Europe

Work has been a paradoxical issue throughout the Covid-19 crisis. It is one of the main channels of transmission, so it has played a huge role in the aggravation of social inequalities during the pandemic. Yet it has been a blind spot in government strategy. This may be one of the factors that contributed to the eventual failure of lockdowns in most European countries.

Work, a blind spot in the Covid-19 crisis

Laurent Vogel
ETUI

In Europe, there have been, in broad terms, four stages to the authorities' responses to the Covid-19 crisis. The first three stages hold numerous points of comparison with the rest of the world. In the current, second lockdown phase, it is too early to identify what might be peculiar to Europe and what might in fact be a taste of future situations elsewhere.[1]

The first phase: strong denial and "mild flu"

It began with denial, perhaps most brutally on the part of Chinese authorities at the start of the epidemic. The virus first appeared in Wuhan, an industrial conurbation peopled by millions of workers, many of them with a precarious status as "internal migrants", constantly monitored by the state and housed in factory dormitories. The authorities' initial response was to order them to keep quiet and carry on working. There was a clampdown on whistle-blowers such as Li Wenliang, an ophthalmologist in Wuhan's central hospital, who was summoned by police on 3 January 2020 and forced to back down. He contracted Covid-19 on 10 January and died on 7 February 2020. For several crucial weeks, the Chinese authorities first denied and then downplayed the human-to-human transmission of the virus. But the upsurge in the epidemic among medical staff in Wuhan left no room for doubt. On 14 January 2020, the World Health Organization (WHO) was still saying that "preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission". In a sharp about-turn, however, Wuhan was placed in quarantine at 8 p.m. on 22 January. The experience of this quarantine was perhaps most poignantly described by the novelist Fang Fang in her diary, published under the title *Wuhan Diary: Dispatches from a Quarantined City*.

In Europe, the basis of the initial denial was different, instead guided to a significant extent by a neoliberal vision of public health. This was then exacerbated by the effect of austerity policies and a hierarchy of priorities in which collective prevention was at the bottom. Most of the preparedness plans developed after the H1N1 flu pandemic of 2009-2010 were abandoned without discussion. The most visible manifestation of this error was the failure to replenish strategic stocks of protective masks. The almost complete stoppage of funding for fundamental research on coronaviruses was part of the same trend. This research had first taken off after the pandemics of SARS (severe acute respiratory syndrome) in 2003 and MERS (Middle East respiratory syndrome) in 2012. In neither case were there more than 1 000 deaths worldwide. If research priorities are decided on the basis of return on investment, it would seem ridiculous to grant substantial resources to a threat of this kind. But this argument draws only from the past. The actuarial calculations of insurance companies were not the only way to assess the risks. The environmental crisis is exposing us to virus reservoirs present within animals in a much more widespread and direct way. The industrialisation of meat production has created huge livestock units that are particularly vulnerable to pathogens. Mass use of air transport has helped increase the risks exponentially. Although there was no way of knowing when

1. This article was completed on 1 November 2020. On the basis of the figures available at the end of October, Europe, together with the US, is the region of the world worst hit by the second wave of Covid-19.

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and where SARS-CoV-2 (the virus that causes Covid-19) would appear, the alarm had already been raised by various research bodies on the inevitability of far more aggressive infectious pandemics emerging in the future. The public health system, for its part, is focused on hospitals, and neglects both primary health care and intermediate levels, such as outpatient treatment. It is becoming common for very elderly people to live away from the rest of the community in care homes increasingly run by private groups, despite the evidence from countries such as Denmark that non-segregated alternatives improve their quality of life.

When the threat in Europe became undeniable, the influence of employers was a determining factor in the delays that ensued. Italy is the most telling example. This was the first European country to be extensively affected. The first cases detected were two Chinese tourists on 31 January 2020, but, from the second half of February, numerous new cases appeared without any direct link to China. The internal circulation of the virus was particularly evident in the industrial regions of the northeast (Lombardy and Veneto). Employers embarked on a large-scale media campaign to avoid any lockdown measures. In Bergamo, which was to become the most tragic epicentre of the pandemic, Confindustria (the Italian employers' federation) launched a video on 28 February insisting, against all the evidence, that "Our businesses have not been affected, and they will carry on as ever." Throughout March, the employers' hashtag, #yeswework, banged the drum on this issue. It took massive strikes to get the Italian government to finally close down some industrial plants.

The first lockdown: back to basics?

Starting in the second half of March 2020, lockdown measures were adopted in most of the European countries that had been hardest hit by Covid-19. These measures were justified on the grounds of the very rapid spread of the virus, the absence of effective treatments or vaccinations, and the rising death toll. But the state of disrepair of public health systems, afflicted by decades of austerity, also played a role. The health system was at breaking point. This is the background to the tragedy of the mass fatalities in care homes. Throughout 2019, strikes and demonstrations by care home staff in France had highlighted the deterioration of working conditions as well as management methods that were based on a kind of industrialisation of care work, which was incompatible with its real purpose. Staff shortages, intensified and standardised work, insecure employment conditions, and no workplace democracy: these deadly ingredients were all already present.

↴ **All over the world, women have been at the forefront of the battle against the pandemic.**
Photo: ©Belga

During lockdown, a double standard emerged between health measures in public places and health at work. In public places, drastic rules of prevention applied. Never in the history of humanity have such demanding public health measures been introduced anywhere within such a short space of time. As far as work was concerned, essential activities were maintained, including in situations where prevention was inadequate. In Europe, the downplaying of workplace risks first came to light in the protective mask crisis. Rather than acknowledging their responsibility for the failure to replenish the strategic stocks built up in 2009-2010, for weeks most governments went on insisting that wearing masks was pointless or even counterproductive in most situations. On 2 April 2020, Anthony Smith, a labour inspector in France, was dismissed by his line management for trying to have masks delivered to the staff of an association providing home care.[2] For several weeks, work went on in hospitals in Denmark, although the inspectorate stopped carrying out checks, considering that this would expose its inspectors to an excessive risk.

The definition of what constituted essential activities was a divisive issue. No one questioned the need to keep the health sector or food production going. But governments adopted criteria that were too broad, to keep industrial sectors such as aircraft manufacture operating or to allow e-commerce giants like Amazon to carry on their activities.

Where it was possible, teleworking became mandatory or strongly recommended, depending on the country. Teleworking is an effective factor in protecting against the spread of the virus. But it does have another side: the major inequalities arising from the possibilities of adapting practical activities to this mode of operation; housing conditions and access to both suitable equipment and high-quality connections; and difficulties when paid work and unpaid family work overlap. This last factor weighed particularly heavily on women. The closure of schools and the suspension of many services for disabled, sick and elderly people seriously worsened women's double working day. Psychological strain and the "return" of large numbers of men to the home full-time contributed to an exacerbation of domestic violence.

There were two options in the case of non-essential activities where teleworking was impossible: temporary lay-offs with specific social security support, or the continuation of certain non-essential activities subject to compliance with hygiene rules (often reduced to social distancing alone).

Failure of the exit strategy: were young partygoers to blame?

From mid-May 2020, most governments in Europe opted for a gradual return to normality. Lockdown had produced encouraging results. The virus reproduction rate (Ro) had dropped below one. Hospitalisations and deaths had fallen very substantially. At the end of May 2020, the prevailing impression was that Europe was coming out of the most critical phase, even though some members of the scientific community were warning against over-optimism. At that time, it was mainly on the American continents that the pandemic was rife. This was partly exacerbated by political factors. The presidents of the continents' two most highly populated countries (the US and Brazil) were holding on to attitudes of denial that were far more radical and enduring than those of their European counterparts.[3]

There is a striking contrast between the trends in scientific data and the inadequacy of prevention at the workplace.

More than anything, it was the existence of very marked social inequalities that magnified the impact of the illness. In Latin America, for tens of millions of impoverished workers in the informal sector, going into lockdown meant they could not afford to eat. The few specific welfare mechanisms introduced were insufficient. In the US, the shortcomings of the social security system left many workers without pay if they took time off sick. This made it difficult to place people in quarantine as soon as the first symptoms appeared. The more substantial influence of social inequalities may help to explain the contrast between Europe and America. In Europe, lockdown brought about a very marked drop in mortality within a few weeks. On the other side of the Atlantic, it fell more slowly. The US, where there was a strong fall in mortality from the end of April to mid-June, was out of sync with the rest of the Americas, where the death toll continued to rise until August. The situation in Asia and Africa was not uniform: there were particularly critical zones (India, the Middle East and South Africa) and then there were areas where the pandemic was continuing at a relatively low level or seemed to have been contained.

In Europe, although the spread of the virus had slowed down, the pandemic was still very much present and spreading geographically, with outbreaks in the Balkans, central Europe and Portugal, where its impact had been low during the preceding period.

All through the summer, the part played by working and employment conditions cropped up again and again. But these alarm signals were consistently ignored. Government policies tended to look elsewhere: towards partygoers and the admittedly antisocial behaviour of a great many people wanting to relieve the anxieties of the period just passed. Hard data on infections seemed now to be framed by a moralising narrative. Recreational activities were seen as hotbeds of infection, demonstrating the immaturity of many young people, while workplaces faded into the background. But infections at work remained at a high level in all sectors involving public-facing roles. This is clearly the case for healthcare but also for social services, prisons, the police, public transport, and so on. From September 2020,

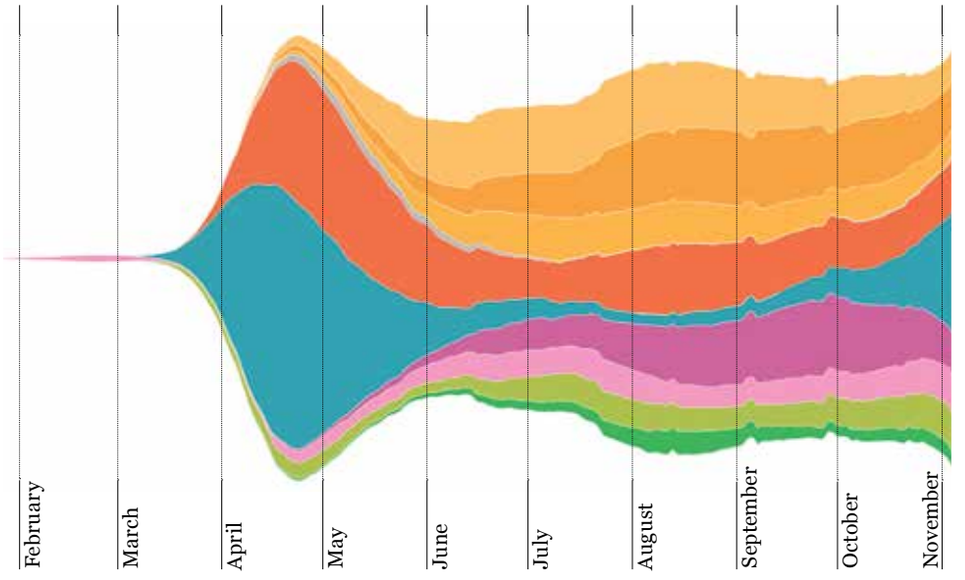
2. Under union pressure, the French Minister of Employment allowed the inspector to resume work on 13 August 2020, but he was transferred 200 kilometres away from his home. In a joint complaint filed with the International Labour Organization, the French unions raised around 30 cases of pressure brought to bear on labour inspectors by their line management.

3. In Mexico, the third most highly populated country in the Americas, President Andrés Manuel López Obrador's position on the pandemic was not as unequivocal as that of Trump or Bolsonaro. He did, however, grant priority to the continuation of economic activity, to the detriment of public health needs.

Breakdown of the human toll of the pandemic

Daily deaths from Covid-19 by country/region: 21-day moving average

SOURCE – Adapted from Johns Hopkins University data.



Brazil · The rest of Latin America · Mexico · The rest of North America · US
Europe · India · The rest of Asia · Middle East · Africa

On 12 November 2020, Europe recorded 2 790 deaths caused by Covid-19, compared to 162 on 1 August and 3 781 on 17 April.

education was also added to this list. And the proliferation of virus clusters in other sectors came down to the interaction of infection with poor working conditions and precarious forms of employment. In Poland and Czechia, work in the mines was at the source of major local or regional clusters. All over the world, abattoirs were flagged as breeding grounds of the disease. And agricultural seasonal labour, which is characterised by the extreme precariousness of its working, living and transport conditions, was also at the origin of many local clusters.[4] The refusal to regularise undocumented workers unconditionally in Europe played a role in the spread of infection in this sector, as it did for domestic workers.

There is a striking contrast between the trends in scientific data and the inadequacy of prevention at the workplace. From February onwards, studies raised the alarm about the persistence of the virus on surfaces. Airborne transmission had also been affirmed by various studies as early as April. On 6 July 2020, 239 scientists issued an urgent appeal to the WHO asking it to take account of this risk in its recommendations. In practice, when it came to prevention practices within companies, these risks were rarely taken into consideration.

If we look at the mortality curve in Europe,[5] this peaked around the middle of April 2020. It then dropped sharply, only to climb again gradually from the second half of August, before going out of control in October. During the last week of October, the milestone of 1 000 deaths a day was passed again, despite a significant improvement in the treatment of severe cases.

The desire to resume economic activity at any cost was not accompanied by the technical and human resources needed to track and trace the contacts of people diagnosed as positive. Many policymakers communicated the illusion that downloadable computer applications could replace painstaking human work of observation and investigation – work that would also have been an opportunity for discussions about the precise circumstances of infection at work, at home or on transport, etc.

Prevention compliance suffered as a result of the proliferation of conflicting signals. Work was generally presented as posing few problems, whereas the day-to-day experience of work, as it really was, gave the lie to these optimistic claims. Moreover, people were rightly being asked to be cautious in the rest of their daily lives, from festive occasions to interpersonal contacts. If rules were rarely adhered to at work, why would they be in other activities? This question raises a more fundamental issue which cuts across all the phases of the pandemic: a highly authoritarian approach to prevention.

Partial return to lockdown

From the start of October 2020, there was no longer any doubt about the reality of a second wave in Europe. This was attested by a rise in hospital admissions, and then deaths, in Spain from August onwards. The second wave spread over larger areas than those which had been seriously affected by the first wave. The spectre of the collapse of hospital services loomed again with the added concern that the damage arising from inadequate treatment of other disorders had been recognised. Most European governments resigned themselves to new lockdown measures. As far as work is concerned, this time everything appears to have been reduced to a dichotomy between activities that can be performed remotely and those that require a human presence. When activities have been suspended, the rationale for these measures is not the protection of workers as such, but the limitation of contact with the public (closure of non-essential retail outlets, gyms and cultural locations, partial recourse to distance learning, etc.). If the transition to teleworking in March took place in a rush, without proper provision in law or coverage by collective bargaining, the situation was hardly better six months later.

4. Before the borders within the European Union were opened, derogations were granted so that large numbers of agricultural seasonal workers could be brought in, in particular from Romania.

5. Data of variable quality on reported deaths attributed to Covid-19 are available. Using overall excess mortality rates recorded in 2020 compared with previous years, the analysis can be refined, and better account can be taken of the limitations of the recording of deaths from Covid-19.

↳ **It is becoming common for very elderly people to live away from the rest of the community in care homes, increasingly run by private groups.** Photo: ©Belga

A common blind spot

The public health policies adopted have been focused on barriers: distance between people, mask-wearing, disinfection. And more often than not, they have been dictated by the authorities. The allocation of roles between policymakers and experts has rarely been transparent and has often been contentious. One of the basic lessons learned from the battle with AIDS has been swept aside, giving way to a strong comeback of a hygiene-based approach that is highly averse to accepting non-expert knowledge from the people affected. In most of the groups of experts advising decision-making bodies, there is minimal representation of the social sciences.

From this viewpoint, work is reduced to a place where individuals congregate, like a religious ceremony or a sports activity. In the case of Covid-19, transmission through the respiratory route necessarily implies that work must be regarded as a major channel for the spread of the virus. It is an intrinsically collective activity involving multiple interactions between people and materials. It is not enough simply to bolt on hygiene rules designed to establish barriers within spaces. Some rules are unworkable, while others would require major changes to the organisation of work, productivity standards and the room for manoeuvre that workers have in their activities.

Statistical mechanisms play a major role in managing the pandemic. As much as they describe reality, they also construct it. Data gathering has been modelled by the WHO. It covers individual data (sex, age, place of residence, comorbidity factors,[6] admission to hospital, death – if applicable – etc.) and does not include any data on the occupations of the people affected or other socio-economic indicators. It is as though it was a question of managing a socially undifferentiated mass of individuals who might transmit the virus from one person to another. Data on the occupational dimension have emerged only gradually, and very unequally from one country to another, sometimes in combination with other factors relating to social inequalities in health.[7]

In our view, there is a close link between these limits and the political will to avoid placing the issue of social inequalities at the centre of prevention measures against Covid-19. Linking prevention with the specific nature of work means interfering with the power balance between workers and employers within companies.

Two diametrically opposed perspectives

There are two sides to the opposition movements that have emerged. One is reactionary and based on conspiracy theories. This involves a mixture of racism (against Asian communities, particularly during the early weeks of the pandemic), the claim to individual freedom as an absolute right, macho glorification of risk-taking, a cult of gross domestic product (according to the academic version of this discourse, a drop in GDP would cause more deaths than Covid-19) and an instinctive distrust of expert scientific opinion. The political parties on the extreme right have generally not managed to harness these responses, except possibly in Spain, where Vox, bolstered by its regional alliances with the classic right-wing, has played a more active role than the Italian Lega or the French Rassemblement national. This opposition feeds on justified criticisms of the inadequacy of welfare mechanisms (particularly in Italy) and the authoritarian approach to crisis management. It does not offer any alternative for society. It is an aggressive call for a return to the old order.

The other opposition has come from the world of work. It is potentially radical. All over the world, women have been at the forefront of the battle against the pandemic, in hospitals, care homes and supermarkets. They have often had to fall back on their own devices in disastrous prevention conditions and they have helped others to survive, often at the cost of their own health. Some people, declaring them to be heroines, have tried to masculinise this situation. But, in reality, the resilience of medical staff is based on prior struggles that forged collective identities.

The hygiene-based vision adopted by the authorities is constantly at odds with the requirements of work in the real world and employers' demands to keep productivity up. An analysis of the clusters that emerged after lockdown was lifted shows that, in certain activities, the protection offered by simple hygiene barriers is illusory. In other activities, work has to be done differently. Teaching, acting or driving a bus while keeping to the personal protective measures often involves unsustainable situations and destabilises professional identities. To a large extent, it is work itself that is feeding a huge potential for resistance.

This has been demonstrated intermittently and unequally from one country to another. It first appeared on 1 March 2020, at the Musée du Louvre in Paris, where staff exercising their collective right to stop work on the grounds that their lives were in danger led to the introduction of a minimum level of preventive measures. In northern Italy, numerous strikes broke out in March, bringing some factories to a standstill, while a desperate revolt took hold in some prisons. Some weeks later, there were new conflicts in France about determining what is, and is not, "essential" from the workers' viewpoint. Sometimes, judicial decisions garnered publicity for these struggles, as in the case of the Renault plant in Sandouville and in various Amazon logistics centres. In Belgium, meanwhile, an overwhelming majority of bus and tram drivers of the Brussels public transport company (STIB) exercised their right to stop work in May. Management had challenged the need for some prevention measures in preparation for the increase in passenger numbers when lockdown was lifted. Other collective struggles also developed, in particular among agricultural labourers in Italy on the regularisation of undocumented workers. The common factor in these movements is the concern to ensure that occupational health requirements dovetail with the needs of public health.

As events unfold in the next few months, democracy in the workplace could occupy a special place in the surrounding debates – but this still remains a challenge rather than a certainty. In the real world, work cannot be reduced to a simple space where hygiene barriers can be blindly applied. To acknowledge this is to allow groups of workers to take control over the conditions of production, draw on their experience, and reshape work in all of its aspects, taking account of both the health imperatives and the actual benefit that their work represents for society. Beyond Covid-19, this is about the essence of democracy: giving people the right to discuss and decide how to carry out their work on a day-to-day basis. ●

The statistical data do not include any data on the occupations of the people affected or other socio-economic indicators.

6. The role of working conditions in certain comorbidity factors, such as pulmonary disease, has not been systematically researched to date. However, it is an important potential factor of inequality in relation to deaths.

7. The European Trade Union Institute will shortly be publishing a report on the available data on Covid-19 as an occupational risk.