



The connection between occupational safety and health and public health

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Following the outbreak of the Covid-19 pandemic, a particular notion suddenly started popping up in EU policy documents and debates, as well as on conference and research programmes in the field of occupational safety and health (OSH): that of the important connection between OSH and public health (PH).

The concept arises particularly in relation to the goal of “increased preparedness for potential future health crises”, as outlined in the EU Strategic Framework on Health and Safety at Work 2021-2027. In this context, the European Commission advocates that “synergies between OSH and public health should be further developed”. In the mandate given to the Working Party installed by the tripartite EU Commission’s Advisory Committee on Safety and Health (ACSH) to undertake this task, reference is made to “the evident interaction between OSH and PH”. However, nowhere in the mentioned documents is this apparently “evident” link explained, nor is there any clarity offered about how such “synergies” should be promoted. And, perhaps most remarkably, the academic literature on the topic does not provide us with much content on this concept of the interlinkage between the two fields either. It is therefore not surprising that at international and EU-level conferences, the topic appears in the form of “an exploration”.

So here are a few initial thoughts to help take this exploration a little further, starting with a couple of key questions. What do we actually mean when we speak about the link between OSH and PH? And what actions and measures should be taken to increase synergy between the two fields?

The basis: a clear causal link

The term “public health” refers to the health of the population as a whole, especially as the subject of government regulation and support. The term is also used to refer to the branch of medical science dealing with public health. Occupational safety and health, meanwhile, refers to the safety and health of workers, especially as the subject of preventive and protective measures put in place by employers, and based on government regulation. These

basic definitions point at the evident causal link between the two fields: occupational health is an important determinant of public health, for work can be and unfortunately often is a cause of diseases. In other words, work, exposure to occupational risks, and working conditions are essential factors for understanding population health. Citizens and workers are the same people: if they work in bad conditions that affect their health, it will show in public health statistics through increased disease rates.

However, as obvious as this may seem, work is hardly ever taken into account as a causal factor in public health data. These data consider individual behavioural elements such as smoking, alcohol abuse and unhealthy diets, but much less so environmental and work-related – what we can call “collective” – factors.

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It is here that the Covid-19 pandemic has been a wake-up call, for it has become clear beyond any doubt that work is a key vector in the spreading of the virus, with workers in many sectors and professions at great risk of contamination. While in normal times occupational risks and the diseases that occur as a result of them, such as respiratory diseases, cancer or depression, usually stay invisible – only a problem for the victims to deal with – this time, becoming ill at work from Covid-19 is an issue of great public interest. Workplace contamination undermined the continuation of essential services like healthcare and public transport and it created a health risk for the population at large – think, for example, of the meat-processing workers who were quarantined after large numbers of them became infected, to prevent them from infecting others. The Covid-19 pandemic has, in other words, shone a spotlight on occupational health risks and, more than this, presented a window of opportunity to act.

The (missing) link between OSH and PH in health data and healthcare

Since, until now, the occupational causes of diseases have hardly ever been taken into account either in public health surveillance and registration systems or the data that result from them, they have remained largely invisible. Moreover – or perhaps we can say to a large extent as a result of this invisibility – healthcare practitioners also seem to have a blind spot when it comes to work. Let's take a simple, hypothetical example to illustrate what the consequences of this situation can be.

Imagine a painter goes to see his doctor. He has been experiencing regular headaches (especially by the end of the week), incidences of fainting at work (his colleagues lie him on a mattress and then when he wakes up he continues working), and lately he has more and more difficulties with his memory. His wife complains that he has outbursts of aggression that are completely out of character for him. The doctor does not ask his patient what kind of work he does and prescribes him a few weeks of rest, and after that, the painter returns to his work, where – what would have been obvious to any OSH expert – the exposure to the

solvents in the paint he works with are the very cause of his health complaints. The painter goes through several of these cycles of work and prescribed rest until, finally, his wife reads something about psycho-organic syndrome (POS), or “painters’ disease”, in their union’s magazine, and recognises the symptoms. By then, however, it is too late to reverse the disease and the painter is severely handicapped for the rest of his life.

If health surveillance and registration systems would include OSH as a possible causal factor, similarly to individual behavioural factors like smoking, alcohol abuse and unhealthy diets, they would more adequately be able to account for the causes of diseases and inequities in population health in all their complexity. A good example here are cancer registration systems. If these were to include a work history of patients, we would gain a much clearer image of the extent to which carcinogens and mutagens at work are responsible for (certain) cancers amongst the general population. This would help to strengthen the case for more cancer prevention measures at work. It would also make medical practitioners more aware of the possible occupational causes of diseases, which would in turn also contribute to prevention.

Establishing the link within health governance

Decisions on health are largely made based on public health evidence in which, once again, OSH is a blind spot. This was clearly shown in the process of classifying the Covid-19 virus in the context of the Biological Agents Directive¹. A panel completely composed of public health experts looked only at the disease’s mortality rate, totally overlooking both contagiousness and working conditions as factors. For OSH experts it was clear from the outset that working conditions contained a built-in risk to multiply contagion, both because of the intrinsic characteristics of

various kinds of work (e.g. client/patient contacts, closeness to co-workers, impossibility to apply basic hygienic rules, low temperatures, etc.) and because of some factors related to work (such as travel to work in packed public transport or poor housing conditions, with too many people living in close proximity). But OSH experts were not involved in the process of classification. As a consequence, Covid-19 did not end up in the highest risk category (4) but in the one below that (3), despite the fact that it has now killed far more people than, for example, Ebola, which is in the highest risk category.

This can only lead to the conclusion that OSH experts should be included in decision-making processes on public health issues. Including them as important stakeholders would be, at the very least, just good governance. An element not to forget here is the expertise of workers themselves. Work as it is implemented in practice is often very different from work as it is designed – a well-known insight of ergonomists. Often workers are not only the best but actually the only experts that can report on the OSH risks in a specific work context.

A final question, then: are there any drawbacks to integrating the knowledge of occupational safety and health into public health registries, data and practice, as well as into its governance? Well, perhaps just one note of caution: OSH should remain a separate and independent field of expertise and policymaking. Its focus needs to stay on the realm of work, and its governance under the umbrella of employment policy, where it is imperative that the institutions and advisory and negotiation bodies dedicated to OSH be maintained. ●

¹ See Musu T., “The Good, the BAD and the Ugly”, *HesaMag* #23, Spring 2021. <https://www.etui.org/publications/workers-food-chain>