up for each department as a principal rule, but several departments may also choose to have a joint Safety Group. The tasks of the Internal Safety Organisation are to chart the individual working environment and establish action plans for problem solving. The Internal Safety Organisation must also check compliance with safety regulations and report on and investigate occupational injuries.

The Safety Group is required to participate in planning, and must be consulted before any final decisions are taken by the company concerning health and safety in the department where the Group is operating.

A Safety Committee must plan and co-ordinate activities in undertakings with 20 or more employees.

It is required that all undertakings - both large and small - carry out work place assessments. This is an important means of strengthening the preventive health and safety work in undertakings.

Training in safety activities is offered to all members of a Safety Group, a Safety Committee and the person responsible for day-to-day safety activities.

The Act provides that newly elected members of the Safety Group must participate in a special safety-training course within four weeks of their election. The course is of 37 hours' duration and its purpose is to teach the participants how they can promote a safe and healthy working environment within their enterprise in actual practice and in co-operation with others.

The training follows modern educational principles placing emphasis on active participation by the course participants.

This training is termed "section 9 training" according to section 9 of the Working Environment Act.

THE 'OCCUPATIONAL' HEALTH SERVICE

The Occupational Health Service advises the Internal Safety Organisation in the individual company, analyses effects in the working environment, and undertakes health surveys. Emphasis is placed on preventive activities. The Occupational Health Service assists undertakings in implementing health and safety measures, such as the

planning of new production and changes in the production system based on ergonomic principles.

Employers are responsible for the establishment, operation and financing of the Occupational Health Service.

Some undertakings are legally required to have an Occupational Health Service, whereas others may join the scheme on a voluntary basis. The compulsory system was established in stages since its introduction in 1977.

The sectors falling within the compulsory arrangement are those with a high risk of occupational injuries and occupational diseases - mainly within industry.

THE SECTOR SAFETY COUNCILS

The Sector Safety Councils assist in solving specific health and safety problems in the different territorial sectors. The Councils may also submit proposals and give opinions on new rules. There are 12 Sector Safety Councils altogether, each covering a specific sector. The Sector Safety Councils are joint bodies.

THE WORKING ENVIRONMENT COUNCIL

The Working Environment Council assists in the preparation of rules, and submits opinions to the Minister of Labour concerning developments in the field of the working environment as well as proposals for improvement.

The social partners and the authorities are all represented in the Working Environment Council.

The Ministry of Labour and the Working Environment Service take part in the Council's meetings, but without the right to vote.

The Working Environment Council also provides information, training, and research in the field of health and safety at work.

A Working Environment Board of Appeal deals with appeals against decisions of the Working Environment Service.

OCCUPATIONAL-MEDICINE CLINICS

The occupational-medicine clinics have been established as special departments in hospitals. Their main tasks are to carry out the examination of patients. The occupational-medicine clinics also have important functions in connection with disablement pensions, rehabilitation, occupational injuries and daily cash benefits.

In Denmark there are occupational-medicine clinics in each of the country's 14 counties. The occupational-medicine clinics collaborate closely with the Regional Inspectorates on the prevention of occupational diseases.

INDUSTRIAL INJURIES INSURANCE

In Denmark everybody exposed to an industrial accident or an occupational disease may receive financial support from the public authorities under ordinary social welfare legislation. In addition, a special Act - the Danish Industrial Injuries Insurance Act - provides for compensation due to occupational injuries.

The purpose of the Industrial Injuries Insurance Act is to offer compensation to employees and their dependants, if an employee has been injured during work. The employer is responsible for financing the scheme.

Amtsrådsforeningen i Danmark og Hovedstadens Sygehusfællesskab
Consisting of:

Amtsrådsforeningen i Danmark
Dampfærgevej 22 (or: PO Box 2593)
DK-2100 København Ø
Denmark

and

Hovedstadens Sygehusfællesskab
Bredgade 34,
DK-København K
Denmark

SPAIN

DEFINITION AND GENERAL INFORMATION

In Spain, occupational medicine, currently called occupational health, is regulated in the Prevention of Occupational Hazards Act of November 8 1995, which covers all employees working in Spain in both the private and public sectors, with just the few exceptions whose special features prevent this (police, security, etc.). The Act is based on the remittal in Article 40.2 of the Constitution entrusting the public powers with occupational safety and health responsibilities. It brings European regulation in this field into the Spanish legal system, notably EEC Directive 89/391 concerning application of measures to enhance the safety and health of employees at work. It is basic legislation providing the legal framework for the implementation of regulations on the more technical aspects of the preventive measures and the base upon which wage bargaining can fulfil its specific function. The Spanish Act focuses on prevention and on improving working conditions, and covers four main areas: industrial health, occupational medicine, occupational safety, and applied ergonomics and psychosociology, all dealt with on a multidisciplinary basis. This general regulation is fully applicable to the hospital sector, albeit with the adaptation of the pre-existing structure to the terms of the Act.

OBJECTIVES

The general aim is to prevent hazards that may be caused to workers by labour activity. Such prevention must be planned by the company on the basis of an appraisal of risks inherent to the job and the corresponding adoption of measures appropriate to such categories of risk.

ORGANISATION

At the national level, general responsibility for health at work is in the hands of the Ministry of Labour and Social Affairs, although the Ministries of Health and of Industry also have significant jurisdiction. The regional governments to which these services have been transferred have their own authorities. The National Work Safety and Health Institute, a specialised State Administrative technical scientific body, is responsible for analysing and studying the conditions of safety and health at work, and for promoting improvements, to this end co-operating with all the regional governments' bodies with authority in the field. The Work and Social Security Inspectorate ensures compliance with the provisions on the prevention of labour risks. The National Work Safety and Health Commission, which consists of representatives of the central and regional administrations and of employer organisations and trade unions, advises the public administrations on the definition of prevention policies and is the channel for official involvement in the field of occupational safety and health. It is the responsibility of all employees to implement the measures needed to prevent risks to workers in the work place: they may organise the resources needed to develop preventive actions, taking into account the size of the company and the risks to which employees are exposed, according to the following categories: by personally assuming such activity; by appointing one or more employees to implement it; by creating their own prevention service with the necessary installations, material resources and qualified personnel, or by outsourcing. The Social Security system's Work Accident and Professional Sickness Provident Organisations may act as out-

sourced prevention services. Joint prevention services can also be created between undertakings sharing a building. Changes are currently being made to the preliminary structure put in place under the 1959 Company Medical Services Regulations, which required such services to be set up in general in undertakings with more than 100 employees. The new provisions cover all workers although the prevention system, as already indicated, is optional for the employer, except for the requirement to create prevention services in undertakings with over 500 employees or in particularly hazardous industries with 250 or more employees.

ACCREDITATION

In order to operate as a prevention service, specialised entities must be accredited by the Labour Authorities (whether national or regional) following approval by the health authorities. Companies that do not arrange the prevention service with a specialised entity must undergo an external audit of their prevention system every five years.

MONITORING

Monitoring compliance with the occupational risk prevention regulations is entrusted at the national level to the Labour and Social Security Inspection Service, with the collaboration of the National Labour Safety and Health Institute. The National Labour Safety and Health Commission reviews and may report on and make proposals concerning the activities of the relevant administrative bodies.

FUNDING

Employers must bear all costs of the legal requirements for the protection of employees. However, the Act provides for the creation of a Foundation, designed to promote the improvement of occupational safety and health conditions, particularly in small undertakings. This foundation, which has to report to the National Labour Safety and Health Commission, is funded in part by the Prevention and Rehabilitation Fund drawn on management surpluses of the Social Security Work Accident and Professional Sickness Provident Entities (the "MATEPSS"). On the other hand, this fund is also used in part for MATEPSS prevention services activities. The basis for funding is the time needed for occupational health related activities per employee and per year, for example. For these purposes two categories of employees have been defined according to their occupational risks and the number of health activities necessary to protect their health: -68 minutes/employee/year and -34 minutes/employee/year.

PREVENTION SERVICES

Both types of company and out-sourced prevention services must advise the company about the risks present, and must include the following: an assessment of risk factors that may affect the health of employees; the design and implementation of appropriate preventive schemes; a definition of priorities in the adoption of the appropriate preventive measures and monitoring of their efficacy to inform and train employees; provision of first aid and emergency and surveillance plans for the health of employees in relation to occupational risks, particularly for employees with a high-job-risk profile (pregnant or breastfeeding employees, minors, those more sensitive to certain risks or particularly exposed to known risks). The monitoring of the health of employees must include initial check up on recruitment, to be repeated following

prolonged absence for reasons of health, in addition to regular check ups. The prevention service's health personnel must also provide first aid and emergency treatment required by employees, search for possible links between exposure to professional risk and health hazards, and propose measures to improve working conditions. Any special health condition suffered by employees must be known, in order to identify any potential link between such conditions and occupational risks. Collaboration is also necessary with the first aid and hospital service for the diagnosis, treatment and rehabilitation of occupation-related conditions, and with the health authorities in occupational health activities as well as in any planned health and epidemiological campaigns.

STATISTICS

The following table gives the data on undertakings and employees as at 31 December 1997. Some sectors, such as agriculture and the Public Administration, are not included.

Employees/Company	No. of Companies	No. of Employees
1 - 5	753,691	1,497,031
6 - 49	204,879	2,849,244
50 - 249	16,149	1,569,811
250 - 499	1,705	591,360
500 - 999	786	542,238
1000 or more	630	2,237,355
TOTAL	977,840	9,287,039

Instituto Nacional de la Salud (Insalud)
 C/Alcalá 56
 E-28014 Madrid
 Spain

FRANCE

GENERAL INFORMATION AND DEFINITION

France is the first country in the world to have organised Occupational Medicine Departments for the whole working population.

In theory the law is applied in all private and public sectors, thus also in hospitals, for all employees, including civil servants, temporary staff, daily helps. In practice 80 % to 90 % of the working population is covered.

ORGANISATION OF HEALTH AND SAFETY AT WORK

Laws and regulations are prepared at government level, on the one hand by the Council for the Prevention of Occupational Hazards, which includes representatives of employees and trade unions, public authorities and experts, and on the other hand by Technical Committees of employers and employees belonging to the National Organisation of Social Security.

In each district, the labour authorities, including the labour medical inspection and factory inspections, supervise the implementation of regulations and the efficiency of occupational medicine services, and provide technical assistance. This duty is also performed by engineers and industrial hygienists belonging to the local Social Security authorities, who can fine or reward employees whose work injuries and occupational disease rates are too high or very low.

In each company or factory with more than 50 employees there is a Health, Safety and Working Conditions Committee, made up of employees' delegates and the manager. It meets every three months and when a severe accident occurs. The occupational physician is the Committee's advisor.

ORGANISATION OF OCCUPATIONAL HEALTH DEPARTMENTS

Occupational Medicine comes under the supervision of employees and labour authorities.

There are two types of occupational medicine organisations: the "company department" and the "inter-company department". The company departments are set up by the employer, under the supervision of the "Joint production committee" (the manager and the unions' representatives). The inter-company departments are private departments which provide services for small or medium-sized undertakings (usually less than 200 employees). They are set up and paid for by employers: each of them pays an annual contribution according to the number of employees. The Control Committee's participants are made up of one-third employers and two third employees' representatives.

The evaluation of the work of Occupational Health Departments is carried out by means of the annual report on occupational medicine. This report is presented to the Employees' Committee or the Control Committee (for inter-company departments).
financing

Employers pay for occupational medicine, even if the employer is the State. The cost of occupational medicine is lower in inter-company departments than in company departments. The average annual contribution is about 0.4% of total salaries. But it can be much more in large undertakings.

MISSION

Law defines the activities at the work place (1/3 of working time): improvement of working conditions; general hygiene of the work place; ergonomics; prevention of work-related diseases; food hygiene at work; health education; epidemiology of work-related diseases.

In all cases the occupational physician is considered as an advisor to both employer and employees.

HEALTH SURVEILLANCE

Health surveillance of employees: pre-employment medical examinations; annual or biannual medical examinations including biological monitoring in case of particular risks; medical examinations following any absence due to occupational disease or work injury; or any absence of more than three months.

FACTS AND FIGURES

The number of occupational physicians is 5883 (1990). There are 4565 occupational nurses.

The law defines the time due to each employee by the occupational physician: one hour per month for 20 employees, one hour per month for 15 manual workers, one hour per month for 10 employees exposed to particular risks. A nurse is mandatory in some work places depending on the number of employees: in the industrial sector, one nurse for undertakings from 200 to 800 employees, two nurses from 800 to 1,400, and one for each additional group of 600 employees; in the non-industrial sector, one nurse for undertakings from 500 to 1,000 employees, and one for each additional group of 1,000 employees.

Fédération des Etablissements Hospitaliers et d'Assistance Privés à but non lucratif
179, rue de Lourmel
F-75015 Paris
France

Fédération Hospitalière de France
33, avenue d'Italie
F-75013 Paris
France

FINLAND

In 1995 a survey of the structure, input and output of occupational health services in Finland was conducted as part of the national follow-up system for occupational health services (OHS). It was ordered by the Ministry of Social Affairs and Health. In May 1996 a questionnaire was mailed to all known OHS units in Finland. The mailing list was based on the first similar survey conducted in 1993 (Räsänen et al. 1997). Additional new addresses of possible OHS units were collected from the register of the Social Insurance Institution. The mailing list contained 1 142 addresses of which 969 proved to be correct addresses of the main OHS units (including 111 subsidiaries). Thus the overall number of OHS units was calculated to be 1 080 at the end of 1995.

A total of 855 OHS units (88.2%) returned the original (80.3%) or a shorter form of the questionnaire (7.9%). Non-respondents (N = 114) were contacted later in the autumn by phone, and the number and working hours of OHS physicians and nurses as well as the number of client employees were recorded. This basic data was thus gathered from 945 main OHS units (97.5%).

Altogether 1 575 000 employed persons were covered by OHS. Of these, 1 525 000 were salaried employees and wage earners, and some 50 000 were entrepreneurs (37 000 of them being farmers). According to these figures and the national employment statistics, 75% of the employed labour force, and 87% of salaried employees and wage earners were covered by OHS at the end of 1995. Thus, the economic depression of the early 1990s did not affect the coverage of OHS significantly. Also, the variation in the geographical coverage percentage among the 11 counties was small, the lowest coverage percentage being in the county of Michael in East Finland (78.5% of salaried employees and wage earners).

Though the number of OHS units was the same as in 1992, the average size of the units had decreased especially in municipal health care centres. At the same time the unit size had increased among undertakings' own units and among the regional OHS units of the state.

The OHS units of municipal health care centres were the most important providers of OHS both in terms of the number of persons served (41 % of all) and undertakings (70%). Of these undertakings 85% employed less than ten workers. Private medical centres served 22% of undertakings and 15% of employees. Individual OHS units in undertakings served 28% of persons, but only 2% of undertakings. Joint-model OHS units and the regional OHS units of the State together served 6% of undertakings and 16% of employees (Figure 1).

The number of posts in OHS units was about 4 400. When the personnel figures were compared for 1992 and 1995 among those units that returned the questionnaire in both years (N = 667), an increase of 30 persons per year was observed in the physician resources. At the same time the nurse resources had decreased by 10 persons per year, and the ancillary staff resources by 34 persons per year, respectively. The physician resources had increased more often in the OHS units of

those municipal health care centres that had the worst physician resources in 1992. However, the OHS units of the municipal health care centres still differed from the other models according to both physician and nurse resources. On the other hand, these units had more often a physiotherapist and a psychologist in their OHS team.

Three quarters of the physicians and nurses and somewhat fewer physiotherapists had completed a complementary training course (3 to 4 weeks) in OH. Of the physician's posts, 426 were occupied by a specialist in OH covering 40% of OHS units. Part-time posts (under 20 h/week) were more common among physicians (48%) than among nurses (11 %) or physiotherapists (35 %).

The number of health checks and the number of work site visits per 100 persons served had increased from 1992 to 1995. The explanation for this development is that in 1992 the employment balance was negative (7.6% fewer employed persons in 1992 than in 1991), while in 1995 the corresponding figure was positive (+ 2.6%) for the first time in five years. The new reimbursement system, which directs the contents of OHS to prevention and which came into force at the beginning of 1995, may have had an effect too. However, due to the short follow-up time, no definitive conclusions can be drawn on the development, as the number of illness related visits had also increased. As a consequence, the number of radiological and laboratory tests per 100 persons was greater in 1995 than in 1992 in every OHS model.

The OHS units often collaborated, not only with physiotherapists and psychologists, but also with dieticians, opticians, work hygienists and building engineers.

The economic depression in the early 1990s did not significantly affect the infrastructure of OHS in Finland. It is obvious that the legal basis of OHS together with the reimbursement system have influenced the stability of OHS in Finland. This data is, however, based on statistical information, and the information may thus be biased to some extent. In particular the data does not allow us to draw conclusions on the OHS arrangements of the increasing number of employees in so-called untypical employment, or on the outcomes or quality of the services provided.

Suomen Kuntaliitto
(Association of Finnish Local and Regional Authorities)
Toinen linja 14
FIN-00530 Helsinki
Finland

UNITED KINGDOM

GENERAL INFORMATION AND DEFINITION

The Health & Safety at Work Act 1974 provides that an employer (including hospitals) must do that which is reasonably practicable to ensure that his/her employees are reasonably safe. Delegated legislation in the form of statutory instruments made under the authority of the act lays down detailed provision for safety representation, first aid and substances hazardous to health. There are other specific regulations on noise, manual handling, use of display screens and biological agents. The management regulations (from the European Framework Directive) cover all health risks.

The United Kingdom consists of England, Wales, Scotland and Northern Ireland. As a general note, Acts of the United Kingdom Parliament relating to health and safety apply in all countries. However with recent devolution each country may introduce additional standards. The law imposes a number of specific obligations on the employer relating to the health of his workers and, more generally, in the Health & Safety at Work Act obliges him to ensure their health and safety so far as is reasonable practicable. So far there is no specific duty in our law on the employer to provide qualified medical or nursing staff at the place of work. The Health & Safety (First Aid) Regulations 1981 oblige employees to provide adequate and appropriate first aid equipment and facilities and an appropriate number of adequately qualified and trained persons to render first aid to their employees.

OBJECTIVES

In general an attempt is made to improve the health of the employee by the general application of Health & Safety measures in the work place. The employer has a responsibility to monitor the risks in the work place and minimise their effect.

ORGANISATION

The origins of Occupational Health provision originated in the heyday of manufacturing and heavy industry earlier this century when paternalism was in vogue, classic industrial disease was observed and employers tried to get people back to work. A number of reports on the provision of occupational health services concluded that there was occupational medicine and occupational hygiene and that these were very closely related.

The Health & Safety at Work Act set up the Health & Safety Commission to undertake the function of encouraging and organising research, making proposals for new legislation and reviewing standards, approving codes of practice and generally laying down policy guidelines for the inspectorates.

The Health & Safety Executive (HSE) is responsible to the Health & Safety Commission (HSC) for the enforcement of the safety laws. The HSE is split with a number of Directorates and Divisions covering policy, technical advice and operations.

HSE uses several mechanisms to collect information, pinpoint health and safety problems in industry, identify areas of research and maintain consistency of enforcement practice.

Local Authorities also enforce health and safety legislation, usually in lower risk establishments. The Health & Safety at Work Act (Northern Ireland) Order 1978 enacts similar provision to the HSWA for Northern Ireland, where enforcement is through the Health & Safety Agency. (This will become the Health & Safety Executive for Northern Ireland after April 1999.)

ACCREDITATION

Occupational Health has evolved separately from the NHS and because of treatment services offered by the NHS in the post war it was not considered necessary to make it a legal obligation. A non-statutory code of practice was drawn up. Tax incentives were conferred on those who implemented the code. The Health & Safety Executive is responsible for taking action against employers not complying with the law. The Health & Safety Executive does not accredit occupational health services but professional bodies offer qualifications and employees should look for qualified personnel to help,

FINANCING

In the United Kingdom there has evolved a separation between treatment and prevention. The NHS provides medical care for injuries through hospital services and primary health care through the general practitioners. Prevention is the responsibility of employees and the law is enforced by the Health & Safety Executive and Local Authorities.

The ultimate political responsibility lies with the Department of Trade and the Regions with Department of Health interest. If the principle function of the Occupational Health Service is seen to be part of the preventative role, facilities for the treatment of non-emergency conditions at the work place can with justification, be charged to the employer.

SERVICES FOR PREVENTION AND PROTECTION

The law imposes a number of specific obligations on the employer relating to the health of his workers and, more generally, the Health & Safety at Work Act obliges him to ensure their health and safety so far as is reasonably practicable. So far there is no specific duty by law for the employer to provide qualified medical or nursing staff at the place of work. The Health & Safety (First Aid) Regulations 1981 oblige employees to provide adequate and appropriate first aid equipment and facilities and an appropriate number of adequately qualified and trained persons to render first aid to their employees.

The guidance accompanying the approved Code of Practice advises that in low-risk areas like offices, a first-aider is necessary for each 100 employees, whereas in areas of medium risk like light engineering and assembly work at least one first-aider should be present when the number of employees at work is 50 or more.

The Approved Code of Practice requires employers to provide a suitable First Aid Room or rooms where the assessment of First Aid needs identifies this as necessary. Guidance explains that rooms are usually necessary in high-risk work places, e.g. shipbuilding, chemical sites and large construction sites and large premises at a distance from medical services.

FACTS AND FIGURES

Some 99% of firms in the UK are small, employing fewer than 50 people, accounting for about 50% of the working population.

In total, 8% of private sector establishments use health professionals to treat or advise about health problems at work. Health Professionals here include physicians and nurses and other professions allied to medicine, whether or not they have specialist occupational health qualifications.

The use of health professionals varies significantly by size of company with over two-thirds (68%) of large employers using professionals compared to 5% of employers with less than 25 employees. In the private sector, use is highest in manufacturing (14%). The high level of use of health professionals in the public sector means that overall almost half the total workforce is employed by organisations using health professionals.

National Health Service
Department of Health,
Richmond House,
79, Whitehall
GB-London SW1A 2NS
Great Britain

GREECE

OVERVIEW

I. LEGISLATIVE BASIS:

The basic legislative frame of the Occupational Health Services is defined by:

- a) The basic law on the creation of the National Health Services (N.H.S.) (1397/83), including the Occupational Health Services and laying down as well the other responsibilities of Health Centres for Primary Care.
- b) The basic law (1568/85) on Hygiene and Safety of the Employees at the work places, including hospitals, which introduced the following:
 - the Occupational Physician (specialised in Occupational Medicine)
 - the Technologist (specialised in safety)
 - the Employees' Health and Safety Committee
 - legislation of exposure limits and biological indicators for the appraisal of the employees' exposure to physical, chemical, biological and ergonomic risk factors
 - the Preventive services including a periodical test of the employees' health by the competent Occupational Doctor
 - the control of the working conditions
- c) The Presidential Decree (213/86) which introduces the speciality of Occupational Medicine of 4 years minimum training (3 years of clinical and practical training and 1 year of theoretical courses, according to the requirements of the E.U. directive 16/93/EU).
- d) Article 40 of the «Disease Regulation» issued by the Social Security Institution, which defines the catalogue of 52 occupational diseases recorded. This «Institution» is the largest social insurance institution in Greece, covering the largest part of the labour force of the country.
- e) The Presidential Decree (17/96) which incorporates into the national law the E.U. Directive 89/391/EEC on the introduction of measures to encourage improvements in the safety and health of workers at work, and which supplements the national legislation by:
 - creating services for protection against and prevention of occupational risks for the Employees' Health and Safety
 - imposing a written occupational risk assessment as basic obligation of every Employer (is also applicable to every hospital)
 - prescribing a personal booklet on exposure to occupational risks
 - drawing up regulations on hygiene and safety in every undertaking or service, including hospitals.
 - connecting the effect of the working environment with the general environment.
- f) The recent reform for the development and modernisation of the N.H.S. (2519/96), which in a series of articles makes provision for the creation of first, second and third degree Occupational Health Services on central, regional and prefectural hospital services' level.
- g) The law on Big Accidents (catastrophes) and the studies on environmental consequences.

h) A series of E.U. Directives on several matters which have been incorporated into the national law (more than 15).

II. INFRASTRUCTURE OF OCCUPATIONAL HEALTH

The existing infrastructure includes:

- the Diagnostic and Occupational Health Centre of the Social Security Institution (I.K.A.).
- the Department of Occupational Health and Environment of the Elefsina hospital, which is now being staffed.
- the Chair of Occupational and Industrial Hygiene of the National School of Public Health.
- the Institute of Research in Respiratory Disease, Hygiene and Safety (I.E.N.T.I.A.E.) at work which depends on the Ministry of Health.

III. OCCUPATIONAL HEALTH PERSONNEL

a) In Greece, the number of Occupational doctors - title holders of the relevant speciality - does not exceed 50, while the doctors who are now being specialised in Occupational Health are 20. The existing needs both in the private and public sectors exceed the figure of 2,000 specialists in Occupational Health. At present, these needs are largely either not covered or covered by other doctors of related specialities (e.g. internal medicine or pneumonology), based on the provisions of the relevant legislation until the number of specialised Occupational Doctors is sufficient. Only 2 health centres in industrial regions (1 in Athens, 1 in Salonica) and 2 hospitals (1 in Elefsina and 1 in AHEPA Salonica) employ occupational physicians.

b) As far as the other health professions are concerned, there are:

- Public Health Supervisors, coming from higher technological schools (studies of 3 years' duration) with relevant training in occupational hygiene topics
- Health Visitors, with relevant training.

There are few Industrial Hygienists educated abroad and even fewer health officials.

IV. FINANCIAL ISSUES

According to official assessments of the Institution, the cost of labour accidents for those insured by the Social Security Institution is more than 40 billion drachmas, annually.

The Hygiene and Safety Committee of the General Association of Greek Employees estimates the cost of professional diseases at more than 200 billion drachmas, annually, for those insured by the Social Security Institution, which is the biggest but not the only one. There is no social security covering occupational diseases for those employed at the N.H.S. hospital and/or public health services.

Nevertheless, according to the existing legislation, the cost of occupational health services should be borne by the employer. In other words, 1% of the Employer's contribution should cover the prevention of professional risks for those insured by the Social Security Institution.

ONGOING REFORMS

- a) The first concerns the setting-up and functioning of Services for Protection (95/99) from Professional Risks under the Presidential Decree recently published, which defines the terms and the procedures of the work permit.
- b) The setting-up of occupational health services within the framework of Public Health Services on both second and third degree organisation level, in accordance with the relevant provisions for the development and modernisation of the N.H.S. (2519/96).

FUTURE PRIORITIES IN OCCUPATIONAL HEALTH

- a) Production of sufficient numbers of health professionals (Occupational Health doctors mainly), taking into account the existing needs.
- b) Systematic diagnosis and prevention of (new) professional diseases.
- c) Limitation and prevention of industrial accidents and rehabilitation of victims thereof.
- d) Support of Health Promotion Programmes at the work places.
- e) Development and staffing of the second and third degree infrastructure in order to deal with those problems of Occupational Health that cannot be faced at the first degree infrastructure.
- f) Quality control of occupational health services provided and efficient control of the existing legislation.

LONG TERM VISIONS IN OCCUPATIONAL HEALTH

The achievement of substantial cohesion of these developments - not least - with the most developed E.U. countries.

Ministry of Health and Welfare
Aristotelous Street 17
GR-10187 Athens
Greece

ITALY

LEGISLATION

Italian health and safety legislation relates directly to the Italian constitution which considers health a basic right which should be achieved by taking the preventive measures that are technically feasible regardless of the economic costs involved. The recurrent general principle in legislation (supported by criminal sanctions) is that employers are responsible for taking these technically feasible measures to reduce risks.

Legislation is based on decrees enacted since the 1950s and has recently been supplemented by the adoption of law (decreto legislativo) no. 626/94 modified by law no. 242/96 followed by many sectorial ministerial decrees (some are still in progress), which implement a number of European Directives including framework directive 89/391 EEC. The general regulation is fully applicable to the hospital sector.

The list of occupational diseases was last modified in 1994 when the number was raised to 50 in industry and to 27 in agriculture. Diseases that are on the list are recognised without the need to prove their occupational origin.

The link with occupational exposure has to be proved for any disease not included in the list.

OCCUPATIONAL HEALTH AND SAFETY STRUCTURES

In 1978, the Health Service Act (law 833/78) transferred some of the powers of the Labour Inspectorate to the healthcare sector (at the local level of the Local Health Unit of the districts). Since 1981 the mission of the Occupational Health Service (O.H.S.) has not simply been to ensure compliance with the existing laws, but also to promote positive changes in the work places.

Since 1994 there is an Occupational Health Service within the Prevention Department in each Local Health Area.

OHS staff include occupational doctors, industrial hygienists, chemists, engineers, prevention of the environment and of the work places technicians (profession recently regulated) and nurses.

OHS main activities are: evaluation of prevention plans drawn up on the basis of risk evaluation by employers, inspections, assessment of compliance with the law provisions of measures implemented by employers, medical assessment of employees, when asked jointly by workers and employers, evaluation of the construction plans of factories prior to building authorisation by Municipal Administrations.

INTERNAL OCCUPATIONAL HEALTH SERVICES

Companies' prevention and protection services are structured in relation to the size of the company and the type of risk of professional exposure.

Companies also have formalised emergency plans and means so as to be able to act in medical emergency situations.

Medical checks of employees are performed by a specialist in occupational health or "medico competente", Italian term to define medical doctors whose competence and professional experience in the field of occupational health have formally been recognised.

OCCUPATIONAL HEALTH INSURANCE

Occupational health insurance in Italy is organised by a public institution, the National Institute for Insurance of Occupational Accidents and Diseases (INAIL), which is responsible to the ministry of labour. Its General Director is nominated jointly by government, trade unions and employers.

INAIL also makes provisions for disabled workers. Insurance is compulsory for all undertakings in the industrial, agricultural and services sectors. It is financed through employers' premiums, which vary among sectors depending on the levels of estimated risks and on the accident and disease rates of individual factories or work places.

RESEARCH

Research in occupational health is mainly performed by universities, by the National Health Institute (Istituto Superiore di Sanità) and by the National Institute of Occupational Safety and Prevention (Istituto Superiore per la Prevenzione e la Sicurezza del Lavoro - ISPESL), which reports to the Minister for Health and is a technical-scientific body of the National Health Service. It also acts as a national centre for information, documentation, research and experimentation. The Institute is the focal point in Italy for the European Agency for Safety and Health at Work, based in Bilbao (Spain). ISPESL also has also a role in regulatory proposals and in occupational health training and education.

HEALTH AND SAFETY OUTPUTS

Occupational accidents and diseases are still a concern for public health authorities. In 1999 there were 959,907 occupational accidents reported (872,092 in the industrial sector and 87,815 in agriculture).

The recorded incidence of occupational diseases between 1985 and 1999 shows fluctuations of 20,000 to 30,000 recognised notifications per year. Nearly 50% of the recognised cases were in relation to noise, with diseases caused by skin irritants (nearly 20%) being the next largest category, followed by diseases caused by silica (just over 6%) and other dusts (just under 6%).

A number of attempts have been made in recent years to assess more accurately the economic cost of occupational accidents and diseases and absenteeism. A broad study based on 1991 data estimated the total cost of occupational accidents to be about 3.05 % of GNP.

The cost of the public prevention services in Italy was estimated to be around 3% of the total National Health Service cost. Trade Unions and scientific associations proposed to double this amount.

CONCLUSIONS

There are still several critical points for actions to be mentioned:

- Unemployment, migrant workers and precarious employment in the country can affect the improvement of working conditions and even worsen them.
- There is a recognised need to conduct specific and effective campaigns to reduce work accidents and occupational diseases in critical sectors (such as the construction industry and agriculture), using on the one hand the powers of control

and inspection and on the other hand information and education, including the mass media.

- Universities and technical schools should be made aware of the need to assess new situations, technologies and practices in order to ensure the availability of effectively trained professionals and experts.

Anyway the educational system has to build up culture and awareness about prevention of work related diseases.

- Any government programme of work should pay constant attention to health and safety at the work places

Ministero della Sanità
Piazzale dell' Industria 20
I-00144 Roma
Italy

IRELAND

INTRODUCTION

Prior to 1989, the law in relation to safety at work was poorly organised in Ireland. The Barrington Commission was set up to examine safety at work and found that only 20% of the then workforce was covered by legislation which was outdated. The legal protection was mainly as a result of judgements in civil actions against employees. Under common law the employer had a general duty to provide for employees a safe place to work, safe equipment and a safe system of work. However changes in European Union law and greater European integration was a catalyst for new legislation.

SAFETY, HEALTH AND WELFARE AT WORK ACT 1989

The Safety, Health and Welfare at Work Act was brought into law in 1989. This has been the most important piece of legislation relating to public health and safety in the work place enacted in Ireland. The Safety, Health and Welfare at Work Act 1989 placed the responsibility on both employers and employees to maintain safety and also made the employer responsible for preparing a safety statement for the work place and to consult with employees on methods of safety at work. The law is fully applicable to the hospital sector.

The 1989 Act also anticipated the EC Directive of 1989 on safety at work. This was called the Framework Directive because of the general principles set out in it. EC Directives are implemented in Irish domestic law by means of Regulations, also known as Statutory Instruments (SI). A number of Directives were in existence prior to 1989 (e.g., on lead, asbestos and noise in the work place), others came into existence at the same time as the Framework Directive (e.g. work equipment, personal protective equipment and manual handling) and others post-date this period (e.g. carcinogens and biological hazards). Specific regulations were also been introduced in 1993 -1995 to protect pregnant women, those working with chemical and biological agents, carcinogens and in the construction industry.

THE 1993 REGULATIONS

The Safety, Health and Welfare at work (General Application) Regulations 1993 (SI 44 of 1993) provide the details for the general principles set out in the 1989 Act and also implement seven EC Directives on Safety and Health, including the Framework Directive, which were to coincide with the advent of the single market. The specific legal requirements set out in these regulations relating to maintaining the well-being of the workers are, in summary:

- the work place - safety standards for ventilation, temperature, lighting, floor surfaces, doors and gates, sanitary facilities
- work equipment - suitability, risk reduction, information and instruction for employees, control devices, emergency stops, guards, warning devices and maintenance.
- personal protective equipment - the employer must make provision for the protection of head, foot, eye and face, respiratory system, hearing, body, arm and hand.

- display screen equipment - the employer's duties in relation to the screen, keyboard, space, lighting, reflection and glare; the provision of eye tests and corrective appliances.
- electricity - e.g. safeguards to protect against shock, safeguards for overhead lines.
- first aid - there must be adequate, suitably marked and easily accessible equipment and first aid room for larger work places used for the first time after December 31st 1992
- manual handling of loads: Part VI of the 1993 Regulations merits particular attention. Manual handling accidents account for about 30% of notified accidents and back injuries are the single biggest cause of health problems and absenteeism from the work place. The 4th Individual EC Directive of 1989 set out the general principles in relation to manual handling which recommended avoidance where possible and where unavoidable, to assess the risk and reduce it and to provide training and information for employees.

THE HEALTH AND SAFETY AUTHORITY

The Health and Safety Authority (HSA) was established under the Safety, Health and Welfare at Work Act, 1989 as the national body responsible for all aspects of occupational safety and health. As well as providing advice and guidance the HSA is also responsible for enforcing occupational safety and health law. The Board of the HSA consists of representatives of employees' organisations, trade unions and Government. Its funding comes solely from the Department of Enterprise and Employment.

The functions of the HSA are as follows:

- to arrange for enforcement of legislation on occupational safety, particularly through Inspectors
- to review existing legislation
- to promote, encourage and foster prevention of accidents and injury to health at work
- the provision of information and advice
- to issue licences for certain activities

Enforcement of the law is undertaken by the HSA's Health and Safety Inspectors. The Inspectors' powers include:

- the power to enter, inspect examine and search premises at all times
- to require production of books, registers, records (manual or otherwise), certificates, notices, documents, maps, plans or any other documents
- to examine or analyse any article or substance.

The 1989 Act enables the Inspectors to prosecute in the case of non-compliance or to serve improvement notices or prohibition notices.

FACULTY OF OCCUPATIONAL MEDICINE OF THE ROYAL COLLEGE OF PHYSICIANS IN IRELAND

The objective of the Faculty of Occupational Medicine is to advance the science, art and practice of occupational medicine, to promote education, study and research in occupational medicine and also to act as an authoritative body for consultation. It also represents the speciality of Occupational Medicine on international, national, and regional councils and advises on all matters concerning occupational medicine for specialist registration in Ireland.

Department of Health
Hawkins House,
Hawkins Street
IRL-Du

The Safety, Health and Welfare Act 1989

Employers' Duties

- To ensure as far as practicable, the safety, health and welfare at work
- To design, provide and maintain condition of work place that is safe and without risk to health
- To provide safe means of access and egress
- Safe plant and machinery
- Safe systems of work
- To control or eliminate hazards or to provide such suitable protective clothing or equipment
- To prepare adequate emergency plans
- To ensure safety and prevention of risk in connection with the use of any article or substance
- To provide adequate facilities
- To obtain expert advisory service where necessary

Employees' Duties

- To take reasonable care for their own safety and that of any other person who may be affected by their acts or omissions while at work.
- To co-operate with the employer
- To use protective clothing, equipment and appliances which are provided for safety purposes
- To report without unreasonable delay any defects which might endanger safety

Safety Statement Requirements

A. An Employer is obliged to prepare or have prepared a safety statement:

- Identify the hazards and assess the risks
- To specify arrangements made and resources provided
- To specify co-operation required from the employees
- To specify persons responsible for performing tasks
- Safety statement should be in writing and shown to employees

B. Consultation and safety representative

- Duty of employer to consult with employees
- Right of employees to make representations
- Employees may select and appoint from their number a "safety representative"

LUXEMBOURG

GENERAL INFORMATION AND DEFINITION

Occupational health in Luxembourg, the so-called "Santé au Travail", is governed by the laws of 17 June 1994 on safety and health of the worker at his work place and on occupational health services. These framework laws contain the general principles regarding the safety and health of workers and the organisation of occupational health services. They were completed by provisions transposing the clauses of Community law in regard to this matter, respectively specifying the manner of functioning of the occupational health services.

OBJECTIVES

Ensuring the protection of the workers' health in the work place through the organisation of medical supervision and the prevention of accidents and occupational diseases.

SCOPE

All salaried and wage-earning employees in the private sector fall within the scope of the law on the organisation of occupational health services. State employees, local government officials and employees of the European Communities are excluded.

ORGANISATION OF SAFETY AND HEALTH AT WORK

The Inspection du Travail et des Mines, depending on the Ministry of Employment, is charged to control the application of the regulations regarding prevention of work accidents and professional diseases, safety at the work place and the installations of the undertakings.

The department of occupational health, depending on the Ministry of Health, is charged to control the organisation and functioning of occupational health services. The higher council, composed of representatives of the Ministries of Health and of Employment, of representatives of occupational physicians, of employers and of salaried employees is charged to fix priorities concerning prevention, to propose prevention and information or training programmes and to appraise them.

ORGANISATION OF THE OCCUPATIONAL HEALTH SERVICES

Each company must:

- either create its own service if the number of salaried employees is superior or equal to 5000, or if at least 100 of its 3000 salaried employees have a work place where they are exposed to danger,
- or join forces with other undertakings to create an inter-company occupational health service,
- or adhere to the National Occupational Health Service.
- A company may also create its own health service, provided it employs an occupational physician on a full-time basis. This service must receive regularly renewed approval by the Ministry of Health.

FINANCING

The cost of the National Service is covered by the contributions of all employers, but it may not exceed 0.20% of the wage bill taken into account for the contribution to the state pension scheme. Complementary examinations are included in this contribution.

For other services, the contributions are annually fixed by the service's general meeting, exclusively represented by the employers. In addition, undertakings will bear the costs of supplementary tests.

The contribution rate is not established according to the risks of the company or of the salaried employee.

NUMBER OF OCCUPATIONAL PHYSICIANS

The minimum number of occupational physicians is laid down by law, i.e. one occupational physician for 5000 salaried employees, but large undertakings with existing hazards must create their own service with a full-time occupational physician, when they employ 3000 or more persons.

MISSION

The employer is obliged to analyse and assess the professional risks in the company and to eliminate or reduce the hazards in the work place.

The occupational physician is obliged to identify risks, to contribute to their elimination, to survey the working environment factors that might affect health, to adapt working conditions and to survey the workers' health through medical examinations.

MEDICAL SUPERVISION OF THE WORKERS' HEALTH

Medical examination is obligatory before any employment, but only jobs with a risk factor do benefit from a periodic examination at different time intervals, according to the kind of risk. The occupational physician can, on his own initiative or on that of the employee, the employer or the union representatives, re-examine an employee either because of health problems or because of particular working conditions. A medical examination is due after six weeks of sickleave.

The occupational physician can only provide treatment if there is an emergency. He will not check absences from work, his activity is incompatible with exercising a free profession. He can declare occupational diseases. He is not entitled, under threat of punishment, to ask for an AIDS serology. He has no particular duty towards persons at risk (pregnant women, handicapped persons) but the person he devotes himself to on the occasion of an employment examination.

FACTS AND FIGURES

By 1 January 1995 seven health services had been created or restructured since the law came into effect.

There are five inter-company services:

- the National Occupational Health Service mainly deals with small undertakings and has 105,000 affiliated members. The industrial sector's occupational health service is answerable for 39,000 salaried employees, the financial sector's service for 21,000 employees, the steelworks sector with Arbed and its subsidiaries for 9,000 employees, and the hospital sector for 5,400 employees
- and 2 company services: the railway company's service (3,200 employees) and Dupont de Nemours (1,300 employees).

At the moment, 35 occupational physicians are trained or are undergoing training; they are working full-time in the 7 services. In the new inter-company services, most

of the medical activity is being devoted to employment examinations, whereas the company services existing prior to this law mostly dealt with periodic medical examinations.

At present, the text of the law of 1994 is being amended, in order to correct the inaccuracies and imperfections concerning its practical application.

Entente des Hôpitaux Luxembourgeois
13, rue Jean-Pierre Sauvage
L-2514 Luxembourg-Kirchberg
Grand Duchy of Luxembourg

THE NETHERLANDS

GENERAL INFORMATION AND DEFINITION

In the Netherlands, prescriptions for working conditions in firms are regulated under the Occupational Health Law (Arbowet), which is a framework act on the basis of which further decisions and regulations can be made. Concrete material regulations under state control have long been playing a greater part in the field of working conditions. These concrete prescriptions can be found in the Occupational Decision (Arbobesluit) and the Occupational Regulation (Arboregeling). It is up to the Labour Inspectorate to supervise the observance of the regulations. The Occupational Health Law was last revised in 1994. At present there is again a draft bill before Parliament to replace the current Occupational Health Law.

Under the Occupational Health Law, the adoption of an occupational health policy is the responsibility of the employer in collaboration with employees. Occupational health policy is not considered something separate but as an integral part of total management policy. In recent years the employers' responsibility for working conditions has been increased considerably by expanding his financial liability for absenteeism and disability. Indeed, a healthy occupational health policy makes it possible to restrict the cost of absenteeism and disability.

The most important provision in the Occupational Health Law is that the employer is obliged to adopt a structured occupational health policy. The so-called "risk inventory and evaluation" (RIE) is used as a basis for this. The employer has to identify the firm's potential risks and decide on the measures to be taken to reduce these risks. The risks in question are both in the field of safety and health and in the field of welfare. When implementing the RIE, an employer should seek support from an occupational health service. Occupational health services are certified independent companies that support firms in the field of occupational health and absenteeism policy. The Occupational Health Law enumerates five obligations for which the employer must seek support from an occupational health service.

OCCUPATIONAL HEALTH RISKS IN THE HEALTHCARE SECTOR

The healthcare sector is characterised by high occupational risks. This also has repercussions on the degree of absenteeism and the number of recipients of disability insurance benefits, which in the healthcare sector are on average 40% higher than in the market sector. Physical strain, work stress and irregular and special services are the most straining factors. Physical strain occurs in both nursing and caring staff (lifting, posture while working) and in technical staff (pushing, carrying). Work stress is especially related to heavy workload, sometimes in combination with considerable emotional stress, restricted regulation possibilities and bottlenecks in the field of labour relations. Further occupational risks relate to dangerous substances, biological agents (risk of infection) and physical conditions (e.g. climate).

RESULT OF THE POLICY ADOPTED

In recent years healthcare institutions have made the efforts required to improve working conditions and to embed activities in a structural policy. Institutions

particularly endeavoured to develop a policy relating to physical strain (lifting), dangerous substances, working hours and breaks and infection risks. An occupational care system has also been developed in most institutions. An investigation recently carried out by the Labour Inspectorate shows, however, that a lot can still be improved. A risk inventory and evaluation is indeed made in most institutions, but the required measures are often not taken. It appears also that stress-related problems at work occur in many institutions. A high rate of absenteeism and the large number of recipients of disability insurance benefits also provide an indication that working in the healthcare sector is not always 'healthy'.

A structural problem which arises when improving working conditions in the healthcare sector is that the institutions are financed on the basis of budgets, thus making it very difficult for institutions to reserve sufficient means for investing in better working conditions that do not yield immediate profit.

In 1996 the number of jobs in the healthcare sector was 527,000. In the same year the number of jobs was 4,244,000 in the market sector. In the Netherlands some 10% of the working population are active in the healthcare sector. In 1997 total healthcare expenditure amounted to 63.4 billion. Healthcare expenditure expressed as a percentage of the gross national product amounted to 9.1% (source: CBS, JOZ).

Nederlandse Vereniging van Ziekenhuizen
(Postbus 9696, 3506 GR Utrecht)
Oudlaan 4
NL-3515 GA Utrecht
The Netherlands

PORTUGAL

GENERAL INFORMATION AND DEFINITION

In Portugal, Occupational Health is regulated by the Framework Law on Safety, Hygiene and Health at Work (OHS) - Statutory Order 441/91 of 14 November - which transposed into national law the EEC Framework Directive 88/391 of 12 June. This statutory order, which was revised and slightly amended in 1999, was designed to guarantee the introduction and creation of conditions for the effective application of occupational health and safety in the private, co-operative, public and social sectors, in all undertakings, establishments, work places and for all self- employed workers.

The text of this statutory order was proposed within the scope of "Social Conciliation", a national council consisting of representatives of the Government, Trade Unions and Employers' Associations, through the Economic and Social Agreement of 1990 and the specific Agreement on Safety and Occupational Health at the Work Place of 1991. This proposal was signed by all the bodies represented in this Council, as a topic unanimously voted for the first time. It can thus be seen as constituting a true paradigm of social conciliation. It was ratified, unchanged, through the above-mentioned Statutory Order 441/91, which came into force in July 1992.

Since this date, significant efforts have been made relating to the regulations governing the organisation and functioning of safety and occupational health activities at the work place as provided for by Statutory Order 26/94 of 1 February. Due to the difficulties in implementing this regulation, a revision took place following the debate amongst the main political parties in the Portuguese Parliament. It was modified by Law 7/95 of 29 March. In 1999 a new proposal for revision was submitted to Parliament. It is expected that this proposal will be approved in 2000.

This regulation (Statutory Order 26/94 amended by Law 7/95) and the transposition to Portuguese law of the Complementary EEC Directives on the health of workers have replaced the former legislation on occupational medicine (1962 and 1967), the former general regulations on safety (for industry, commerce and offices) and all other specific regulations on occupational safety, hygiene and health, and on environment conditions in the work place.

From the 1960s to the 1990s the only officially recognised post-graduate and master's degree courses in occupational health were organised by the Public Health School of Lisbon and by the Medical Schools of Coimbra and Oporto. Most of the graduates were occupational health physicians. There thus exists a complex situation partly due to a lack of tradition of generalised multidisciplinary practices in the field of safety and health at work. The acute shortage of qualified and certified non-medical professionals and technicians was aggravated by the fact that many undertakings and Public Administration departments and institutes had not created OHS services. New courses in OHS oriented towards other fields have only recently been introduced at universities, high schools and professional schools. In addition, there are difficulties with the certification of technicians having acquired their professional skills through

practice, and the implementation of the accreditation system for OHS services has not yet been institutionalised. The Regulation is therefore subject to much criticism.

OBJECTIVES

The main objectives are the achievement of good ergonomic conditions for all workers, the implementation of occupational safety, hygiene and health programmes and services, and health promotion at the work place. In addition to these explicit outcomes, the objectives must result in improved productivity and quality of services and goods provided.

PUBLIC HOSPITALS

The majority of Portuguese hospitals are part of the National Health Service. They are owned and managed by the public sector. Compared with private hospitals, only a few public hospitals have occupational health services. Very few have a safety at work programme; most of them have a programme relating to surveillance of hygiene and toxicity conditions at the operation rooms and to the fight against hospital infections.

On the basis of the Agreement of 1996 and the Medium and Long Term Negotiations, the Public Administration and the Trade Unions had decided to create and revise the regulations on OHS in the public sector. On the basis of Statutory Order 441/91, the group of experts and representatives in the Committee of Conciliation in charge of this task prepared bills for "harmonising, by way of legislation, the requirements for safety and occupational health at work in Public Administration". Three fundamental vectors were considered: Prevention of Occupational Risks, Repairing and Rehabilitation. As a result the group of experts representing the Government and the Trade Unions prepared the following legislation projects:

- Statutory Order 83/98 of 3 April, laying down the creation of the Council on Occupational Health and Safety for Public Administration (the regulation by which it is governed is enclosed)
- Statutory Order 448/99 of 17 November, laying down the modes of application of the legal system of Safety, Hygiene and Health at Work (OHS) in Public Administration. Being in force since 1 January 2000, it considers all specific obligations resulting from the Framework Law on the implementation of OHS Public Services and repeals Statutory Order 191/95 of 28 June.
- Statutory Order 503/99 of 20 November, approving the new legal system applicable to Occupational Accidents and Professional Diseases in Public Administration services

ORGANISATION

The Government, through the Ministry of Employment and the Ministry of Health, has the principal responsibility for defining the policies, legislation and regulation - and vouches for its applicability - on the basis of the agreements and laws elaborated in collaboration with the Trade Unions and Employers' Associations.

Employers are responsible for the elaboration of preventive programmes and projects concerning Occupational Health and Safety services (OHS), as well as for their implementation and preservation. The costs of this legal obligation on OHS are entirely borne by the employer (and by the Government, as employer, in the case of Public Administration).

Employers with more than 800 workers (400 according to the current project of revision of Statutory Order 26/94) and all undertakings (or establishments) engaged in activities that may cause professional diseases are required by law to have an internal health service (own, private services). All other employers may either set up their own internal service, affiliate with an inter-company OHS service, or contract an external OHS service. Any of these modalities of preventive services should be equipped with the necessary apparatus, equipment and installations, and have sufficient medical and technical professionals specifically trained in occupational health and safety. Legislation permits either a multidisciplinary OHS service or the coexistence of two specialised prevention services, one for occupational health, another for occupational safety. It allows the employer to make different modality options for safety and health. If this is the case, both specialised services should jointly and complementarily cover the employer's entire legal obligations as regards OHS. The legal system lays down a maximum number of 1000 workers per occupational health physician, but does not mention the number of workers that may receive attention from other OHS professionals.

Supervision is carried out at the national level by the Labour Inspection (under the Ministry of Employment and Social Security and integrated in the National Institute for Development and Inspection of Working Conditions). The General Directorate of Health (under the Ministry of Health) is entrusted with the supervision of the Occupational Health Services and the health personnel involved.

The General Directorate of Health is responsible for the certification and registration of medical doctors for the practice of occupational medicine. It can authorise temporary practice by medical doctors with no specific training in occupational health under special conditions and provided they agree to enter a post-graduate or master's level course on occupational health within the first three years of exercising their duties.

The mechanism of accreditation of internal, inter-company or external OHS services has not yet been set up. Nevertheless, the guidelines proposed for accreditation have been outlined and many of the services already active have provided the national authorities with the information considered necessary to apply for this accreditation.

SITUATION OF THE NATIONAL HEALTH SYSTEM

The National Health System includes the National Health Service (public service, under the Ministry of Health) and the private health sector. Of the approximately 120,000 health workers of the National Health Service more than 50% are employed in hospitals. Both the public and private health sectors are legally obliged to implement the Framework Law, the Regulation and other legislation resulting from the transposition into national law of different Directives of the European Union (on radiation, biological agents, carcinogenic and mutagenic substances, pregnant and breastfeeding workers, toxic products, and so on). In addition the public sector must also take into consideration the recent legislation specifically approved for the Public Administration services and its increased responsibility to implement and have implemented the above laws and to develop models of good practice and health promotion.

Information, training and education, general participation as well as the identification, evaluation and control of the risk factors at work are vital prerequisites for promoting, preserving and supervising the health and safety of all health professionals. They are also essential for ensuring the continuous registration and improvement of the working conditions and for implementing activities aimed at promoting healthy lifestyles as well as medical and technical preventive actions.

Direcção-Geral da Saúde
Alameda D. Alfonso Henriques 45
P-1056 Lisboa Codex
Portugal

SWEDEN

EMPLOYER RESPONSIBILITY

Occupational health care in Sweden is regulated within the framework of the general legislation on the working environment. The basic principle underlying the Working Environment Act is the prevention of ill health and industrial accidents and the provision of a good working environment in other respects. The Act focuses on preventive working environment efforts and on the development of job content. According to the Act, the employer has the primary responsibility for the working environment and shall take all the measures required to prevent employees from suffering from ill health or having an industrial accident. Employers and employees shall co-operate to achieve a good working environment. If the working conditions concerned so require, the employer shall arrange for the provision of occupational health services to the extent the operations involved demand.

INTERNAL CHECKING

The employer shall continually check whether the working environment is satisfactory. This involves systematically planning, managing and inspecting the operations concerned so that demands concerning the working environment are met. This includes investigating occupational injuries and the risks associated with the operations of the company, taking the measures required, documenting the working environment and drawing up action plans.

REHABILITATION

Employers are also obliged to ensure that their operations include suitably organised work adjustment and rehabilitation services. The National Insurance Act regulates the obligations of employers with regard to the rehabilitation of employees with an impaired capacity for work as a result of illness. Employers are responsible for investigating the rehabilitation needs of such employees and shall ensure that the measures required for effective rehabilitation are implemented. In this context occupational health care services are a valuable and frequently used resource for both employers and employees.

RESPONSIBILITIES OF THE AUTHORITIES

A special State authority, the Occupational Safety and Health Administration, under the Ministry of Labour, has the task of ensuring compliance with the Working Environment Act. The Occupational Safety and Health Administration consists of a central authority, the National Board of Occupational Safety and Health, which issues regulations and advice specifying demands and obligations in the working environment field in more detail, and which is also responsible for information and training. There are a great number of regulations dealing with different aspects of the working environment. The authorities also have a regional organisation, the Labour Inspectorate, which visits work places and which can demand that employees implement improvements in the working environment. These demands can be combined with injunctions or bans. The Occupational Safety and Health Administration is also entrusted, together with other relevant authorities and organisations, with following up and promoting the development of occupational health care.

CO-OPERATION BETWEEN THE SOCIAL PARTNERS

Work on the work environment is carried out in co-operation between employers and employees. Special trade union representatives and bipartisan committees take part in the planning and follow-up activities in the field of the working environment. The form and structure of occupational health care is regulated in collective agreements concluded between the employers and the employee organisations in several sectors. In the county council sector (within public health and medical care) there is a central agreement entitled "Agreement on Competence within the Field of the Working Environment and Rehabilitation - Competence 93". This states that occupational health care, or the equivalent, is an asset in both preventive and long-term working environment efforts, as well as in terms of direct action in the event of acute problems in the working environment or rehabilitation work. In the agreement, the social partners also state that they have a common interest in ensuring that such occupational health care has the preconditions required to continue its operations and development.

ORIENTATION AND STRUCTURE

The core activities of occupational health care are preventive work environment efforts and working life-oriented rehabilitation. These activities are based on a broad range of expertise in the fields of medicine, technology, behavioural sciences and work organisation.

Occupational health care is wholly financed by employers.

Taking Sweden as a whole, approximately 73% of the working population have access to occupational health care. In the public sector (employees in the medical and health care sector), 100% of employees have access to occupational health care.

There are some 700 occupational health care units throughout the country with a total of approximately 7 000 employees. These units are staffed by doctors, nurses, industrial safety engineers, physiotherapists and psychologists. Specialist training with an orientation towards occupational health care is available for medical staff. In general, those working in occupational health care have a very high level of skill, training and expertise.

There are different types of occupational health care centres. Some are specific to a particular industry while others have agreements with employees from different industries in both the private and public sectors. There are both locally based occupational health care centres and units which cover the entire country. Restructuring is underway towards the creation of larger occupational health centres, which often have local departments.

A special quality assurance system has been developed for occupational health care. The Swedish Association for Occupational Safety and Health, the social partners and the National Board of Occupational Safety and Health are behind this model. It is intended that the quality assurance process will lead to certification.

PLANNED CHANGES

The Ministry of Labour has recently produced a report on occupational health care, which contains proposals on changes to the Working Environment Act. These changes would involve a clarification of the employers' obligation to arrange occupational health care services and the co-ordination of this obligation with the regulations concerning the internal inspection of the working environment and rehabilitation work. The report also proposes that a definition of occupational health care be incorporated into the Working Environment Act.

Landstingsförbundet (Federation of County Councils)
(PB 70491, 10726 Stockholm)
Hornsgatan 20
S-10727 Stockholm
Sweden

HOPE

standing committee of the hospitals
of the european union
Kapucijnenvoer 35 B-3000 Leuven
Tel.: 32/(0)16/33.69.02 Fax: 32/(0)16/33.69.06
E-mail: sg@hope.be
<http://www.hope.be>