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Agenda Item 6: Trade union policy in occupational health and safety (OSH)

Documentation on Health and Safety at Work for the PERC meeting
The two papers will be published in the next HesaMag.
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Union action can make the difference

Workers have little or no say in the organization of their work, and it is time that their views were properly recognised as being equally valid as those of employers and self-styled experts. What unions have to do is support their members in wresting back ownership of their labour.

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In one region of Italy, some hospitals assess the risks to reproductive health and take preventive measures, while others do not. The activity of union health and safety reps is clearly key to getting this result. In France, workers in firms with a health and safety committee are twice as likely to have been given health and safety information or training on a like-for-like basis (i.e., comparable sectors and company sizes). Examples abound in Europe, as elsewhere[1]. The existence of proactive trade unions with specific health and safety reps often makes the difference between real prevention and a management tick-box exercise. These facts are important, but do not explain the why and the how. In other words, why is trade union action so important, and how can it be effective?

Health at work was a central factor in making workers conscious of forming a class distinct from other classes of society in the early period of the industrial revolution. Intensive exploitation of the first generations of industrial workers left its marks on their bodies. All 19th century accounts point to a very high rate of early deaths among industrial workers. Organised labour had to act immediately and urgently to do something about these life and death issues. The unions actively rebutted attempts to portray accidents as inevitable in the late 19th/ early 20th century. In the closing third of the 19th century, joint initiatives were launched beyond national borders, including for shorter working times and the replacement of certain hazardous substances like white phosphorus in match manufacture and lead in paint.

Even today, most surveys that ask workers what they want trade unions to do find that improving working conditions comes high on the list.

Yet problems and pitfalls abound. There is no hard-and-fast guarantee that union action will achieve improved working conditions. It takes critical thought, discussion, strategy formulation and experience-pooling. It may sometimes seem to conflict with other priorities of union action for pay or jobs. It raises many immediate questions, some of which require long-term answers. The current

[1] Walters D. and T. Nichols (2009) *Workplace Health and Safety. International Perspective on Worker Representation*, Palgrave-Macmillan.

situation where EU health at work policies have petered out has increased the role of trade union action. “Top-down” reform through EU directives is unlikely to drive major changes until bottom-up pressure evens up the playing field.

What only unions can do

For upwards of a century, occupational health has developed more as the purview of specialists. The hazards of work have been pigeonholed into different disciplines. Occupational medicine, industrial safety and industrial hygiene have developed as separate areas. After World War Two, ergonomics and occupational psychology gradually marked out their territories. More recently, psychosocial factors have come to the fore, addressed through different approaches by professionals more often in competition than cooperation.

The union approach does not preclude what each of these disciplines has to bring provided those concerned act for occupational health rather than putting it second to other concerns like employee selection, productivity and discipline. What gives union action its uniqueness and potential is that it starts by recognizing that workers have their own perceptions and knowledge of working conditions and how they affect health. In some cases, that perception is immediate: having a bad back or joint pain, feeling tired or demoralised, seeing that scaffolding is unstable or that the pace of work cannot be kept up. In other cases, the perception needs to be organized. It may take different forms from one person to the next according to age, gender or other factors, and it may be difficult to see the collective dimension of the problem. Sometimes, a link needs to be made between the experience of workers from different generations where long-term effects are concerned - immediate perceptions can mask a less visible problem. The large-scale advent of computers into offices in the late 1970s, for instance, prompted widespread fears that the new work equipment might cause miscarriages. This seemingly irrational response was in many cases an indirect signal of being ill at ease with an increasingly impenetrable work organization and the dangers of increased employer control bypassing the means for workers to fight back handed down by union struggle.

There may be no quick fix, but there is a solid baseline: empower workers, not let specialists annex matters relating to their health. It is an important starting point because it calls into question one of the major elements of work organization: the division between managers who devise and operatives who put into practice. Getting them to talk about working conditions is to make a start on regaining dignity for all those who have such conditions forced on them by others.

Workers’ unique experiences can fill the gaps and overcome the biases of number-counting scientific methods when it comes to exploring new issues. In the 1970s, workers’ complaints about the limits on exposure to certain organic solvents were often looked at askance. The protocols agreed on by scientists found no biochemical abnormality below certain exposure levels. Yet the workers complained of memory lapses and irritability. Investigations instigated by some unions found that these complaints reflected genuine health problems. Over time, a section of the scientific community developed more accurate analytical methods that identified the problems. The employers and public authorities used the uncertainties and controversies as an excuse for doing nothing. The late 1980s saw a rash of newly-

named diseases like chronic painter's syndrome, solvent encephalopathy, and psycho-organic syndrome. It took a further few years for a handful of countries to recognize these conditions as occupational diseases, while others continue to ignore them. The tenacity with which some unions campaigned on the issue and the alliance they forged with a section of the scientific community helped improve the conditions of prevention. In the late 1990s, union networks launched EU-wide projects to replace hazardous chemicals, particularly in the building industry.

This is anything but an isolated example, and is an object lesson in what is specific to the union approach. Giving visibility to what is invisible, identifying the collective dimension to what is often seen as an individual health problem, turning that collective consciousness into interest articulation.

Pitfalls...

Obviously, not all stories are success stories. There is also a catalogue of failures that are just as instructive as the successes.

It took the labour movement in many countries generations to demand a ban on asbestos. A sorry tale, but one that reflects the pressure from industry holding jobs to ransom. Any significant improvement to health at work has been portrayed by employers as a threat to competitiveness. Apocalyptic howls have greeted everything from taking children out of the mines, to banning asbestos or requiring an assessment of health risks before putting chemicals on the market. Employer pressure has had its biggest effect when it has relied on a productivity-driven ideology that automatically sees output growth as creating social progress. The obsession with productivity often goes in hand with the illusion that science will solve problems as they arise.

In the late 19th/early 20th century, the issue of compensation for health damage pushed the need for prevention in the workplace into the background. New laws picked out specific risk factors, creating compensation schemes (work accidents first, a small number of diseases later on). To some extent, the focus on these issues took the momentum out of challenges to work organization and demands designed to eliminate risk factors and give workers control over their working conditions.

Compensation for accidents and certain diseases apart, the most visible and recognized forms of health damage may be included in wage setting. Night work and some particularly hazardous exposures can result in a direct (through so-called "danger pay") or indirect (where certain health risks are treated as part of the job) wage adjustment. In these cases, job blackmail may be combined with threats to income, whereby better working conditions almost automatically means forfeiting pay or bonuses. Looking beyond this key material aspect, risks may be hard-wired into the occupational identity of some categories of worker. Short of being able to eliminate them, the risks are played down or given a positive spin. This is a false defence mechanism to protect health by playing down unease and developing practices to "manage" some risks; but it can also produce a kind of fatalism. In many cases, it is turned against workers by some experts who treat it as irresponsible risk-taking without inquiring into where it comes from.

Another obstacle has been the unequal influence of different categories of worker within unions. Women, migrant workers, young workers, workers in contingent jobs or with less recognized qualifications had little say. In certain eras, women were not allowed to join trade unions, and the occupational health solution offered was to bar them from certain jobs like mining, night work, etc. By and large, the most exploited categories are those where occupational health problems are most disregarded. This second obstacle also shows the huge potential of a dynamic, union-led workplace health policy. It is both key to getting a foothold in new, less organized sectors or categories and goes to make for sound internal democracy in action. It is also vital to create solidarity between workers in different firms working on the same job. One probable criterion for successful trade union action is the ability to address the issues raised by subcontracting, and identify the least well-represented categories with the worst working conditions. A close look at major chemical industry accidents shows that in many cases, subcontracted workers from other industries are exposed to the most hazardous situations.

… and many problems

While most available data point to a significant link between trade union action and prevention, the practical outcomes vary by company, type of risk and other conditions. This makes it relevant to consider the conditions for effective trade union action in this area[2].

The autonomy and strategy-formulating ability of unions are key factors. From the blanket level of inter-industry policies right down to workplace safety reps, enormous pressures are in play to reduce the trade union role to that of carrying out policies set by others. In occupational health management systems, company management will often set the priority objectives and ask the workers' reps to "pass them on" to their colleagues. The poor performance of health and safety representation systems in non-unionised workplaces evidences this problem. The role of a safety steward is not to be confused with that of a "mini-technician" or, worse, an overseer.

An integral part of union autonomy is their ability to independently determine things they agree on with the firm (e.g., preventing industrial disasters), things where compromise can be reached, and things they cannot agree to. On this basis, union action can be thought of as a sort of pendulum movement: starting from workplace health needs, exercising the leverage needed to get agreements that will change work organization, assessing the outcomes and organizing labour action over the sticking points. In that process, any real improvement, however small, increases workers' confidence in their own strength and the importance of organized action.

Other things can play into the success of that movement, including: a defined framework of statutory rights, training, adequate and accurate information, effective control by the Labour Inspectorate.

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[2] Menendez M., J. Benach and L. Vogel (2009) *The impact of safety representatives on occupational health. A European pespective,* Brussels, ETUI.

Two factors arguably play a particularly important role. Unions' ability to build networks that can identify problems, develop the preventive solutions applied in some workplaces and effect regular exchanges of experience between safety reps. This avoids endless repetitions of the same obstacle course, and also helps to create bonds of solidarity between trade unionists in different firms and support their activism through improved knowledge[3].

Another major thing is the union's ability to tie occupational health issues into other aspects of its agenda both in the workplace and in broader society. In collective bargaining, leveraging the experience of safety reps from the initial demand formulation stage helps avoid the frustration of getting agreements that sacrifice the quality of working life to other claims. Linking occupational health requirements to the fight for gender equality is also important. Giving recognition to the work hazards that women workers are exposed to is part and parcel of action for job desegregation. Pay differentials can only be tackled by challenging stereotypes that deny some of women's professional qualifications. This is one lesson of the grievance disputes staged by nurses in Europe over the past twenty five years. They were able to mount blanket protests encompassing occupational health, recognition of qualifications and better conditions to ensure more effective health care for patients. Such actions helped to raise questions about the authority structure in hospitals and health budget cuts. Similarly, trade union action to get the most hazardous chemicals eliminated is calculated to improve occupational health, public health and environmental protection.

On the offensive on work organization

Dividing workplace health into boxes dealt with by experts from different disciplines goes against workers' correct perception that health is bound up with work organization. A survey of ceramics industry workers in Spain found that: "Unlike the distinctions usually made by the specialised language of prevention techniques, workers generally instinctively see the hazards of work as being an inter-related whole where, for example, dangers to safety or hygiene are linked to specific forms of organization and their physical manifestation is perceived in the form of health damage (...) In the discussion groups where a less media-spun collective perception of risks emerges, workers voice different problems and priorities from those identified by technicians. Particularly striking is the importance that workers attach to health problems related to work organization, as compared to the almost exclusive technical focus on safety and workplace accidents"[4].

Generally, there is no mechanistic link between exposure to a risk factor and its health impact. The division of labour, the company management structure, the amount of control workers collectively and individually have on how to organize work, the ability to give opinions, make demands and influence decisions are all factors that can lessen or worsen the health impact. This is illustrated by

[3] Based on the experience of unions in Ontario, Canada, A. Hall and others describe this strategy as knowledge activism (Hall A., *et al*. (2006) Making a Difference: Knowledge Activism and Worker Representation in Joint OHS Committees, *Relations Industrielles/Industrial Relations*, Vol. 61, No. 3).

[4] Boix P., *et al*. (2001) *Percepciones y experiencia. La prevención de los riesgos laborales desde la óptica de los trabajadores*, Valence, ISTAS.

occupational accident figures which show that agency workers have a higher accident rate than employed workers in the same jobs and production sectors. The same trend is found in some outsourcing situations where the scope for influencing working conditions is reduced by the existence of a dual power relationship: that of the employer and the work specifier. The absence of democracy in the workplace has a negative effect on two fronts. It makes it harder to put knowledge to work for prevention; and it affects the overall quality of life at work and can dramatically limit its positive potential for personal self-fulfilment and development.

Huge potential

An offensive trade union policy on occupational health holds tremendous potential because it forges a daily practical link between broader societal issues and workers' daily lives. There is a constant interplay between the "micro" level of diseases, accidents, premature aging of the body, psychological distress and the "macro" level of social inequalities, where work fits in, economic development strategies and the way our societies work generally. It is also a daily class in how absurd and damaging the traditional division is between those who are purported to know and order and those who are purported to do and produce.

Two important developments bear a moment's attention. There is some unease about the very meaning of work. The groundswell of discussion on psychosocial factors to some extent shows the quality of work to be an issue in industry as much as in services[5]. Many of the changes in management systems have provided answers that do not work because they are based on a vertical approach (top-down from management to the workforce), they are immediate-profit-driven and apt to discount the collective dimension of work. The warning signs abound: recall after recall of vehicles even though the car industry subcontracting chain is meant to ensure top quality at least cost; unease in public services at the constant pressure on resources, be it in health or education.

There is a growing awareness that our development model is incompatible with environmental constraints: global warming, water issues, the growing mountain of waste, disastrous urbanization in many parts of the world. Embracing human working conditions and social equality are two areas ripe for a union approach. Getting back to the vision of human work in balance with its natural environment is a central challenge for any environmental policy whose aim is more than just greenwashing capitalism. In this way, the union movement can tie the immediate defence of the workers it organizes in workplace with the global aspiration to change society.

[5] Clot Y. (2010) *Le travail à coeur. Pour en finir avec les risques psychosociaux*, Paris, La Découverte.

Work and health – how some are more equal than others

Social inequalities in health are growing in most European countries. Public health policies are apt to ignore how much of the development is due to working and employment conditions.

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Spain has mortality atlases broken down by small geographical areas[6]. The higher the mortality, the darker the shading. If the maps for very different causes of death (cardiovascular disease, different cancers, suicides, infectious diseases, etc.) are overlaid, the dark areas tend to match up. A baby in Glasgow (Scotland) can have a life expectancy 10 years longer or shorter simply because of the social characteristics of the neighbourhood it was born in. Behind these geographical inequalities lie social inequalities. The darkest areas tend to be those where social conditions are least favourable: higher unemployment, higher proportion of manual workers, derelict industrial sites, etc.

The public health figures tell the same story. A 35-year-old French female manual worker has a disability-free life expectancy of 27 years, compared to a senior manager's 35 years[7] - a healthy life expectancy difference of eight years. Where total life expectancy is concerned (including years lived with disability), female managers can expect to live almost three years longer than female manual workers. Male manual workers die six and a half years earlier than male senior managers. Social inequalities in health are not just about mortality - they cross all health-related conditions and most injuries and disorders, both physical and mental, are a major factor in disabilities, the ability to live an independent life, the rate and consequences of aging. They scotch the idea that health is mostly conditioned by individual behaviour or genetic factors. Whether as commonly-held beliefs or scientific speculation, these beliefs mix simplistic guesswork with a deliberate whitewashing of the most inhuman and unacceptable aspects of employment relations.

Social inequalities in health are not a black-and-white contrast between the haves and have-nots, but a scale of changing shades of grey going up the social hierarchy. In epidemiology, these are called social gradients. They can be based on educational levels, occupational classifications, income categories, or social status of other family group members. All the data point to the glaring conclusion that property, power and work are distributed unevenly and health is largely determined by these social relationships.

Social inequalities in health in most European countries are showing a worrying trend[8]. The gaps closed over the four decades following World War II, but the overall increase in wealth and income inequalities seems to have reversed this trend. The most critical situation is that of some Central and Eastern European countries. In Estonia, the life expectancy gap

[6] Benach J. *et al.* (2001) *Atlas de mortalidad en áreas pequeñas en España,* Barcelona.
[7] Cambois E., C. Laborde, J.-M. Robine (2008) La double peine des ouvriers. Plus d'années d'incapacité au sein d'une vie plus courte, *Population et sociétés*, No. 441, January.
[8] Mackenbach J. (2006) *Health Inequalities: Europe in Profile,* Rotterdam.

between a 25-year-old male graduate and a man of like age with the least formal education has widened dramatically, rising to 13 years in 2000[9].

A range of factors play into social inequalities in health, mutually reinforcing one another throughout life. What specific role do working conditions play in these inequalities? How can action for health at work reduce them? These are questions that tend to be underplayed. Working conditions are missing from a large part of the literature on social inequalities in health, while the overall impact of social relationships on health often slips off the radar of the stakeholders in health at work.

Some traditional contributors to social inequalities in health have receded for the great majority of Europe's population. Access to care is more or less guaranteed, albeit not equally or fully. Access to drinking water, a healthy diet and housing can be a problem for some highly marginalized groups, but these factors account for only a small part of all the social inequalities that are in evidence. The burden of infectious diseases remains a reality, but their role in overall inequality is far less than a century ago. This relative reduction in a combination of factors suggests that working conditions play a particularly important role. The worldwide EMCONET research network has released a report giving a good overall picture of this issue[10]. To appreciate the scale of the problem, it needs examining on several levels.

Physical working conditions

Working conditions can create physical risks. Hazardous machinery, awkward postures, toxic chemicals, noise, vibration - all these factors are unevenly distributed between occupations. The general trend is that the lower one goes down the job ladder, the more hazardous exposures tend to increase, often with a combination of exposures and a lower standard of prevention. This accumulation of hazardous exposures that are evident at a point in time of working life interact over the total length of a person's career. Broadly, it can be said that someone who has been exposed at work to carcinogens at the age of 25 has a much greater probability of being exposed to carcinogens at the age of 50. In some cases, the exposures will be identical, in others, they will be different. Most often, they will be combined with other health-endangering factors.

Relatively robust data are available on point-in-time occupational exposures in different European countries. Data on the build-up throughout working life are much patchier. Where they exist, they reveal the link between work activities and the stratification of society into social classes. An analysis of a set of factors on physical and mental wear has found that point-in-time data for a working life did not differ very significantly from data that incorporated changes in working conditions at different periods of workers' lives[11]. This suggests that there is an overall contextual consistency of individual life stories in social relations which marks the different stages of working life.

Work organization

Behind the physical conditions of work stands an organization of work in various forms. Human labour is a social activity. It is never confined to the relationship between an

[9] Leinsalu M., D. Vågerö and A. Kunst (2003) Estonia 1989-2000: Enormous Increase in Mortality Differences by Education, *International Journal of Epidemiology,* Vol. 32, p. 1081-1087.
[10] www.emconet.org
[11] Coutrot T. and L. Wolf (2005) *L'impact des conditions de travail sur la santé : une expérience méthodologique*, Paris.

individual and their natural environment. It posits relationships of cooperation and hierarchy, a division of labour and different social valuations of activities. Flying an aeroplane, caring for babies in a nursery, preparing a meal, collecting refuse or selling drugs are all activities - legal or illegal, paid or unpaid – carried out on very different social terms. The description of their physical attributes will mark them out by the different actions, tools, materials, cognitive activities, etc. Their social position will set them within a hierarchical and unequal structure which will determine the links between the different persons involved in those activities, and between them and the rest of society. There is a continuity between social relations in and out of the workplace.

Work organization can also be seen to be a key health determinant. Data on cardiovascular diseases show that problems increase in severity the lower down the social ladder one goes. The same applies to most mental health problems.

The role of work organization has often been studied on the basis of two sets of criteria – one focused on task discretion or degree of control, the psychological demands of work and social support, the others on the potential imbalance between the input and the reward. Data from numerous surveys show these criteria to be relevant and complementary. They help explain the wide gaps between occupational groups in areas as different as cardiovascular mortality and musculoskeletal disorders. They are sometimes used by separating psychosocial factors from the place occupied in the social pecking order. That kind of approach tends to reduce work organization analysis to perceived individual characteristics. UK research on public service workers argues a close link between these individual dimensions of work and socioeconomic status[12] which appears to be behind both an uneven distribution of the relevant factors (autonomy, recognition, etc.) and their greater health impact on the lower socioeconomic groups.

One of the most worrying developments in work organization is the increased time-pressure of work. This has a wide range of health impacts. It is a major contributor to musculoskeletal disorders which afflict almost one in four workers in Europe. It also adds to what can only be described as work-induced accelerated aging (see table).

Health disorders and work under pressure among workers aged 50 and over

	Never worked under pressure	Under pressure in the past	Currently under pressure
Pain	53%	65%	66%
Fatigue	43%	55%	61%
Sleep disorders	35%	46%	51%
Memory disorders	24%	34%	37%

[12] The Whitehall II study was set up in 1985 by Professor Sir Michael Marmot to investigate the importance of social class for health by following a cohort of 10,308 working men and women. Read more on: www.ucl.ac.uk / whitehallII

Health deteriorated in recent years	23%	35%	41%

Source: Mardon C. and S. Volkoff (2008) Les salariés âgés face au travail "sous pression", *Quatre pages CEE,* No. 52, March

Job insecurity is bad for health

A second level of analysis is the employment relationship. There is an intrinsic insecurity in wage labour as an institution. History shows that the free market in labour developed only through duress. Impoverished populations were forced by the twofold impact of hunger and government violence to put their labour under the dominion of others. From the onset of the industrial revolution, the labour movement held that insecurity in check by creating balancing forces in the form of individual rights, collective rights and specific forms of organization and struggle. Social security has to varying extents in different countries loosened the constraints to decommodify human labour[13], enabling withdrawal from the labour market in particular circumstances like old age, illness or disability. Through unemployment or early retirement schemes, it permits workers to distance themselves to some extent from worsened working conditions. Vested rights can be undone. Over the past thirty years, the deterioration of employment relationships has worked against a real improvement in physical working conditions. This has played into growing inequalities. Three things are worth noting.

Unemployment is a key factor in declining health. This observation might seem counterintuitive if one were simply to list the physical factors in the workplace that affect health.

However, the link between unemployment and poor health can only be explained by looking at three features of what unemployment is:

1. Unemployment rarely means doing no work at all. It is a legal status. For women, it usually means adding yet more of the family work to their load. In the general population, it may go together with undeclared work in particularly poor conditions;
2. Unemployment is almost never a permanent status throughout adult life. It can often occur after spells of work which have already involved health damage. It is common among people rendered vulnerable by poor health, including from non-work-related factors. So, unemployment rates are generally found to be higher among people with mental illness, cancer or who have suffered a work accident even though still healthy enough to work. It is as if by excluding cancer patients from work, employers were second-guessing future productivity losses or the nuisances of adapting working hours or jobs;
3. Unemployment is not just a legal status. It also partakes of social relations. In addition to lost income, it often also undermines social networks, increases isolation and feelings of worthlessness.

Insecurity is on the rise in the working world, and may take specific forms for young people, women and immigrants. It may be reflected in a special legal status. European Union (EU) countries have witnessed a startling rise in so-called non-standard forms of employment which are now becoming the norm for some groups! In the Netherlands, three-quarters of women work part-time, compared to an all-EU average of about one-third. This reflects the lack of public childcare provision and the unequal division of family labour. But it is not just that: part-time work is often imposed by employers and denotes worsened working

[13] Esping-Andersen G. (1990) *The Three Worlds of Welfare Capitalism,* Princeton University Press.

conditions and reduced career opportunities. Young people face myriad kinds of non-standard jobs ranging from apprenticeships to a wide variety of work placements, a much higher incidence of agency work and less job stability. Immigrant workers, and the descendants of immigrant workers of certain nationalities, are also facing rising insecurity.

Work can be subcontracted under a fixed, full time employment contract. But there is a clear link between subcontracting and worse working conditions. Cost-cutting considerations are mainly behind increased outsourcing by business. It tends to impose a division of labour whereby the outsourced activities lead both to over-exposure to occupational hazards and employment uncertainty. Unit outages for maintenance and repair in nuclear power stations incur significantly greater exposure to ionizing radiation for outside subcontractors than permanent employees. In the carmaking industry, lean production imposes work rates that are hard to sustain over time for workers who make the different components of a car which is generally assembled by the work specifier. Multi-tier subcontracting is a major cause of fatal accidents in the building industry.

Working and employment conditions interact in many ways. For individuals, a lower level of job security is generally reflected in worse working conditions. Spanish research based on a large-scale trade union survey has developed a comprehensive precariousness scale that takes a range of factors into account[14]. These include conditions of employment but also the exercise of rights, pay levels, the ability to influence working hours, the risk of unemployment, etc. The study found a close correlation between adverse health outcomes and insecurity. It shows higher levels of insecurity in the lowest socioeconomic groups and among women, young people and immigrants. One merit of the study is to highlight the importance of workforce-driven approaches in the workplace.

Nuking personal development

Health is an ongoing process played into by socially constructed expectations and the ability to adapt and repair anything that limits them. It is not so much a state as a balance that is constantly under challenge from various factors and may, under certain conditions, recover or improve. While many physiological and psychological processes operate subconsciously, maintaining health is related to the individual's life objectives. The centrality of work for adults in our society means that more than direct damage to health, work plays an important positive and negative part in maintaining health. Swedish studies report often worse health conditions among women homemakers for reasons that are probably less due to the physical conditions of what they do than being trapped in the home and having fewer and less diverse social ties than women in paid work. Contingent employment status and poorer working conditions have an impact beyond the individual risk factors found in the work itself.

The American sociologist Richard Sennett has highlighted the role of flexible working in undermining personal development and all forms of long-term commitment[15]. It is a useful analysis for recontextualizing what are sometimes called individual risk behaviours. A big part of public health policies focuses on changing individual health behaviours largely in isolation from their social determinants. Nagging building workers to eat more fruit or stop smoking even though they are hugely exposed to carcinogens in their work is disingenuous at best and smacks of cynical, bureaucratic box-ticking. There is a significant link between

[14] Vives *A.* et *al.* (2010) The Employment Precariousness Scale (EPRES): psychometric properties of a new tool for epidemiological studies among waged and salaried workers, *Occupational and Environmental Medicine*, Vol. 67.
[15] Sennett R. (2003) *Le travail sans qualités : les conséquences humaines de la flexibilité,* Paris.

behaviours singled out as individual and the quality of work life. It is a link pointed to in a wide range of studies. In road safety, for instance, younger male manual workers have a known higher incidence of more severe driving accidents than other social groups. Likewise, harsher working conditions can encourage smoking or heavy drinking. The failure of many prevention campaigns can be put down to a wilful disregard of the way working conditions contribute to shaping specific types of behaviour.

Perhaps the best picture to take away is a set of overlapping circles over large areas. Physical working conditions, work organization, employment conditions and life objectives all interact with one another. Each of these spheres has individual and collective dimensions. All are cut across by gender relations. The links between work and social inequalities of health point to an ownership of human bodies through a social rationale of wealth and power accumulation at one extremity of our societies. They show the limitations of policies that disconnect occupational health from public health.