

Hauss, Friedrich; Rosenbrock, Rolf

**Working Paper — Digitized Version**

## Occupational health and safety in the Federal Republic of Germany: A case study on co-determination and health politics

WZB Discussion Paper, No. IIVG pre 82-206

**Provided in Cooperation with:**

WZB Berlin Social Science Center

*Suggested Citation:* Hauss, Friedrich; Rosenbrock, Rolf (1982) : Occupational health and safety in the Federal Republic of Germany: A case study on co-determination and health politics, WZB Discussion Paper, No. IIVG pre 82-206, Wissenschaftszentrum Berlin (WZB), Berlin

This Version is available at:

<https://hdl.handle.net/10419/82995>

**Standard-Nutzungsbedingungen:**

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

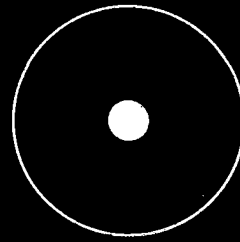
**Terms of use:**

*Documents in EconStor may be saved and copied for your personal and scholarly purposes.*

*You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.*

*If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.*

Wissenschaftszentrum



Berlin

IIVG/pre82-206

Occupational Health and Safety in  
the Federal Republic of Germany -  
a Case Study on Co-determination  
and Health Politics

Friedrich Hauß/Rolf Rosenbrock

Internationales  
Institut  
für  
Vergleichende  
Gesellschafts-  
forschung

International  
Institute  
for  
Comparative  
Social  
Research

IIVG preprints

## Abstract

Der Artikel wurde für einen vorwiegend internationalen Leserkreis geschrieben.

Die Bundesrepublik Deutschland gilt im Ausland vielfach als "Musterland" der industriellen Demokratie, die in vergleichbaren Ländern nicht das hohe Ausmaß an institutionalisierter Mitbestimmung erreicht hat wie in der Bundesrepublik. Anhand der Analyse der betrieblichen Arbeitsschutzpraxis wird jedoch nachgewiesen, daß zumindest in diesem Feld betriebliche Austausch- und Konfliktprozesse das Ausmaß der Mitbestimmung nicht der vielfach geäußerten Einschätzung entspricht. Vielmehr besteht im Arbeitsschutz-System eher weniger Mitbestimmung als in einigen westeuropäischen Ländern und z. B. in Kanada.

Das führt z. B. dazu, daß vor allem Arbeitsbelastungen, die sich der Meßbarkeit durch naturwissenschaftliche Methoden der Arbeitsmedizin entziehen, nicht zum Gegenstand des betrieblichen Arbeitsschutz-System werden, da sie von diesem gar nicht erfaßt werden können. Die einzig sinnvolle Möglichkeit zur Erfassung dieser Arbeitsbelastungen besteht jedoch darin, die Kontextnähe und Kompetenz der Beschäftigten bei dem Aufspüren und bei der Bewältigung von Arbeitsbelastungen zum integralen Bestandteil des professionellen Arbeitsschutz-Systems zu machen. Darin sehen die Autoren einen gesundheitspolitischen funktionalen Beitrag zur Prävention moderner Volkskrankheiten.

Friedrich Hauß/Rolf Rosenbrock:

Occupational Health and Safety in the Federal Republic of Germany -  
a Case Study on Co-Determination and Health Politics

1. The Philosophy of Occupational Health and Safety in the  
Federal Republic of Germany.

The occupational health and safety system (OHS-system) of the FRG differs from that in other western industrial countries in two main respects. First, OHS is an integral part of the system of co-operative conflict-solving within the framework of co-determination. Secondly, the implementation of OHS is to a large extent the task of professionals (occupational physicians and safety engineers).

The rights of the individual worker or of a worker-group are less developed in FRG than in comparable countries:

- Except in some carefully defined situations there is no right to refuse dangerous work.
- There is no right of the individual worker to call in the work-inspectorate.
- There is no direct representation of health interests by elected delegates (as for example in Sweden) or by a worker group (such as the homogenous groups in Italy).

In spite of these characteristics of the OHS-system in the FRG it would be wrong to consider it as being mainly repressive towards the individual worker. Rather, the structures of OHS in the FRG are based on a compact philosophy, which integrates the system of co-determination at plant level with a specific emphasis on experts. This philosophy of OHS is based on three main assumptions:

- Scientifically trained professionals (ergonomic and safety experts, occupational physicians etc.) know most about the health problems at the work-place, and therefore best results regarding healthy working conditions can only be obtained if these professionals apply their knowledge to the work-place. This practice is assumed to be

more advantageous than a system in which workers protect themselves from health hazards.

- Workers' complaints regarding stress and hazards are not effective if they are expressed by individual workers. For this reason - and also in order to rationalize and to routinize the procedure - such complaints should be brought forward only by the works-council.
- The possibility that the practice of professionals could be more in accord with the economic interests of the employer than with the health interests of the employees is, in this view, counterbalanced by a certain control of the works-council over the activities of the professionals. (1)

Any critique on this system must be two pronged: First, there is the question of the validity of these premises. Only if all the three premises are valid, OHS in the FRG could be considered as a model for industrial democracy. Secondly, since OHS-systems are not designed for scientific research in industrial democracy, but should assist in solving the health problems of the workers, it is reasonable to question which problems OHS-systems should refer to. That may lead to more precise criteria for the evaluation of the practice of OHS. It is the main approach of this paper to point out that the professionally dominated OHS-system in the FRG is not able to deal with most of the important work-hazards and work diseases such as hazards originating from shift work, work-organization etc. This deficiency can be attributed to three main reasons:

- the kind of regulations, rights and norms which concern the workplace and the working-conditions;
- the medical paradigm which is personal orientated and not capable to interfere with the technical reasons of many work-hazards;
- the kind of co-operative conflict solving routines which are the common way of industrial democracy in the FRG.

Some of these matters will be discussed in the following sections.

## 2. The state of the problem

There are at least three important health problems in most western countries, which indicate the extent and gravity of health hazards and risks at the work-place. As a part of the health care system any OHS-system must face these problems and contribute to health policy as a whole.

1. Early retirement problem: Only 30% of all employees keep on working until they reach the official retirement age. The rest of 70% retire early for health reasons or die before reaching retirement age. The growing trend within the last ten years indicates the severeness of the problem.
2. The second indicator is the rapid change in the pattern of diseases, people die of or suffer from. In 1952 only 14,4% of the West-Germn population died of six chronic diseases (besides accidents). But in 1971 the quota of these diseases on the mortality scale rose to nearly 40% and is still increasing. As far as morbidity is concerned, things are even worse. Six or (as some authors say) seven chronic diseases account for over 80% of whole morbidity.

In spite of all differences there is one common characteristic in these six or seven diseases: They are not curable by means of (traditional) medicine. In some cases it is possible to soothe pains or to counterbalance some specific handicaps, but there is really no reasonable chance of recovery from these diseases.

3. With respect to these health problems there is hardly any doubt even among conservative positions that many of the reasons for this development are to be found in the area of the work-place. But since knowledge in this field is quite limited, health measures improving the work-place haven't been implemented in the FRG to any reasonable degree.

The characterization of the main health problems by these three indicators helps to describe more precisely the tasks and efforts

of any OHS-system:

1. The OHS-system is supposed to have a preventive character in the sense that employees are not only protected by personal protective measurements (personal prevention). It should also include measures to overcome the risk-factors for chronic diseases such as stress due to the work-organization, the wage-system, piece- und shift-work, night shifts, exposure to chemical hazards, etc.

There are a lot of regulations of technical prevention in the FRG concerning the equipment of certain machines, buildings or assembly systems. But to a large extent such preventive measures only refer to risk-factors which could lead to work accidents or to one of the 54 work-diseases which are defined and accepted by the work accident insurance institutions. They definitely do not apply to risk-factors which could lead to the majority of chronic diseases.

Traditional medicine with its natural-science dominated methods is not even able to detect a significant amount of single risk-factors, not to speak of combined hazards. On the other hand the approach of the traditional medicine is to attribute a specific disease to a single risk-factor. When facing the large number of risk-factors, that approach seems to be a kind of Sisyphus task in the chemical industry for example it could take years to prove the dangerous effects of the most common chemicals.

2. This leads to another criterion any OHS-system should fulfill. It should involve the employees as active partners and encourage them to deal with their own health problems. There is lots of evidence that workers are very capable of detecting and coping with many health problems at the work-place. Risk-factors which could hardly be detected by the traditional medicine or the engineering sciences can be recognized by the employees as a health handicap or as reduced well-being. The three items: continuity, close regards to working conditions and, resulting from both, competence of the workers, make them a factor which is indispensable for a preventively operating OHS-system.

Of course, besides those three operative items on the employee side, an OHS-system will not work without additional help of professionals.

The question of whether the predominance of experts is a paradigm which could guarantee an OHS-practice in accord with the main health problems of employees is seriously discussed at least in the FRG.

3. A third effort should guarantee that the economic interests of the employer does not predominate over the health interest of the employees. In fact, this is a problem which touches the basic structure of industrial relations. In the FRG these different interests are supposed to be balanced by the system of co-determination at plant level. Co-determination in this sense is a framework for conduct and a structure which sets up rules and possibilities for coping with industrial conflicts. The main function of co-determination in counterbalancing health interests and economic interests is to make conflicts negotiable. It assumes that either the conflicting interests are considered as common interests of management and employees or that the economic interests of the employers are confronted with an equally powerful counterstructure on the employee's side. Only that would guarantee that the economic interests are not enforced against the health interests of the employees but at least with regards to them.

### 3. The practice of the OHS-system at plant level

#### a) Predominance of economic interests in the OHS-system.

In the context of this paper we refer only to the predominance of economic interests at plant level. We do not discuss the strong influence of capital on the legislative process (capital successfully opposed the legislation of OHS in the FRG for more than 20 years, and then shifted to opposing certain parts of the law) and in the threshold values (for instance the threshold values in the FRG are set up in committees where the chemical industry is powerfully represented).



With respect to the practice of OHS there are some factors which establish the predominance of economic interests and, as a consequence, limit the practice of OHS (at best) to accident prevention and personal protective measures.

- According to the law experts are not directly responsible for the health problems of the employees but have only advisory competence vis-a-vis the employers, who are held responsible for the implementation of the law at plant level (that differs for instance from the Swedish model where a safety committee with equal representation is responsible for OHS).

The very close relationship between OHS-experts and the employers gives management the possibility of utilizing the knowledge and authority of the experts for their own economic purposes and makes it more difficult to utilize the experts for the health interest of employees.

- The economic, social and legal dependence of health safety experts on the employer is by no means counterbalanced by the influence of the works council or by legal regulations. Co-determination in the field of OHS is very weak:
  - The works council does only have the right to co-determine the kind of medical and engineering services which an enterprise is to engage (there are several types of services, run by the enterprises themselves, by work accident insurance institutions or by private persons). There is hardly any influence on management decisions concerning hiring or firing the experts.
  - Members of the works council are a minority in the safety committee, which anyway has only advisory status and is not entitled to make any binding decision.
  - The individual employee does not play any active role in the OHS-system. He is merely counted as a recipient of safety advice and rules. Certain rights such as the right to know, the right to participate and the right to refuse are not established in the West-German OHS-system. It is even not possible for an individual employee to call in the work inspectorate.

As in other fields of common or conflicting interest between management and labor there is a certain deficiency of effective participation - by the works council or by the individual worker-- within the OHS-field, which diminishes the contribution of the OHS-system to healthier working conditions. An expansion of co-determination in this area might turn out to be a powerful instrument for overcoming unhealthy or even unworthy working conditions. It is a great advantage of the law to apply in principle to all kinds of working conditions. But it is a great disadvantage that it provides no effective instruments to establish a preventive OHS-practice.

- Another factor which indicates the predominance of economic interests is the competition among the different health and safety services. They engage not only in price competition but also agree to the demands of employers not to apply certain regulations or not to offer any advice which could lead to higher costs for the enterprise. Some employers even ask for a special "no-show-service". That means the service is hired just to fulfil the law formally, but not engage in any real activity at plant level.
- Times of decreasing economic activity force the employees to weigh the health risk against the risks of unemployment. Employers usually argue that every amount spent on measures for OHS is at the expense of lost jobs. This kind of "black-mailing" is very effective and keeps employees in a continuous situation of having to calculate the different risks. Usually risky or unhealthy working conditions are tolerated under such circumstances.

b) Predominance of experts in the OHS - system

When in 1974 the ASiG (the German OHS-law) was enacted, it was the first time that an obligatory health-orientated institution was set up at plant level. Also the term "work-related diseases" was established for the first time in legislation and the results of the law in statistics look impressive at first glance. Within eight years the number of workers treated by company doctors increased from about 5% to over 50% of the work-force, the number of company doctors increased from about 1.500 to more than 12.000. Within the same period 60.000 occupational safety professionals were appointed.

To understand these statistics it should be noted that the majority of company doctors act as freelancers in addition to their own practices. The level of training of the physicians is not at all sufficient. Only a few hundred of them have a special degree in occupational medicine. Only one sixth of the appointed safety professionals are employed fulltime for this task; the others have additional tasks as foremen and/or production engineers. As a consequence of this conflict of interests, reasons for reducing expenses and/or increasing productivity are often given more emphasis than safety tasks: Even big enterprises usually divide the scheduled amount of time among several persons to avoid having safety experts whose main job is safeguarding the health interests of employees.

But even if there were a sufficient number of fulltime professionals there is still considerable doubt as to their efficiency with respect to health problems: As shown above OHS-professionals are highly dependent on the employers for economic, legal and social reasons. On the other hand they are in practice the ones who define OHS-problems in a twofold sense: What are the OHS-problems? And: By what means are these problems to be solved? Because of the narrow and natural-science-defined paradigm of medicine, some essential dimensions and reasons are eliminated. Under these circumstances only those complaint hazards and health handicaps can appear as health-problems, and only those solutions are worked out, which can be defined in terms of medicine or engineering sciences.

In enforcing this restricted approach, the professionals are supported by two mechanisms:

1. OHS-problems are defined from the beginning in the restricted way which was described above. Beyond very unspecific and broad definitions of the problems, regulations include as their precise core only some defined threshold values. Restricted definitions in the early stage of setting norms is a consequence of the co-operative negotiation of these norms in the responsible committees. This leads to the second item.
2. Within the framework of co-determination, co-operative solutions are worked out especially for those problems which are measurable and where the cause-effect-relation is unequivocal. As a consequence other problems are not even negotiated or they are reduced to problems of measurable thresholds.

The question arises, how the works council faces these problems. At first it can be stated that OHS-related activities of the works council have increased to a certain extent since the ASiG was enacted. On the other hand the works council because it is caught up in the procedure of this law tends to share the narrow view of problems. Under these circumstances for most works councils the best and only way of looking after the health interests of the workers seems to be to translate their complaints into the terms of the experts and to look for solutions by co-operative bargaining. Moreover, the works council normally does not have the time to deal with all health problems, because it is at the same time responsible for all aspects of workers' interests at plant level. Their two key roles within OHS, representing the interests of workers and controlling the professionals, can therefore only be inadequately performed.

From the first step of the recognition of work-problems by the workers themselves to the solution of these problems by the OHS-system several bottle-necks have to be passed. That leads to the elimination of some problems by means of professional definition and

economic power:

1. Workers usually raise only those health problems to which a solution seems feasible within the framework of the established conflict-solving procedures.
2. The works council is not able to deal with the whole scale of problems that arise.
3. It translates these problems into professional norms, to make them negotiable within the safety committee.
4. The works council is a minority in the safety committee which moreover has only advisory status.
5. The final decision on OHS-measures is made by management which bases its decision more on short term economic interests than on the health interests of the employees.

There is much evidence that during this procedure a lot of aspects, among them expressions of impairments of individual well-being, get lost. This is all the more important because knowledge about these impairments of well-being is an indispensable base for an efficient primary prevention. Moreover the potential for prevention which lies in activating workers' concern for their own health interests is blocked.

More than one half of the workers often speak with their colleagues about matters relating to health and work; nearly 40% would even give up part of their wages if that would lead to reasonable reductions of work stress. This, as well as several casestudies in the FRG, indicates that it is justified to speak of an "overflowing health consciousness" on the part of workers which remains ineffective as long as there is no creative power for the workers to influence their own work environment. The delegation of authority to the professionals and the partial integration of the works council in a restricted view of health problems leads instead to resignation and/or individual escape from unbearable work stress.

As a result it can be asserted that none of the three premises which are basic to the philosophy of West-German OHS in a framework of professionalism and co-determination is completely fulfilled:

- The professional point of view eliminates the workers experience of their own stress.
- Neither does <sup>the</sup> representation of health interests by the works council, which is to a large extent incorporated in the system of bargaining over threshold values, represent a sufficient counterweight
- There is no adequate control over the practice of experts through the system of co-determination: Economic interests of capital still predominate over health interests of the workers.

Therefore the structures of OHS in the FRG do not fulfil the criteria of industrial democracy nor do they meet the health policy prerequisites which were discussed above. The activation of workers for their own health interests is sacrificed to a large extent to tendencies of problem-suppression, personal protective measures etc. This tendency, founded in the system of legal norms and its implementation by professionals, is enforced by various practices of OHS at plant level. Some of them are discussed in the following section.

#### c) Counterproductive tendencies in OHS-practice

An estimated amount of 30% to 75% of all company doctors only examine workers and never inspect for instance a work place. Besides the legally prescribed medical examinations, pre-employment check-ups play a most important role. Contrary to the legal regulations they normally are carried out during the time which is scheduled to provide medical service to the company. Pre-employment check-ups are carried out in more than two third of the plants covered by medical services. Especially in periods of high unemployment, pre-employment check-ups are in reality and in the impression of the workers a tool of personnel selection. This medical examination is the first experience with the OHS-system a worker has and the company

and it is often nothing more than the company doctor's judgement that decides, if he is hired or not. It is hard to imagine such a beginning can promote a steady relation between workers and company physicians. Rather, it must be assumed, that the individual worker identifies the company doctor and thereby the whole OHS-system as part of the control system of the enterprise. After all, nearly 80% of all workers covered by the questionnaire, reported that the enterprise selects employees according to health criteria. On the other hand 30% of the questioned workers are also aware that as a consequence of a routine examination they might lose their jobs; more than 40% of the questioned members of works councils (according to German law, the works council has to get a written notice in every dismissal) report, that health reasons are important for dismissals. When there was short-time working during the last 12 months, this figure increased up to 50%.

2. The extent, as well as the subjects and purposes of the practice of the professionals are largely not transparent for employees: Less than 40% of all enterprises have a program for OHS. In less than one half of the enterprises doctors control the area according to a fixed program; the legally prescribed safety committee provides only little opportunity to exchange experiences and planning of the OHS-practice with the professionals moreover it only meets with the minimum frequency of four sessions a year, in 40% of all cases. There is a lot of evidence that a professionally dominated OHS-system cannot initiate an adequate participation of the workers as long as it is identified as a personnel selection agency and its activities are not transparent for the employees.

3. Consequently it is not surprising that the professionals are not accepted as partners in dealing with work problems at plant level: One half of those questioned takes their work problems to the works council, more than 40% to their chief and only 1.1% to the company doctor or the safety expert. That demonstrates, how far away the professional OHS-system is from being a reasonable partner for the workers.

It is evident that most of the severe health problems do not come to the attention of the professionals. Instead they remain in the "inofficial" OHS-system which is carried among the workers themselves. The constituency of that informal system is mutual assistance, as well as advice and tips to reduce or avoid stress at the working place. The integration of both, the official and the inofficial OHS-system, would offer the chance to enrich the latter through the professional knowledge of the health and safety experts and thus make it more efficient. Nevertheless, this opportunity is passed up. The reasons can be found in the structure of the existing OHS-system and cannot be interpreted as temporary impediments to the implementation of the law, which might improve in the long term. On the other hand there is no question that those disadvantages still exist.

#### 4. Some perspectives

In criticizing the structure and practice of OHS in the FRG the possibilities this system offers when it is applied consequently should also be pointed out. It can be shown that if there is a strong and vivid political consciousness among workers the works council has an increasing ability to deal with other workers' demands. Under these circumstances it is also possible to deal with the problems of the workers much more effectively. This entails that "health at the work-place" is no longer regarded as an area of common interests between capital and labour, but in the context of bargaining and conflict between the industrial parties. In the end this means, that, for example, it should be possible to attain health demands, even if the criterion of measurability is not applicable. That happens mostly in plants which are highly unionized, and have a powerful works council. Often in these cases even the professionals change their attitudes and are willing to cross the restrictive borderlines of their natural science paradigm. In other cases their authority to define problems is neutralized by means of trade union strategies or by external experts. Furthermore, union strategies can eliminate the workers' dilemma between health risks and high wages. But even in highly developed plants from the



point of view of union strategy, there are some de facto limits to the politics of works councils. They have nearly no influence on the pre-employment check-ups and other measures of personnel selection. In the final analysis any union strategy against personnel selection cannot be successful if it does not transcend the limits of a plant level perspective.

At the plant level the system can be improved

- if the system of co-determination is supplemented by autonomous workers' rights (such as the right to refuse dangerous work and the right to call in the work inspectorate),
- if a specific representation of health interests is integrated in the representation body of the employees. The "health and safety stewards" which could be elected by the workers should fulfil the following criteria:
  - Close connection to the working process and its stress and strains,
  - no difference in social stratification or status in the hierarchy,
  - special training by union courses,
  - :

Under these conditions it is possible that the paradigm of safety engineering and occupational medicine could better address the central health problems of working life.

- (1) This paper results from the research project "OHS and health politics" which was carried out at the International Institute for Comparative Social Research, Section Work Politics and the Science Center Berlin (Member of the project were: F.O. Hauß, H. Kühn, R.D. Rosenbrock). Questionnaires were given to nearly 1.500 workers who participated in trade union training courses from about 380 individual plants.

The complete results are published in three volumes:

Rolf Rosenbrock: Arbeitsmediziner und Sicherheitsexperten im Betrieb

Hagen Kühn: Betriebliche Arbeitsschutzpolitik und Interessenvertretung der Beschäftigten

Friedrich Hauß: Belastungsthematisierung im Arbeitsschutz

(all: Frankfurt und New York (Campus) 1982)