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Introduction - the historical and political context

Occupational Health is concerned with aspects of occupational safety and health. Thus, in terms of their objectives and consequences Occupational Health Policies contribute significantly to Public Health. Occupational Health Policies are therefore not only crucial for the social good 'Public Health', but Occupational Health Policies constitute a central part of the welfare state of Western, industrialized countries.

In order to gain a deeper understanding of how Occupational Health is embedded in the welfare system and how mutually dependent they are, it is necessary to outline in a few words the history of the welfare state of Western, industrialized countries and the particular social and political circumstances of its emergence. The welfare state as we know it today is the institutionalized result of a continuous political struggle for a system in which basic provisions for individual well-being are guaranteed by the state (Girvetz 1968, p. 512, quoted from Kaufmann 1994, p. 357). The concept 'welfare' has a long political tradition in Europe. Three different notions can be distinguished. (1) 'welfare' is defined as the well-being of the community as a whole; (2) the welfare of the citizenry is the responsibility of the ruling class, (3) and the well-being of the individual stands for the well-being of the community as a whole. Underlying these notions is a conviction that certain social conditions can be established in society that allow for a congruence of individual interests and benefits with the interests and benefits of society at large, and that contribute to the existence of each other. This conviction is central to the theory of Public Health, and thus also to be concept of Occupational Health.

The 'production' of welfare stands in close correlation with the economic capacity of one country. Seen from a macroeconomic perspective, the performance of the individual at work and the extent of the social security system are crucial for the working and productivity of the economy at large in that they ensure stability and effectiveness. Thus, loss of labour productivity through ill-health, invalidity and premature death endangers economic performance as well as the well-being of the community as a whole. If the physical and social well-being of the individual is directly linked to the availability of work, at is the case for the majority of the adult population, then the inability to work, due to invalidity, illness, injury, and unemployment severely puts his existence at risk. Therefore, it can be stated, it is in the interest of the individual as well as the state to maintain the ability of the individual to work.

The ways in which the interests of the individual in welfare, and the interests of the state and/or the community in welfare are brought in accordance, is one of the central questions in social policy debates (Kaufmann 1994, p.365).

Modern Europe has known a comparatively long history of the development of the national welfare state. Taking account of the variety of social and political backgrounds, different 'welfare types' have emerged. It has to be emphasized, however, that all countries of Western, industrialized Europe are welfare states. The European Union now faces the challenge of integrating different elements of national welfare states to establish the foundations of a European welfare system and thereby to overcome the traditional divide that social security is the affair of each particular

nation-state (Leibfried 1995). So far, Occupational Health has been the area in European policies in which the most of progress has been made. Taking into account that the process of European integrations is primarily one of economic forces and interests, this seems to be no surprise. Occupational Health Policies are essential to the productivity of industries and are therefore one aspect of economic integration. However, with European integration taking new directions, a common European social security system figures high on the political agenda.

The above description of 'welfare', defining Public Health Policies and Occupational Health Policies as central elements of a comprehensive welfare system, raises a number of questions: under which conditions is individual well-being directly put at risk or even threatened? Who are the actors and groups in society who have articulated a right to well-being, and what are their motives, their interests, and their means of achieving their goals? Of our various understandings of the relationship between the state and the individual, the state and the family, the state and society, and the state and industry, which one has dominated the political debate? Is it possible to discern actors - institutions of the state and/or of society - that are central in the determination and securing of 'welfare', that is, in protecting individual well-being? What are its functions and how effective is a legal framework in protecting the physical and social well-being of the individual? Which of our multiple notions of welfare, social security, living standards, health, and social rights - as a right of each member of a community to participate in political decision-making processes -, can be taken as a standard?

To answer these questions in a systematic manner, and to avoid too detailed an assessment of the various social, political and historical backgrounds of each European welfare-state, Esping-Andersen's typology of three different welfare regime types is very useful. Having analysed and compared several welfare states, he distinguishes between three regime types (see table below).

Tab.Clustering of Welfare States
Source: Esping-Andersen 1990, Tabl. 3.3, P.74

	Degree of: Conservatism	Liberalism	Socialism
Strong	Austria France Germany Italy	USA	Denmark Finland Netherlands Norway Sweden
Medium	Finland Netherlands Norway	Denmark France Germany Italy Netherlands U.K.	Germany U.K.
Low	Denmark Sweden U.K. USA	Austria Finland Norway Sweden	Austria France Italy USA

In a **conservative** welfare regime strong corporatist structures and a long tradition of etatism prevail. The social security systems relies on social insurances and private benefits. This structure tends to maintain firm class and status distinctions and thus promotes social stratification. A strong Catholic conservative influence (the 'subsidiary principle' originates from there) and absolutism have been of major importance in its historical development.

The **liberal** regime type can be characterised by the relative absence of working class mobilisation, catholic, and absolutist mobilisation. Social insurance benefits are modest and the state promotes a reliance on the market and private social insurances.

The **socialist** or **social democratic** regime type promotes universalism and equality as the leading principles, with a large emphasis on solidarity. The degree to which welfare state concepts of this regime type have been implemented depends on the strength of left party mobilization and the ability to form class coalitions. The policies resulting from these coalitions have a strong etatist orientation.

However, in his comparative studies Esping-Andersen does not consider Occupational Health Policies and aspects of Public Health. In general it can be stated that comparative studies on Occupational Safety and Health remain rare.

According to Kaufmann (1994, p.360-361), the effects of welfare state policies can be categorized as follows:

1.- neutralization of class antagonisms: the welfare states takes over the role of the guarantor of social rights to participate in decision-making processes, of the right to a fulfilled social existence and to physical well-being, and of the right to live in dignity as a member of society.

2.- Political and social equality as well as the right to participate in political decision-

making processes result in a higher loyalty of the citizens towards the political, economic, social and legal structures of their country.

3.- An increase in the loyality and acceptance of present social structures has significant economic benefits. Institutions and regulations of the welfare state contribute to an increase in the productivity of the working population (working hours, real wages, qualification). Individual benefits as well as collective benefits thus consists of an increased use and a higher effectiveness of human resources ('Humanvermögen)' while at the same time cushioning the negative effects of economic activities (industrial pathogenity, such as accidents, ill-health, death, and unemployment).

The notion 'Humanvermögen', describing the 'human resources' or in other words the 'human capital', makes it possible to theoretically depict the congruence of interests between the individual on the one side and the interests of the state and other collective groups on the other. An orientation of both these groups towards the preservation, protection, rehabilitation, and promotion of 'human resources' can have synergetic effects, beneficial to both sides.

'Human resources' can be split into the 'Arbeitsvermögen' (capacity to work) and 'Vitalvermögen' (vital capacities). The term 'labour capacities' describes individual competencies that can be mobilized for paid employment. The term 'vital capacities' describes capabilities and skills that are crucial for non-profit, social and reproductive roles in society. Health is a central category of 'Humanvermögen'. Thus, it can be argued that Occupational Health Policies have as their prime objective the promotion of 'Humanvermögen'.

'Humanvermögen' as the central category in the theory of Occupational Health

The notion 'Humanvermögen', as employed in the theory of Occupational Health, is identical with the notion of 'Humanvermögen' as used in the fields of stress-research, social support research, and social epidemiology. These areas of research have in common a holistic understanding of 'health' and 'ill-health', and of the relationship between the individual and his environment. Of central importance in this approach are the concepts of 'risk' and 'resources'. It is of definite advantage that different behavioural aspects of the individual can be integrated into this theoretical construct, underlying this holistic understanding: in terms of his behaviour, the individual can be portrayed as risk-avoiding on the one hand, and as risking his own health on the other. Yet, he can also be portrayed as a person in full awareness of the chances to stabilize and harmonize his social and physical well-being. These notions of 'risk' and 'resources' can be analysed according to the methods, models and theories of the natural as well as the social sciences, and at the same time they allow for active health prevention. In this context 'health' and 'ill-health' a being understood as relative. They are merely the focal points on a continuum. Risks can influence directly and in a specific manner, as well as indirectly and in an unspecific manner the course of an illness or reconvalescence. The notion of (social) 'resources' is helpful in so far as it helps to illustrate how formal and informal institutions, such as the family, the local community, collegues, and institutions of the welfare state, are crucial in supporting, compensating for, and counterbalancing harmful effects of 'risks' as described above. Simultaneously, the concept of (social) 'resources' allows for a description of the individual capacity ('Humanvermögen') of the person affected to cope with the harmful consequences of 'risks'. This conceptualisation of 'risks' and 'resources' as categories explaining complex developments and attitudes in the social fabric of society, is

closely related with the concept 'salutogenesis' by Antonovsky (1987).

However, the crucial question remains: should the theory of Occupational Health incorporate the holistic approach which takes account of the 'risks' and the 'resources' in society, as described above, or should it continue to follow the more traditional orientation of the medical sciences with their rather narrow and one-sided conception of risks?

Occupational health and occupational hazards; issues in social policy

As stated above, ill-health, accidents, ageing, and unemployment constitute real risks to the social and economic status of the population. These processes, except for unemployment, are taken as natural features of live. However, taking account of their origins, their significant for the life course and the well-being of the individual, and the subsequent treatment and 'management' of these ills in society at large, it becomes necessary to recognize these risks as part of a broader occupational 'risk-structure' (Risikostruktur).

There are three different strategies policy-makers can employ to manage the effects of the occupational 'risk-structure' of industrialized societies: the first strategy - financial aid - has a 'bridging' effect in times of individual economic hardship due to a loss in income. This strategy aims at maintaining the economic and social status of the individual affected, a status which in the Western industrialized world is achieved through work. The second strategy relies on the instruments of rapid restoration and rehabilitation, once the effects of the 'risk-structure' become apparent. In terms of its scope, this strategy encompasses the whole of the population, regardless of the nationality of each individual member. It is therefore not confined to the working population. In contrast to the two preceding strategies, the third policy attempts to tackle these risks by focusing on the precention of health-hazards. This type of social policy aims at securing the status of certain groups in society as well as promoting 'health' on a more general level, covering the whole of the population.

These three different welfare strategies have become paradigmatic for present debates on social policy: either social security as a policy of monetary transfers, or social security as a policy of social services, and eventually social security as a policy of intervening in the competencies of the working population and the whole of the citizenry, as well as industry and the environment. Underlaying these policies are diverging notions of the causes of the 'risk structure', their treatment and the ultimate social policy objectives.

Within the medical sciences it is commonly assumed that the treatment of problems as well as the objective behind it depend on certain, causal problem constellations. However, this approach works only as long as illnesses can be explained in categories such as infections, epidemics and accidents. The approach of focusing merely on the causality of certain health problems, substantially reduces human attitudes, and neglects the importance of social behavioural structures. This has as its consequence that the direct connection between health problems and its causes and effects leads to assumptions about the 'normality' of certain health problems, where only the symptoms are cured, and to calls for more medical specification on the other, according to which certain illnesses can only be treated if it can be proved that occupational conditions have caused these health problems.

The ability to follow paid-employment is put at risk by natural processes of ageing and illness and sometimes even by fateful ones. An acceleration and intensification of theses problems, however, can also be the result of paid-employment. Occupational

risks are inherent to the economic structure of industrialized countries, having its causes in the organisational, textural and contextual dimensions of the workplace. Occupational risks, therefore, are often described as being part of the 'nature of the process of work'. An approach that is basic to the German 1869 and the 1891 Statute of Labourers (Gewerbeverordnung) which is still valid today. This is also the case in todays medical sciences: in trying to analyze occupational risks, scientists in Occupational Health differentiate between stress ('Belastung') and strains ('Beanspruchung').

Within the sociological debate today, approaches can be found, that emphasize the interrelatedness between and interdependence of processes of industrial pathogenity, such as immature ageing and ill-health, and social policy strategies. Following these approaches, Kaufmann has sketched the main issues and difficulties of coordinating social policy initiatives.
According to his theory three problems have to be solved:
a) guidelines have to be established, so that actors can assess the usefulness of their work for a third party (issue of 'guidance')
b) information and motivation has to be provided, targetting behavioural aspects at the workplace (issue of 'control')
c) securing of communicative channels as a precondition for learning processes
(Kaufmann 1985, p.196)
These three operations can substantially contribute to an increase in productivity but they have to be continuously repeated and reinitiated.

Other reports from the field of policy research show that legislative regulations or other public programmes, e.g. Occupational Safety Acts and Humanisation of Work-programmes, have distinctive effects on the multilayered cooperations and relationships between private and public actors. Assessing these effects on an 'if-than' basis does not seem appropriate (see Windhoff-Heritier 1989, p.89). Within the field of Occupational Health, the cooperation between private and public actors requires a high degree of consent. The fact that in Germany responsibilities for social issues of the state have been transferred to the social insurances and other organisations and interest groups in society - industries and business, Accident-Insurances (Berufsgenossenschaften), public and private health insurances, trade unions, administrative bodies, expert groups - all of which the Accident-Insurances have been historically the most dominant ones, has had a distinctive marginalising effect. Windhoff-Heritier points to the fact, that this marginalisation has fatal consequences, especially with the recent developments of occupational hazards increasingly taking the form of non-physical, psychological stress and strains. These examples emphasize that an effective social policy needs the cooperation of all social actors involved.

In Germany, in order to respond to the occupational risks and their detrimental effects on the health of the workers, within the framework of social policy strategies a process of specification has been initiated. As characteristic for the administration of social problems in general, institutions, organisations, interest groups and professions have been established to separately tackle problems of occupational risks and diseases. The public Accident Insurances (Unfallversicherungen, Berufs-genossenschaften) and the Factory Inspections (Gewerbeaufsicht), for example, are

entitled to intervene in the competencies of each business in order to enforce preventive regulations and to tackle occupational risks. Together with the Social Insurances, the medical professions, and various other professional and social groups within industry, they form a system which intends to reduce the number of occupational risks and diseases through prevention, curation, and compensation, and to maintain the status of the worker in terms of his health as well as in terms of his financial means.

Medical practicioners are only one group among many in this complex system. Interestingly though, they assume a role that has little to do with therapy, rather one could describe their fuction as 'gatekeeping'. It is them who define, decide, and regulate who is entitled to benefits and provisions of the social services and social insurances. Thus, within this welfare system, medical practioners hold a central position, 'negotiating' between the individual, enterprises, the labour market, and institutions of the welfare state. They are thus defining life courses and life chances (Behrens ed. 1990). Our notions of risks, rehabilitation and prevention as well as our conceptions of ability and disability to work are determined by the medical profession.

The concepts dominating the theory of Occupational Health are based on the categories of 'occupational disease' and 'occupational accidents'. It has to be made clear, however, that these manifestations of industrial pathogenity ('Industrielle Pathogenität') are not exclusively a medical problem, rather a medical-juridical construct. The issue of occupational disease still lacks conceptual clarity and precision, especially, concerning the competencies of the institutions involved. It remains difficult to understand, categorize, and analyse industrial pathogenity in its multiple manifestations, and thus it remains difficult to promote preventive measures.

The marginalisation of occupational risks and diseases

The dilemmas social policy faces in dealing with the occupational risk structure of industrialized countries, as well as the 'dividing up' of responsibilities between various insurances as described above, show that occupational risks and strains are continuously being marginalised. This can be explained as a result of a certain social construction of reality which simply categorizes occupational risks and strains as Occupational Diseases, and thereby ignores the complexity of the social and physical challenges an individual faces at the workplace. This attitude of ignorance towards the complexity of occupational diseases, may have it origins in the importance of 'productivity' in our society. Fixation on such values prevents a questioning of certain social values and the way they are determined. It thus appears appropriate to use the term 'industrial pathogenity' to describe the effects, causes and underlying values of occupational risks in their complexity.

In the present political debate, ecological issues figures high on the agenda (encompassing various ecological aspects, from the pollution of our environment to the energy system). The causes of industrial pathogenity, on the contrary, having their origin in the sphere of industrial production too, are being ignored. The significance of and value attached to industrial productivity in our society finds its expression in a process of immunization: the social and political conseqences of occupational risks are aspects in debates on social policy, the way in which occupational conditions actually produce occupational risks remains overlooked. In our individualized society with its fixation on technology, the victims of occupational risks have little success in creating an awareness for their problems. The fact that industrial pathogenity affects only certain groups in society, points to the inequalities of life chances. Inequalities in

health contribute to the lack of public awareness for issues related to industrial pathogenity. The alarmingly large discrepancy between the significance of industrial pathogenity not only for the life chances of workers, but for the social, political and economic fabric of society as a whole, and the scientific and public awareness of this issues has a long historical tradition (Milles, Müller 1987). In Germany, this is primarily a result of a process of 'sharing out' responsibilities for active health promotion in all spheres of life, between various institutions of the welfare state, in particular the Social Insurances, and the remaining problems come increasingly come under the supervision of the Accident-Insurances (Berufsgenossenschaften). Social policy measures addressing industrial pathogenity remain selective and increasingly ignore the causal interdependence of occupational health problems. Legislation as well as Occupational Health research is insignificant compared to what could be done.

Seen from a historical perspective, there has always existed in the history of the medical sciences and even in the history of modern Europe a tendency to individualize and marginalise 'health' and 'ill-health'. This has been reinforced by the emphasis of the liberal tradition on the independent 'citoyen' and his sense of rational reasoning. Notions of public health, derived from discussions on urban problems, remained restricted to measures of technocratic, scientific promotion of hygiene and calls for moral improvement. Access to social insurances, as well as the emergence of medical practioners had as their consequence a process that reduced ill-health to an individual problem, it made it a private issue. As pointed out above, the traditional medical science focuses on physical symptoms and pathological substracts, and does not take account of the risks and strains employees encounter at the workplace.

Transference of social responsibility

The change in responsibility for occupational diseases and stress resulting from processes of individualisation, and the increased emphasis on public liability expressed in the proliferation of social insurances, have transferred the social responsibility for occupational diseases from the sphere of productivity to the sphere of reproduction. The authority to intervene and change working conditions of the Accident-Insurance or the Factory Inspection has been significantly curtailed, thus giving priority to the interests of industries. This is clearly expressed in the fact that businesses and not workers are the members of the Accident-Insurances. This is the same for Factory Inspections. In contrast to England, the German Factory Inspection has assumed since its inauguration in 1878 an advisory role for enterprises. Entrepreneurial responsibility ('Unternehmerische Fürsorgepflicht') for social policy issues has a long tradition in German industries, being well aware of the economic advantages of having a healthy and content regular workforce.

Change in puclic measures for occupational safety: the Social Insurances

With the Statute of Labourers ('Gewerbeverordnung') of 1869 and 1891 the state for the first time in German history intervened in economic affairs. Following this statute, the entrepreneur was placed under an obligation to take preventive measures, safeguarding the worker against occupational risks as far as the working conditions permitted. Following these acts, the public Factory Inspections were established. Paralleling this developement, and originating from the Accident Insurance Act ('Unfallversicherungsgesetz') of 1884, Accident-Insurances were built to establish the Social Insurance system. The enactment is crucial in the developement of the German

system of public welfare: for the first time employers were compelled to participate in public social programmes. One year earlier another important regulation, the Health Insurance Regulations ('Krankenversicherungen'), had been enacted. This act started the integration of workers into the German state, a process that is still crucial in understanding German history and society.

As long as the welfare of the population on the whole depends on industrial capitalism, social policy strategies of the state face the dilemma only to be able to intiate a treatment of the symptoms of occupational risks and not their causes.

The separation into public institutions for occupational safety on the one hand, and insurances on the other, as well as the division into **Accident** and **Health** Insurances institutionalised a high degree of selectivity regarding the different responsibilities for occupational diseases. It is only in pointing to the interrelatedness of the causes of occupational diseases that the scope of responsibilities can be shown. To acknowledge morbidity and mortality only in connection with our notion of accidents, means to ignore the complex background of occupational risks.

Industrial pathogenity and occupational accidents

Recent developments of marginalisation of occupational risks have taken the form of reducing occupational risks to occupational accidents. Occupational accidents are being defined as sudden, unexpected and exogen events, and it is only their immediate effects that have to be dealt with. Prevention, on the contrary, is generally defined as technological preventive measures and pedagogical condemnations. Occupational accidents as described here serve as paradigms. It legitimizes the 'normality' of other occupational risks and thus excludes chronic risks which have their origins in the structure of work. In Germany, since 1925 a regulation is in force that classifies certain occupational risk as 'occupational diseases'. This restrictive version of occupational risks and diseases is highly effective as a filter: diseases of a more complex character have thus been excluded from social policy provisions and strategies, and from scientific research on their causes and effects.

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