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Editorial

Main European Models of Workers' Health Protection

Health protection at work is not only a matter of national policy and legislation. For many years, standards for occupational safety and health (OSH) have been elaborated at an international level. Organizations, such as International Labor Organization (ILO), World Health Organization (WHO), and also Council of Europe and European Economic Community (currently European Union - EU) have been active in this field for a long time. There are also many other organizations and institutions which are involved, e.g: International Commission on Occupational Health (ICOH), European Agency for Safety and Health at Work.

In the past, workers' health protection (WHP) as provided by physicians, was a part of general health care rather than a part of complex system built on different assumptions. Even in the second half of the 20th century, many European countries designed their WHP mainly from medical point of view. Although no European country established occupational health services (OHSs) to be merely curative, in some countries, especially in central and eastern Europe (CCEE), it was a case. Medical examinations carried out by any physician in some countries, or authorised physician in other countries, were and still are considered to be the most important activity of OHSs.

WHO/ILO Recommendations Influence

Although both the adjustment of work to man and of man to work was included in the wide definition of occupational health, jointly worked out by ILO and WHO in 1950[1)], the trend has been more and more to establish priorities on the adjustment of work to man. In 1985 the ILO adopted the Convention on Occupational Health Services[2)] which can be considered as a cornerstone in establishing new trends in OHS. The term "OHS" means services entrusted with essentially preventive function and responsible for advising the employer, the workers and their representatives in the undertakings on:

(i) the requirement for establishing and maintaining a safe and healthy work environment which will facilitate optimal physical and mental health in relation to work; and

(ii) the adaptation of work to the capabilities of workers in the light of their state of physical and mental health.

Assessing well-known functions of OHSs it is worth noting that stress has been put on primary rather than on secondary or tertiary prevention. According to the Glossary which has been included into the ILO Guidelines[1, 2)] "workers' health surveillance" does not necessary mean medical examination carried out by physician. It reads as follows: "*Workers' health surveillance is a generic term which covers procedures and investigations to assess workers' health in order to detect and identify any abnormality. Results of surveillance should be used to protect and promote health of individual, collective health at workplace, and health of exposed working population. Health assessment procedures may include, but are not limited to, medical examination, biological monitoring, radiological examination, questionnaires or a review of health records*"[1)]. That is why prevention services such as those operating in Ireland, Denmark, Norway or the United Kingdom may not include any physician even if, in practice, at least one is always found in large companies. Such practice entails a question whether is there still a room for medical care in modern multidisciplinary OHSs? Should medical care be included in OHSs or should be rather placed among support services?

A need of establishing multidisciplinary model of OHSs has been stressed by the WHO. In May 1996, the World Health Assembly discussed occupational health and adopted a resolution on the WHO Global Strategy for Occupational Health for All[3)]. Member States were urged to devise national programs on occupational health for all, based on the global strategy, with special attention to pull OHS for working population, including migrant workers, workers in small enterprises, in informal sector, groups at high risk and with special needs, including children at work.

EEC/EU Legal Policy Influence

In late seventies EEC Economic and Social Committee suggested the Community to adopt the respective directive in order to secure coverage of all workers by OHSs. Today, it is evident that European Union has given up its ambition of harmonizing national provisions relating to OHSs. Professor Gevers, an expert in the field of European legislation on OSH, has written in 1991: "*The generalization of occupational health care, its gradual extension to all enterprises and*

its multidisciplinary character, make it more and more difficult to define and impose a single common model, apart from the different conditions prevailing in each of the Member States"[4]. It is a fact, that EU activity in the field of occupational health seems to confirm this approach and one can observe that only so-called soft instruments like opinions, recommendations and programs are used. In fact, such practice has its relevance only to occupational health - one of two constituent part of reportedly indivisible notion "occupational safety and health" (OS&H) — a term used in almost all documents of the EU employment and social affairs policy area. Occupational safety, by contrast to occupational health, is regulated via much stronger instruments - the directives. Regardless of 'Framework Directive'[5], a lot of detailed directives have its relevance to different aspects of working conditions, specific groups of workers, substances, etc.

In 1984, the idea of multidisciplinary occupational health services (MOHS) has been expressed in the EEC Economic and Social Committee's Opinion on occupational medicine[6]. The Opinion stated that, given the importance of occupational medicine in improving health protection and safety at work, it is essential in the general interest to ensure that all workers in the private and public sector (including agriculture) are covered by occupational health services regardless of size of undertakings in which they work. Objectives of an OHS were broadly defined. Its primary aim is prevention of all occupational risks, including accidents at work. This preventive role implies action to improve working conditions and work organization so that these are geared as far as possible to the needs of the worker. Since preventive action must encompass all aspects of working conditions, OHS must be multidisciplinary and employ specialists from different fields (physicians, ergonomists, safety specialists, chemists, toxicologists etc.). Undertakings can not only have either their own service or join a group service, but can also be affiliated to a service in any other equivalent form or structure, provided that the costs of occupational health care is borne directly or indirectly by employers.

The emphasis has been shifting from structure to functions. It would seem more important that an OHS is able to deal with all relevant aspects of working conditions and to operate in close co-operation with employers and workers, than how it is organized or what the compositions of its staff exactly is.

The Framework Directive[5] seems to minimize a role of medical activity because there is only one article: 14, where health surveillance is mentioned. It would be good to ask what about a rich package of medical services, including treatment, contained in ILO Recommendation No.171 accompanying ILO Convention No. 161?

Health surveillance, as introduced in accordance with national law and/or practices, differs greatly between European Countries. Even pre-employment medical check-ups, which constitute an essential part of occupational health practice in certain countries, may be both compulsory (France, Poland, Luxemburg), partly compulsory (in specific industrial sectors or risks – Germany, UK) as well as voluntary (other European Countries)[7]. A compulsory character of pre-employment medical check-ups for all workers and compulsory provision of OHS does not mean the same. The provision of OHS is compulsory in Belgium, Finland, Germany, France, The Netherlands and, to larger extent, in Poland, Spain, Austria, Denmark, Hungary, Czech Republic, Slovenia, Slovakia and Estonia. In other countries, provision of OHS is voluntary.

Models of workers' health protection in the EU

In more traditional OHSs, called Industrial Health Services, primary relationship between physician and worker was crucial. In modern OHSs, number of actors is much bigger. Physician is now expected to act as an advisor or an agent reporting to employer rather than to act on behalf of an individual patient. It is due to the ultimate objective of occupational health defined now as "*a safe and satisfactory work environment in which a healthy, active and productive worker, free from both occupational and non-occupational diseases, can carry out his or her daily work motivated to develop both as a worker and as an individual*"[8]. Work environment seems to be the main target of OHSs. It leads to two theoretical models of WHP:

(i) focused on better work environment ("healthier working conditions") or
(ii) focused on selection of workers on health grounds ("healthier workers")

The first one seems to be fully harmonised with ILO/WHO concept on occupational health. This kind of activity means progressive approach and is favourable to constant development of technology, equipment and work processes. In consequence, as working environment is free from hazardous conditions, more people (women, older people in less good health, people partly disabled) can gain employment. This is a positive answer to question how to allow more people to participate in the labour process.

The second one seems to be based on assumption that more and more healthy people will be available as a workforce. This is in contrary to basic philosophy

of occupational health because medical activity focused on selection of workers on health ground, especially if inappropriate or unnecessary standards of fitness are stipulated for a job, may create a barrier to the individual seeking employment. Such a case should be considered as unethical and unacceptable. Unfair barriers to opportunity for employment should be removed through encouraging an improvement in standards within OHS. Additionally, from economical point of view activity of this kind (focused on selection of employees on health grounds) should be considered as short-sightedness. It may lead to the situation that employers feel free from activities focused on improvement of work environment. In consequence unclean technologies and old machinery still are used.

Thus, question arises: which model, volume of services or strategy, leads to better health of the labour forces? According to common opinion the main problem is that traditional health indicators (number of occupational diseases and occupational accidents) are probably obsolete and, new indicators should be elaborated[3)].

It seems that, the two above mentioned models are to be a matter of restructuring in the nearest future. One of the main driving force for these changes is that recently working population is characterized by growing number of workers aged 50–64 and falling number of aged 20–29. This gap in workforce will affect many of the European Countries where OHSs'staff will be faced with presence of employees with chronic diseases. That is why occupational healthcare with necessary elements of treatment must be incorporated at possible early stage of occupational health practices. In the future, progressive model will be focused not only on work-related health issues, but on all health determinants. It is worthy mentioning that supporting work ability (especially of older people) is and will be a serious challenge for future economy and welfare. Participation at work should be regarded as an important parameter for good health protection[9)].

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