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Working Paper — Digitized Version

Industrial health policy in a crisis: Regressive tendencies and new tasks for the professionals

WZB Discussion Paper, No. IIVG pre 85-209

Provided in Cooperation with:

WZB Berlin Social Science Center

Suggested Citation: Rosenbrock, Rolf (1985) : Industrial health policy in a crisis: Regressive tendencies and new tasks for the professionals, WZB Discussion Paper, No. IIVG pre 85-209, Wissenschaftszentrum Berlin (WZB), Berlin

This Version is available at:

<https://hdl.handle.net/10419/82997>

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WISSENSCHAFTSZENTRUM BERLIN

IIVG/pre85-209

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Regressive Tendencies and New Tasks for the
Professionals

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Internationales
Institut
für
Vergleichende
Gesellschafts-
forschung
Arbeitspolitik

International
Institute
for
Comparative
Social
Research
Labor Policy

IIVG preprints

14. 11. 338 ~~1/5~~

IIVG Papers

Veröffentlichungsreihe des Internationalen Instituts für
Vergleichende Gesel'schaftsforschung (IIVG)/Arbeitspolitik
des Wissenschaftszentrums Berlin

IIVG/pre85-209

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Berlin, Aug. 1985

ISSN 0724-5084

Publication series of the International Institute for
Comparative Social Research/Labor Policy

Wissenschaftszentrum Berlin
Steinplatz 2, D 1000 Berlin 12

030/313 40 81

Abstract

Vorwiegend in den 60er und 70er Jahren sind in verschiedenen westeuropäischen und nordamerikanischen Ländern neue Ansätze für die betriebspolitische Bearbeitung arbeitsbedingter Gesundheitsprobleme entstanden. Diese Ansätze, z.B. die Arbeitermedizin in Italien, legen besonderes Gewicht auf die Aktivierung und Mobilisierung der Beschäftigten und beinhalten Formen der direkten Partizipation der Arbeitnehmer bei der Gestaltung ihrer Arbeitsbedingungen.

Unter dem Druck der international zu beobachtenden Tendenzwende in der Sozial- und Gesundheitspolitik werden arbeitsbedingte Gesundheitsprobleme zunehmend weniger öffentlich thematisiert und gesundheitspolitisch bearbeitet. Unter Druck geraten dadurch nicht nur Modelle der direkten Beteiligung, sondern die betriebliche Gesundheitspolitik insgesamt. Gleichwohl deuten sowohl Diskussionsansätze aus dem Bereich der etablierten Arbeitsmedizin als auch eine zumindest partielle Krisenresistenz von betrieblichen Modellen auf Entwicklungschancen präventiver Gesundheitspolitik in der Arbeitswelt hin. Bei der Entwicklung solcher Modelle häufig auftretende Engpässe, Fehlsteuerungen und Blockierungen auf betrieblicher Ebene werden abschließend benannt.

Das vorliegende Papier ist gegenüber der deutschen Version (IIVGdp/84-221) leicht gekürzt. Es gibt die überarbeitete Fassung eines Referates wieder, daß der Verfasser auf der vom Institut für Psychologie des CNR veranstalteten Konferenz "Direct Workers Participation in Matters of Workers Safety and Health" im November 1982 in Castel Gandolfo (Italien) vorgetragen hat.

INDUSTRIAL HEALTH POLICY IN A CRISIS

REGRESSIVE TENDENCIES AND NEW TASKS FOR THE PROFESSIONALS

by Rolf Rosenbrock

I. No matter how the protracted period of stagnation in the world economy and individual countries is scientifically explained and politically treated (cf. *Naschold*, 1984), there are probably no major differences of opinion about two aspects:

1. In terms of its length and depth, the present crisis goes far beyond "normal economic cycles." With certain national modifications, employment and labour-market indicators have been showing a state of depression since about the middle of the seventies. Even in upswing years of national economies - from the cyclical point of view - unemployment rises and mass purchasing power drops. Apart from professional optimists, no one predicts a basic improvement of this situation in the next few years.
2. A consequence of the economic crisis to be observed in nearly every country and area of politics is a cutting back or change of course in social and health policy. This is true from both the financial and ideological point of view.

Industrial health policy is social policy in that arena in which economic bottlenecks have the most direct effect and/or are cited to justify restrictive policies. This means that it is under the triple pressure of economic constraints, the resulting change of course in social and health policy as well as the wide number of practical and ideological uses to which the crisis is put by employers and governments.

In effect, this leads to the fact that at the moment work-related health problems have less chance of social thematization for the same reasons that cause their objective

increase and aggravation. The impending exclusion of these problems affects not only public but also industrial perception.

In this situation it is possible to observe how the weight and accepted truth of arguments depends not only on empirical evidence and the internal consistency of the argumentation, but also on the politically and economically explainable acceptance by society, and on the vigilance society accords these problems.

This can be seen in exemplary fashion by the fate of the discussions on and practical treatment of attempts at direct worker participation in questions of health and safety at the workplace. The approaches made in various Western European countries in the seventies with different scopes and different political configurations are politically in opposition to the autonomy of the enterprise with regard to the shaping of working conditions and the prevailing health-policy paradigm as it is represented by practising physicians with their predominant training in the natural sciences. In a few countries in the seventies it was possible to partly break open the alliance between the majority of physicians and entrepreneurs resulting from this joint opposition - mainly as a result of the fact that large numbers of medical intellectuals had become politically aware. It is to be feared that this alliance will restabilize under the pressure of the economic crisis and its political functionalization. In the following, the deficits and misdirections of occupational health and safety (OHS) of the kind to be found in more or less every Western European country, will be summarized in the form of theses. The resulting picture characterizes to a certain extent the initial situation *before* the turnabout at the end of the seventies, clarifying the weakness of the approaches encountered by the rollback (Section II). This is followed by a discussion of the regressive lines of development which question the understanding of health necessary for direct worker participation (Section III). In conclusion, the consequences of the present

economic and social-policy crisis which prevent any autonomous articulation of health problems and possible solutions by employees in the plants themselves will be outlined (Section IV).

The result is a rather dark panorama for the chances of activating employees to concern themselves with their health problems at the level of the individual plant. This situation corresponds with an increase in criticism, above all from the area of conventional industrial medicine, leveled at the possibilities of direct worker participation. The four most important objections will be discussed briefly. This increase in criticism from the camp of conventional medicine cannot be viewed solely as an expression of crisis-induced regression. Instead it is, with a certain time lag, the first serious objective attempt from these disciplines to approach concepts of industrial medicine. The chance of a scientific discussion offered here must be used, even though direct worker participation must continue to be developed within the more difficult marginal conditions. Social scientists, psychologists, physicians and engineers, as well as trade unionists, can learn from this discussion (Section V).

Examples from every European country show that strategies to activate employees to see their health problems have not come to a complete standstill. In part, the subject of health has developed a *relative autonomy* vis-à-vis the economic and socio-political development; in part, it is only now beginning to be discussed under the pressure of objective problems and the crisis. Therefore, the bottlenecks, misdirections and obstructions of a worker-oriented health policy will be summarized in the last section as a résumé of international experience gained in the last few years (Section VI).

It may be said that each section applies, to a varying extent, to the majority of Western European countries. Nevertheless, a certain bias as regards the situation in the Federal Republic of Germany cannot be avoided or denied. With regard to the approach of direct worker participation I largely rely on the contributions by *Gustavsen* and *Wintersberger*

(both 1985) without especially emphasizing this in the respective cases.

II. The deficits of the OHS systems in the Western European industrialized countries can no longer be interpreted as the "teething troubles" of state or collective regulations that were mostly passed in the second half of the seventies (cf. *Gevers*, 1983, for a general survey). Rather, they point to basic misdirections without adequate "self-healing" capacities. These deficits can be summarized in eight groups:

- Inadequate range of the provisions: they do not cover all employees or plants, or the employees' needs for health protection (deficits in width and depth of the regulations).
- Insufficient force of state and collective norms. This leads to wide non-compliance, even in the case of legal provisions.
- Lack of plant-related activity by the supervising state bodies. They often see themselves more as consultative partners of the enterprises than as a state control body with the power to impose sanctions.
- Functionalization of the work-protection system for other than health aims, e.g. employment policy (staff selection). In some cases this has reversed the effect of the OHS system.
- The already overburdened workers' representatives (works council, OHS committees, shop stewards, etc.) are too small a counterbalance, legally and in terms of company labour policy, for questions of labour and health. Consequences are far-reaching functional deficits and even non-exercise of important rights.
- Dominance of a scientific/reductionist point of view on the part of professionals (physicians, psychologists, engineers, designers, etc.) as regards the employees' autonomous perception of stress and hazards.
- Mostly silent acceptance of health attrition connected with paid labour, particularly by underprivileged groups of employees, in spite of the advances of the last decade.

- No integration of professional knowledge with the informal OHS potential of the employees. This leads to stable deficits at a high level, which will continue to grow due to new technologies.

No positive impulses for a reduction of these deficits are to be expected from state or industry in the foreseeable future. Any actual exceptions concern a few enterprises mainly in the field of avant-garde technologies where a new appreciation of labour is becoming apparent (Neosmithian Turnabout, cf. *Naschold*, 1984). Once again a general societal task - the creation of humane conditions for the use of the social labour force - is left mainly to the labour movement. It is a matter of pushing through functional necessities of the overall capitalist system against narrow-minded, individual interests.

III. Health policy as a part of social policy has experienced a very profound change of course from the beginning of the 1980s. Since the times of Bismarck's social legislation hundred years ago, the secular trend of social policy has been to provide financial and social support (i.e. state and semi-state support via taxes and contributions) for involuntary nonemployment phases and roles in the lives of individual dependent employees and their families, with exploitation to be prevented by the public structure and surveillance of the services. This tendency has now changed in many European countries, both in terms of programmes and in practice: denationalization of risks and public services, mainly in the health field; individualization and therefore depoliticization of situations of need such as illness and unemployment; crisis-induced falsification of the subsidiarity principle in Catholic social teaching; acceptance of private instead of public unemployment agencies, abolition of training benefits; cutbacks in family support; systematic spreading of uncertainty about old-age pensions; open discussions of unpaid time in the event of illness, lowering of the subsistence level of public welfare assistance.

All these are elements in the termination of a historical compromise much older than the Federal Republic of Germany. It is almost exactly hundred years old. While the reference to the 19th century may be surprising at first, in view of the high level of social security achieved, it seems that one goal of the present tendency is a return to the principles that may have shaped health and social policy prior to Bismarck: What is involved is an attempt to directly subordinate social and health policy to the logic of capital utilization. It was shown that not only monetary savings but also a profound change in the balance of powers are the focus of this process (Kühn, 1984).

The impact of this development on industrial health policy affects not just the political climate. Rather, two central variables of direct worker participation are at issue.

Firstly, the current development aims at redefining illness as an individual fate. The collective aspect, i.e. that diseases are the collectively experienced result of collectively suffered conditions of working and living, fades by this shift of perspective.

Secondly, the present trend of social and health policy may lead to a renaissance of narrow scientific definitions of health and disease, according to which an individual's health is not impaired until the physician, proceeding in scientific fashion, can measure certain changes in bodily functions. However, this narrow method is not very useful for early diagnosis and timely preventive measures, particularly in the case of modern chronic diseases. Subjectively felt disorders are therefore a central and indispensable element of every form of industrial medicine (cf. *Wintersberger* 1982, 1985)

In the course of regressive social and health policy, disturbances in the sense of well-being are being deprived of their role as serious indicators of developing chronic diseases (which are then usually incurable): They are reduced to trifles, for which the individual alone is responsible. Thus in 1983, drugs for "trivial illnesses" were removed from the catalogues

of services covered by the statutory health-insurance scheme in the F.R.G. This development is aimed ideologically at the roots of primary prevention in the plant and therefore at the basis of direct worker participation (cf. *Naschold/Schönbäck et al.*, 1978).

As long as the material and ideological offensive against state health and social policy continues, the industrial social and health services will remain under great pressure as well. This also makes it more difficult to develop defense potentials, because of intimidation at the plant.

IV. As a plant-level action, health protection in the economic crisis is subject to a large number of restrictive factors, in addition to the power asymmetry effective generally. They frequently prevent implementation of health-related demands at the plant, while the threat to health increases at the same time.

Thus, the fear of losing one's job is a stress dimension of its own, accompanied internationally by the undermining of protection provided by collective agreements. In some countries, e.g. the U.K. (cf. *Klasen/Winter*, 1984), elements of forced labour penetrate into private industry via state labour measures. The resulting intimidation is not simply added to the effect of physical, chemical or psycho-mental stresses but can multiply their action. This factor is effective in a situation in which impositions on people's health beyond the risk level are often accepted and not even discussed any more. Numerous reports from plants show that the weak position of employees caused by the labour market is actually exploited by employers. Even state-stipulated health, safety and reasonability standards that are clearly regulated and measurable, are frequently evaded.

Thus, while state protective measures for the health of workers are often no longer effective, performance standards are frequently raised without being seriously curbed by considerations of health. This includes arbitrary regroupings,

work-intensification measures, internal transferrals for rationalization measures and the introduction of new technologies, change of target times, etc. This is happening in a phase marked by the appearance of new, hard-to-define burdens as a consequence of new technologies (cf. *Dörr/Naschold*, 1982). The consequences for health of rapid changes at the workplace as a result of rationalization and new technologies are hardly dealt with from the point of view of health policy.

The industrial balance of powers is at present highly unsuitable for the workers to build up positions of primary power resulting directly from the production relationships between capital and labour. The sphere of collective or legally normed secondary power has not yet adjusted to the new labour-policy problems. Nor do positions of secondary power prove to be safe bastions once they are reached (for the concept of primary and secondary power in labour policy see *Jürgens*, 1984).

Even in plants in which the interest level of the labour force is relatively high, the established path of resistance for development of primary power has often proved to be blocked: with mass unemployment, the representative bodies of the labour force - already structurally overburdened - have other priorities to consider. Health problems take second place to efforts to preserve jobs. That this will tend to produce increasingly younger early pensioners in the near and far future is forgotten by both, the workers and their representative bodies.

In individual employees this produces a feeling of being "at their mercy," without any chance of productive action of their own. This feeling in turn is an independent psycho-mental dimension of stress, which can considerably aggravate the effect of existing stresses on health, while the stress-reducing effect (coping) of having control over healthy working conditions has often been described, also by the medical side (cf. *Gustavsen* 1985, *Rosenbrock/Abholz*, 1984). The options of action left to the individual employee ("grin and bear it," "stay the course," individual evasion strategies) are generally

counterproductive from the point of view of health. They also help to reinforce the view that health problems are "one's own fault" and due to "one's own weakness," and they lend support to the impending change in the paradigms of social and health policy. In fact, they contribute to a reversal of social responsibility.

The OHS professionals working in numerous countries to ward off health hazards are not, for the most part, a real counterbalance. Even in normal conditions they are under constant pressure to harmonize their actions and omissions at the plant with the expectations and wishes of the management. In the crisis, they are under even greater, sometimes open, pressure to make an ideological and practical contribution to the "change of course at the plant." *Ideologically*, this is done by reviving concepts of allocation of guilt to the individual, even with work-related illnesses, concepts that were thought to be long since outmoded, accompanied by the propagation of a climate of social Darwinism and defamation of the workers' enforcement of their rights as "pretentiousness" and "abuse."

In *practical* terms, this is done by tightening up the screening of personnel by means of pre-employment check-ups and selection for dismissal as well as by a more restrictive practice as regards certificates and the approval of social benefits.

Studies have shown that the stronger company doctors believe to be subject to harder competition for well-paid contracts with enterprises, the easier it is to win them over to such behaviour (cf. *Flick*, 1983). Given the competition in this market, it is not (at least in the F.R.G.) only a matter of the price per duty hour of the company doctor, but compatibility of the offered services with the management's wishes and expectations (cf. *Rosenbrock*, 1982).

Result: Social and industrial pressure on health policy threatens to make the subject of health at the plant into a non-subject, which would open the door to ruthless exploitation of the labour force.

V. In parallel to the deterioration of the labour-policy climate, there are indications, mainly from the field of established industrial medicine, of a beginning confrontation with the approaches made by workers' medicine and social epidemiology at the company level (cf. e.g. *Rutenfranz*, 1983, for the F.R.G.). This discussion had been demanded, mostly in vain, by the unions and social scientists for a long time, and it is of major importance under the present conditions because it will decide at a scientific level whether large groups of professionals can be convinced of the health needs of workers. What is at stake - in connection with the problems of direct worker participation - is primarily the value put on the labour force's subjective perception of burdens on its health. There are appropriate and inappropriate objections to the use of this variable as one of the central control variables for industrial primary prevention, and these objections must be clearly distinguished in the discussion.

- a) It is true that there are types of stress which the employees do not perceive, or only too late. This applies mainly to the sector of hazardous chemical substances. In these cases scientifically trained experts must act for those concerned or at least make them aware (cf. *Gustavsen* 1985). However, given the state of knowledge about cumulative effects and interferences between different chemical substances and their interaction with other work stresses, simple results of measurements by professionals must not be confused with measurements of the overall load (cf. *Abholz et al.*, 1981).
- b) It is not true that the workers overestimate their work stress and are tempted to "whine" or "think pretentiously" because of increased awareness or activation. Experience from Canada, Scandinavia, the U.K., Italy and the F.R.G. indicates that articulation of the employees is hardly ever "exaggerated." Instead we find - with far superior understanding of the complexity - a high degree of concur-

rence with other "objective methods of investigation and diagnosis" (cf. *Mergner/Marstedt*, 1981; *Bamberg/Mohr*, 1983).

- c) It is not true that, by activating the workers to subjectively articulate work stress that is relevant to their health, the professional experts (primarily industrial physicians, labour psychologists, ergonomists) are to be pushed out of the plant in order to make way to a cheap, barefoot version of industrial medicine. None of the models existing worldwide intends to forego such experts. But higher demands are obviously being made on the professionals' qualifications, ability and willingness to cooperate as well as their sensitivity.
- d) Finally, it is not true that the results of subjective articulation cannot be compared. To begin with, this is refuted by the high degree of concurrence of articulated stresses even in individual investigations. In addition, *collective* thematization always plays a central role in every industrial model of subjective articulation. This as well as objectively identifiable variables provide a restrictive framework for subjectivity in practice, which is too narrow rather than too wide in view of the present knowledge (cf. (a) and (b) above).

If a common view of these questions can be established between the various scientific disciplines, the scientific preconditions for interdisciplinary cooperation in this area would appear even more favourable now than in the 1970s.

VI. In reality, however, the structure of the OHS systems in most Western European countries does not provide good preconditions for the implementation of such projects, even when leaving aside the restrictive influences of the economic crisis. Although the participatory rights of employees were expanded in the 1970s, partly on the basis of de facto primary power, partly at the level of legally guaranteed secondary power (*Gevers*, 1983; *Kelman*, 1981; *Böhle/Kaplonek*, 1980; Na-

schold, 1978; *Wintersberger*, 1978; *Hauss*, 1981), occupational health and safety is almost entirely a matter for the employer, who appoints and commissions experts for its implementation. OHS committees and similar bodies mostly have only advisory tasks. In this view, employees are not subjects but objects of occupational health and safety. Therefore, aspects of direct worker participation usually have to be pushed through against the system. An investigation of the conditions and chances of such strategies encounters a number of bottlenecks, filters and valves. Such systematic obstacles in the path from an insult to the employees' health to an adequate treatment of the problems in the plant are found at very different levels. Consequently, highly different measures, campaigns and policies in different political arenas are required for their elimination, mostly conceivable only in cooperation with professionals from a wide range of disciplines.

In the following, ten systematic obstacles to an employee-oriented health policy will be sketched. These obstacles stand in the way of a successful *Themenkarriere* (subject career) (*Rosenbrock*, 1985) for problems of "work and health." At every stage, exemplary points of departure for union policy and professional action to overcome these obstacles will be outlined.

- a) Without special support and sensitivation of workers, perception and articulation tend toward understatement, since health attrition from wage work is still largely considered as being normal. In addition, tolerance towards symptoms and ability to articulate vary depending on the social stratum and position in life. This is why employees subject to particularly high stress (e.g. semi-skilled women, foreigners, etc.) usually articulate very little (cf. *Hauss*, 1983). These factors must be carefully distinguished from an alleged deficit of "health awareness" on the part of the workers, which cannot be viewed as an important bottleneck of articulation (cf. *Kühn*, 1982).

Point of departure: Detection of health risks specific to subgroups, sensitivation of specific subgroups at the plant and via available media, utilization of information sources and media of the health insurance institutions.

- b) At the plant, articulation also varies from group to group. It depends to a great degree on the experienced opportunity of actually eliminating recognized and articulated grievances (cf. *Kronlund*, 1976). This factor also works to the disadvantage of highly stressed groups of employees, usually from the marginal groups.

Point of departure: Pedagogically supported propagation of information on actual employee successes in the shaping of working conditions, addressing specific subgroups.

- c) There is a complex process leading from individual perception through collective but unbinding articulation among fellow workers up to public thematization at the plant with the aim of changing conditions that produce illness. In the present OHS system, with its tendency to individualize, desolidarize and depoliticize work-related health problems, this process is not just not promoted but rather suppressed and interrupted (cf. *Kühn*, 1982).

Point of departure: Promotion of collective articulation by addressing the problem in public places of the plant (e.g. common rooms), promotion of "quality of health circles" instead of or together with "quality circles."

- d) In the F.R.G., the collective thematization with the aim of changing unhealthy conditions that has actually overcome the above bottlenecks and filters is the task of the Works Council in 50 percent of the cases. The professionals (e.g. company doctors and safety experts) being responsible for problems of occupational health and safety, has led to the fact that the workers' representatives "translate" the OHS problems articulated by employees into the language and categories of professionals. This means that they are taken

in by their problem reduction: an industrial health problem is often recognized only if it can be clearly allocated, measured, counted and negotiated with the employer within the given scope of state norms.

Point of departure: Union training measures that understand and depict industrial health policy as a field of exchange and conflict between capital and labour. Provision of easy-to-use tools and measures for assessing industrial health hazards incorporating the professionals' specialized knowledge. Conveyance of a way to see and depict industrial health problems "from the grassroots."

- e) In the F.R.G., 40 percent of the, already filtered, thematizations of health problems make their way to plant superiors. There they compete with and usually lose out to aims of productivity and cost minimization.

Point of departure: Promotion of autonomous articulation by the workers, direct election of representatives who meet the criteria of decentralization, social proximity, authority (also legal) and technical competence.

- f) Although employees in the F.R.G. choose company doctors and safety experts as contact persons in only about one percent of cases, most of the articulated OHS problems eventually make their way to the experts via a detour through the works council or plant superiors. But the experts are economically, legally and socially dependent on the employer. And as a rule they only have at their disposal the scientific paradigm which is of limited use. Furthermore, company doctors are often discredited in the workers' eyes by counterproductive health-policy measures such as staff screening.

Point of departure for long-term action: Release of professionals from dependence on the employer (in Italy some of the company doctors are employees of the municipality and the employer pays the costs to the municipal administra-

tion). Influence on the training of industrial physicians and safety engineers.

- g) The, partly legally prescribed, levels and opportunities of communication and clarification of OHS interests and measures are found only at a minority of plants (OHS committees, joint committees). This also applies to joint plant inspections by safety engineers, company doctors, management and the workers' representatives as well as to the existence of OHS programmes, etc.

Point of departure: Guidelines for the workers' representatives for implementation of the institutional preconditions for occupational health and safety: OHS committee, OHS programme, joint plant inspections at regular intervals. In Saskatchewan, the state supervisory board checks these bodies by requiring a signed copy of the minutes of all sessions.

- h) Joint committees frequently act as additional filters: there the employees' representatives present the workers' work-related health problems, usually already reduced to the form negotiable within the framework of regulations. Often enough, the negotiations themselves are a further process of bargaining and compromise. This structure extorts a two-stage compromise behaviour from the people representing the workers' interests.

Point of departure: Creation of directly representative bodies for issues of industrial health (cf. (b), (c), and (d) above).

- i) The employer or management usually has the last say on occupational health and safety measures. Here it must be remembered that a company does not purchase human labour in order to protect the health of their people but in order to turn it to profit.
- j) None of the countries mentioned here has an adequate state counterbalance to the industrial dynamics outlined here,

either in relation to implementation of concrete norms or in relation to the intentions and possibilities of the requisite institutions.

If these bottlenecks are to be gradually eliminated, thus overcoming the obstacles to a thematization of industrial health problems, two secondary conditions must be observed at every stage, in addition to activation and mobilization of the workers.

1. The labour movement should include professionals in the field of health, work structuring and pedagogy at an early point of every stage. This does not mean turning away from the principle of "non delega." Rather, observation of this principle is the precondition for success in the conception and implementation of primary prevention strategies. Inclusion of professionals can help break the hegemony of capital in the utilization of scientific resources.
2. The experience of Italian industrial medicine during the economic crisis shows the necessity of always securing successes at the plant or regional level in the form of law or collective rights. Although this does not provide absolute protection from infringements or rollbacks, as was shown above (cf. III and IV), it does raise the threshold against such developments.

In conditions of persistent mass unemployment and its economic and social exploitation, industrial health policy does not have a good chance of receiving high priority. Nevertheless, recent observations indicate that the absolute dominance accorded to the safeguarding of jobs does not necessarily have to compete with offensive strategies of industrial primary prevention. In some of the plants investigated there are indications of some *crisis resistance* and therefore *relative autonomization of the subject of health at the plant*. Also it would seem a good idea to integrate aspects of health protection in policies to save jobs and reduce unemployment, an important

example being the controversies surrounding a collectively secured shortening of weekly working time in the F.R.G.

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