COMMISSION OF THE EUROPEAN COMMUNITIES

Brussels, xxx
SEC(2007) 215/2

COMMISSION STAFF WORKING DOCUMENT

Accompanying document to the

Communication from the Commission

Improving quality and productivity at work:
Community strategy 2007-2012 on health and safety at work

IMPACT ASSESSMENT

{COM(2007) 62 final}
{SEC(2007) 214}
{SEC(2007) 216}

1. Introduction

This impact assessment accompanies the Communication setting out a Community Strategy on Health and Safety at Work for 2007-2012. It builds on the analysis of data available from Eurostat, Labour Force Surveys, European Surveys on Working Conditions, national and international studies and the results of the evaluation of the previous Community Strategy covering the period 2002-2006. In the light of this information the Commission has re-examined the Community priorities from now until 2012 and set new objectives on health and safety at work to be addressed by all players at EU and national levels.

It is difficult to assess the impact of the new Community Strategy as most of the action will be taken downstream; therefore this document will focus on explaining the fundamental reasons for the new Community Strategy and assessing the general effects that the Strategy might have if it triggers an appropriate response by all stakeholders at different levels.

2. What issue is the policy expected to tackle?

2.1 The extent of the problem in economic and social terms

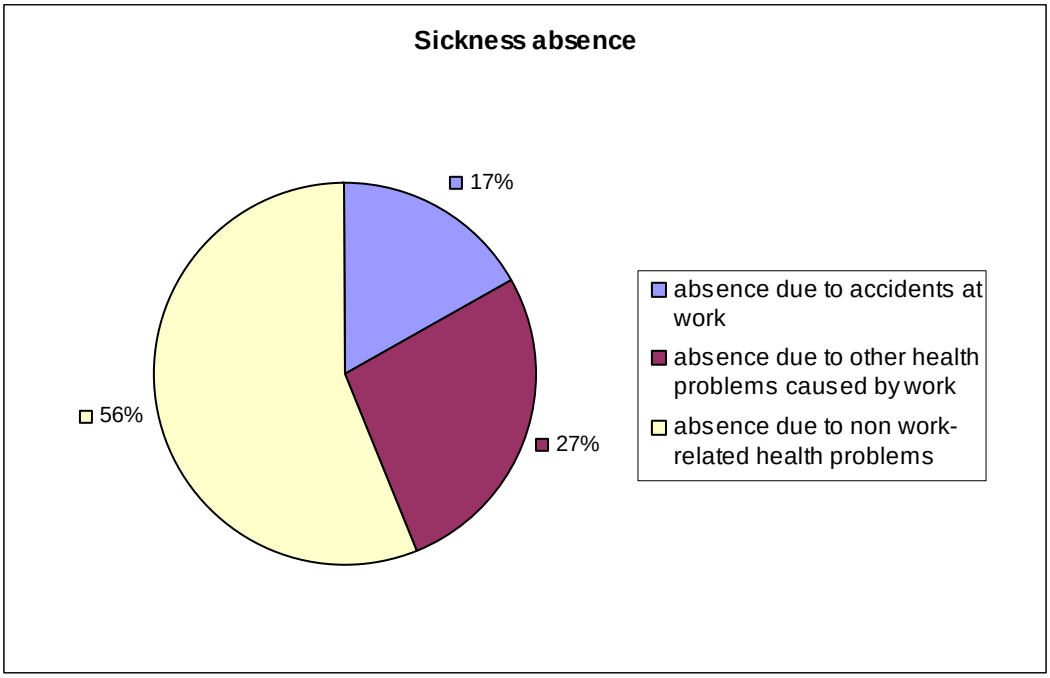
Many workers across the EU are exposed to different risks at their workplaces: chemical, biological and physical agents, adverse ergonomic conditions, a complex mix of accident hazards and safety risks, together with various psycho-social risk factors. Although significant improvements were made in occupational safety and health (OSH) performance in the EU in the period covered by the previous Community Strategy (2002-2006), there is still considerable room for progress. The new Community Strategy aims at continuous improvement of working conditions and health and safety standards.

Accidents at work and work-related ill health are still a heavy burden in social and economic terms, and action to improve health and safety standards at work offers great potential gains not only to employers, but also to individuals and society as a whole.

The scale of the problem is illustrated by the number of accidents at work. Every year there are more than 4 million accidents at work in the EU. According to European Statistics on Accidents at Work (ESAW), about 4 million accidents at work resulting in more than three days off work occurred in EU-15 in 2004. If accidents causing no absence from work or an absence of up to 3 days are added, the estimated total number rises to more than 6 million. In 2004 there were about 4 400 fatal accidents at work.

The consequences of accidents at work and of work-related ill health are multiple and complex. Apart from the impact in human terms, such as hardship and suffering for the worker and his or her family, they generate costs to individuals, employers and society in general. The first component in any quantitative overview of the costs of accidents is absenteeism. Sick leave gives rise to considerable costs to social insurance systems and enterprises. According to workers' own evaluations, 44% of their days off sick are for reasons related to work, with 17% due to accidents at work and 27% to other health problems caused by work.[1] As factors relating to the working environment account for approximately one third of sick leave, potential exists to reduce sick leave by improving the working environment.

[1] Work and health in the EU. A statistical portrait: Data 1994-2000, Eurostat.



In the EU about 1 250 million working days are lost each year due to health problems in general. About 210 million days are lost due to accidents at work and 340 million due to work-related diseases.[2] The total labour costs attributable to accidents at work in EU-15 in the year 2000 were estimated at around 48 billion euros. Other work-related health problems are thought to cause even greater losses of working time and health care costs.[3]

The total costs of accidents at work and work-related ill health are not equally divided between the different players. Employers, workers and society as a whole all bear part of the burden related to absenteeism and ill health. For victims of accidents absence from work means lower income, especially if the absence is lengthy. Workers also face additional expenditure on medical treatment and suffer loss of welfare in the form of pain, grief and suffering. The costs due to loss of income were estimated at 1.18 billion euros and the other costs, such as non-reimbursed costs of health care or rehabilitation, at around 0.18 billion euros in EU-15 in 2000.[4]

Employers face costs linked to sick pay, loss of productivity and replacement of the absent workers, which could have a negative impact on the company's competitive position.

The burden of accidents and ill health goes beyond the costs of absenteeism. For enterprises accidents may generate additional costs linked to the time taken to investigate the incident, loss of output, damage to materials and equipment and subsequent repairs or replacement, profits lost through loss of contracts and delays in production, reputation lost through bad publicity, fines and legal costs. Contrary to what many employers believe, just a small proportion of the costs that arise following an accident or incident is covered by insurance. The ratio between the insurance premium paid and uninsured losses ranges from 1:8 to 1:36.[5]

[2] Work and health in the EU. A statistical portrait: Data 1994-2000, Eurostat.
[3] Statistical analysis of socio-economic costs of accidents at work in the European Union, Eurostat.
[4] ibid.
[5] http://www.hse.gov.uk/costs/costs_overview/costs_overview.asp.

This is described as an iceberg effect, with the majority of losses uninsured and hidden. Usually it is impossible to claim for:

– operating costs arising from damage to or loss of products and raw materials, repairs to plant and equipment, delays in production, loss of contracts, etc.;

– management costs arising from conducting investigations, reviewing and updating policies and systems, redeploying key managers, etc.;

– legal costs arising from criminal and civil litigation, contractual disputes, fines and other legal sanctions.

One group particularly affected by the costs of accidents are small and medium-sized enterprises, as they account for 82% of all occupational injuries and 90% of all fatal accidents.[6] The impact of a serious OSH incident could be catastrophic for a small enterprise. It is far more difficult for SMEs to recover from any OSH incident. The relative impact is greater than on comparable large enterprises, key workers cannot be easily or quickly replaced and short-term interruptions of business can lead to loss of clients and important contracts. A serious incident can lead to closure of a business, due either to the direct cost or to loss of contracts with business customers, and even small incidents and cases of ill health can double the level of sickness absence. Small enterprises have the most to lose from poor OSH standards – but they also have the most to gain. Prevention of accidents and ill health and compliance with legal standards helps to maintain and enhance business performance. The business benefits include higher productivity, greater business continuity (fewer accidents and incidents reduce the length and impact of disruptions), lower insurance premiums and/or compensation payments to workers and higher staff motivation and morale.

The costs of accidents at work and of work-related ill health do not, however, come only at the expense of the workers or employers. Part of the burden, such as the cost of health care, rehabilitation and social security payments to victims of accidents, is borne by society as a whole. There are big differences between Member States on how these costs are actually shared between society, the employer, the victim and the private/public insurance scheme handling the reimbursements. Nevertheless, in each case the costs borne by society are significant. According to some studies, 76% of the average cost of an accident at work is incurred by society, 13% by the victim and his or her family and 11% by the employer.[7] Another approach, in which social security payments are considered a transfer between groups in society and only three components are considered direct costs to society - loss of output, other resource costs (damage, administration, medical treatment, labour inspectorate investigation, etc.) and human costs (pain and suffering) - estimates the share of the costs of injuries, illness and accidents without injuries borne by society at around 27%.[8]

The total cost of accidents at work to the EU economy in the most recent year for which detailed information is available (2000) is estimated at around 55 billion euros, equivalent to 0.64% of GDP for EU-15 in 2000.[9] This estimate covers only accidents at work; other work-related health problems are not included. According to surveys, such problems cause even greater losses of working time or health care costs. In macroeconomic terms the cost of

[6] http://sme.osha.europa.eu/.
[7] Social cost of accidents at work in Poland, Central Institute for Labour Protection – National Research Institute.
[8] The costs to Britain of workplace accidents and work-related ill health in 1995/96, HSE UK.
[9] Statistical analysis of socio-economic costs of accidents at work in the European Union, Eurostat.

accidents at work and of occupational diseases in EU-15 ranges from 2.6% to 3.8% of gross national product (GNP). The less developed the OSH system in a country, the higher the percentage of its GNP spent on health care and State benefits linked to work-related injury and illness, draining resources away from more productive activities.

<table>
<tr><th colspan="5">Costs of accidents at work and of work-related ill health</th></tr>
<tr><th colspan="5">Worker</th></tr>
<tr><td colspan="2">Financial costs</td><td colspan="3">Human costs</td></tr>
<tr><td colspan="2">Loss of income;
Extra expenditure, taking into account costs of health care and rehabilitation, extra purchases of medicines and cost of travel to hospital for treatment</td><td colspan="3">Suffering and distress measured as Court compensation or by contingent valuation methods</td></tr>
<tr><th colspan="5">Employer</th></tr>
<tr><td colspan="2">Costs of absenteeism</td><td>Costs of damage to property</td><td colspan="2">Additional costs</td></tr>
<tr><td>Direct</td><td>Indirect</td><td></td><td>Financial</td><td>Unquantifiable</td></tr>
<tr><td rowspan="4">Payroll costs of time off</td><td>Compensation payments</td><td>Damage to materials and equipment</td><td>Administrative costs</td><td>Loss of trust and lower motivation of employees</td></tr>
<tr><td>Cost of replacing employees who are forced to quit their job (recruitment and training)</td><td>Repair costs</td><td>Higher insurance premiums</td><td>Loss of customer satisfaction</td></tr>
<tr><td>Loss of working hours of other workers</td><td rowspan="2">Costs of renting temporary equipment, machinery, buildings or vehicles</td><td></td><td>Loss of goodwill and reputation</td></tr>
<tr><td>Production losses due to cessation or slowdown of production</td><td></td><td></td></tr>
<tr><th colspan="5">Society</th></tr>
<tr><td colspan="5">Cost of health care and rehabilitation
Allowances for temporary or permanent incapacity to work
Loss of output</td></tr>
</table>

According to some studies, the estimated costs of work-related illness per worker are at least three times higher than the costs of prevention.[10]. Evidence of the economic benefits of effective prevention is clear. Nevertheless the economic approach to health and safety at work is no substitute for the value of human needs and social obligations. Health and safety are part of the social and ethical role of a company, and policy cannot be based on economic parameters alone. It is difficult to quantify costs such as suffering, lower quality of life or

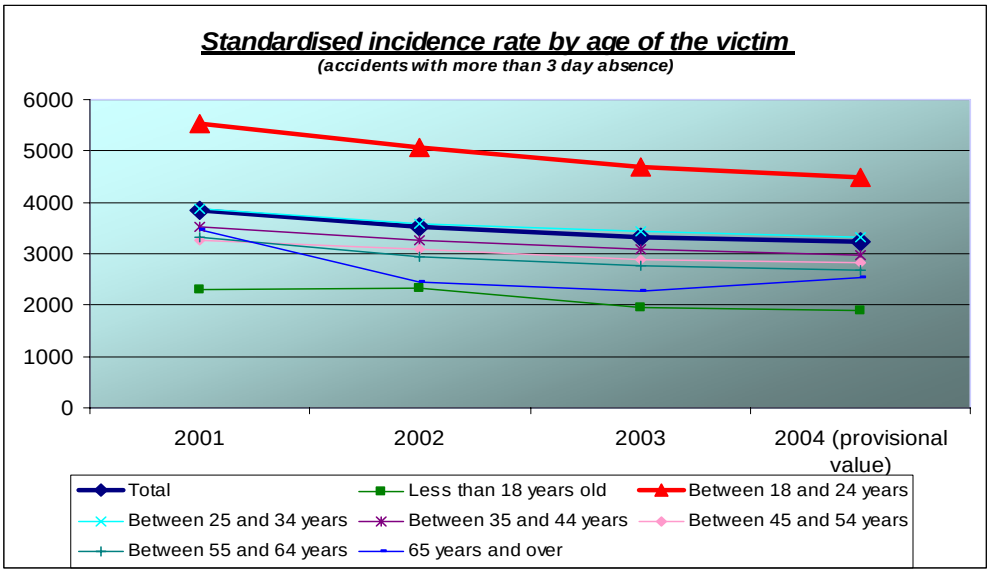
[10] The cost of poor working conditions, European Foundation for the Improvement of Living and Working Conditions, http://www.eurofound.eu.int/ewco/2004/12/NL0412NU01.htm.

shorter life span in monetary terms. This is reflected in the 13th recital of Framework Directive 89/391/EEC which states that measures to improve health and safety at work should not be subordinated to purely economic considerations.

Occupational injuries and illnesses also produce a variety of social consequences. Injuries caused by accidents and work-related ill health can lead to temporary or permanent incapacity to work. According to the ad hoc module of the 1999 Labour Force Survey (LFS), about 5% of victims who have recovered from an accident at work cannot return to the same job. The results of the 2002 LFS showed that about 0.9% of all 16- to 64-year-olds in the EU-15 Member States had a long-standing health problem or disability which, in their judgment, was due to an accident at work. This means that there were about 2.3 million people in the EU-15 Member States with health problems caused by an accident.[11] Restricted opportunities to work often influence not only vocational functions but also psychological and behavioural responses and, in turn, lead to social exclusion, which has repercussions at many levels and adds to the costs for social security systems. The social dimension of the problem is also linked to the fact that some groups, such as temporary workers, immigrants, disabled and young and old workers, are at greater risk of suffering from poor health and safety conditions at work. Failing to ensure that these sensitive groups benefit in the same and equal way from the right to a safe and healthy work environment puts at risk the EU's aim of social cohesion.

2.2. What are the risks inherent in the initial situation?

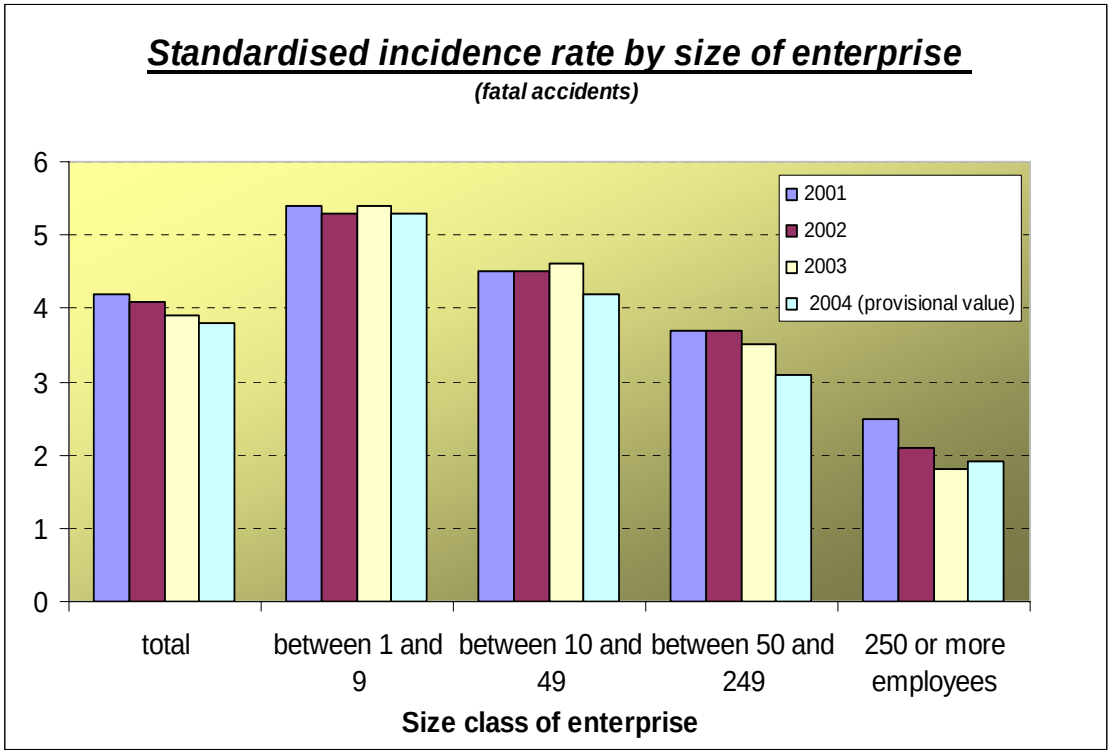
Two trends were identified as the main risks inherent in the present situation. The first is linked to the fact that the reduction of occupational risks is not homogeneous. Certain categories of workers, e.g. young workers, are over-exposed to occupational risks, certain categories of enterprises, e.g. SMEs, are more vulnerable and certain sectors still have high incidence rates of accidents at work and occupational diseases.[12]



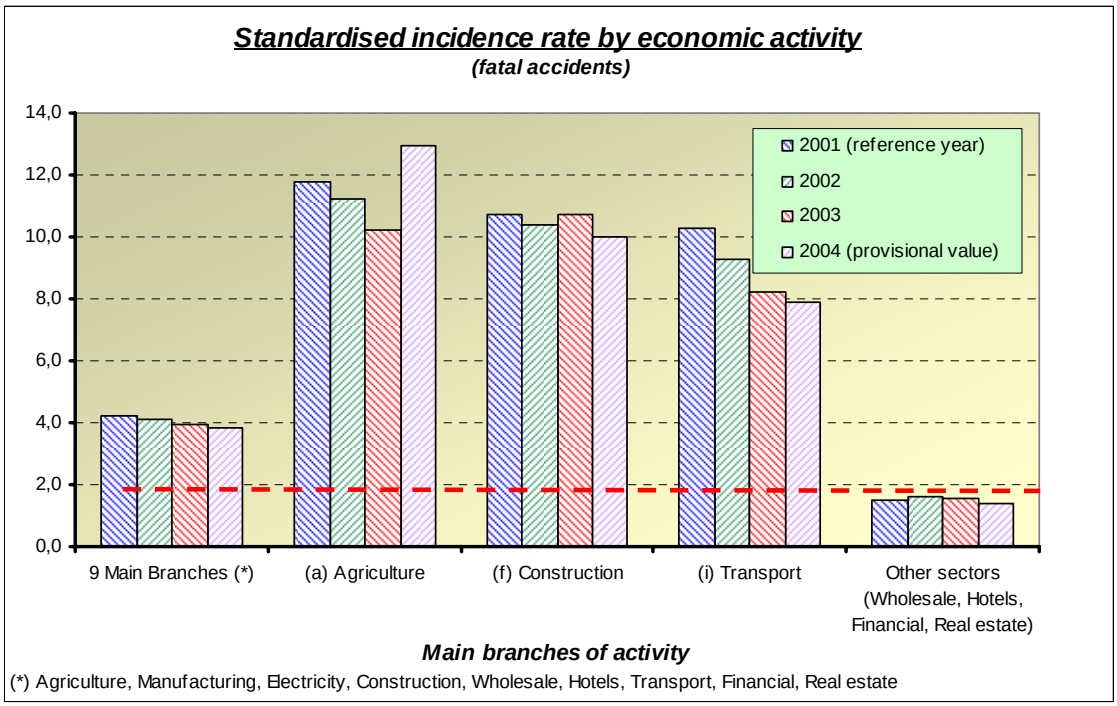
Source: Eurostat

[11] Work and health in the EU. A statistical portrait, Eurostat.

[12] Standardised incidence rate per 100 000 persons in employment is calculated per Member State by giving each branch the same weight at national level as in the European Union. For full methodology refer to: EuropeanStatistics at Work (ESAW) Methodology.



Source: Eurostat



Source: Eurostat

The second trend is linked to the changing nature of occupational risks in the context of the rising pace of innovation and changes in working life.

As regards the levels of practical implementation of the Community legislation on health and safety at work, there are still significant differences between Member States. Deficiencies in

target-setting and in monitoring progress towards attaining policy objectives have also been identified as common weak spots in many Member States.

2.3. What would happen under a "no policy change" scenario?

If the status quo were maintained and no special attention were paid to the challenges that exist, the response to the new risk trends, in terms of general policy action and specific prevention measures, might not be sufficient. Stagnation or, in the worst-case scenario, an increase would be expected in incidence rates of accidents at work (especially in high-risk sectors such as construction, agriculture, transport or health and social services), missing the opportunity to lighten the social and economic burden that accidents at work and occupational diseases place on the EU.

Perpetuation of the differences in practical implementation of the minimum requirements set in the EU directives across the European Union would hinder establishment of a level playing field for EU businesses and could be conducive to competition based on low standards for working conditions.

The limited resources for OSH prevention and inspection and for training activities and awareness-raising campaigns call for wise target-setting to take account of the cost-effectiveness of action. Failure to do so could mean diverting resources towards lower priority action that will yield fewer results.

2.4. What is the driving force for action?

One of the central commitments in the Lisbon Strategy to increase employment and productivity by enhancing competitiveness calls for an intensified effort by all players to improve OSH performance in the EU. The role of OSH in improving business competitiveness and productivity by reducing the cost of accidents, incidents and ill health and promoting higher workforce motivation is paramount. Occupational risk factors are responsible for 8.8% of the global burden of mortality and 8.1% of DALYs[13] due to unintentional injuries worldwide.[14] The magnitude of the occupational ill health burden is overwhelming, and the causes behind it are multiple and complex. The scale of the problem calls for an integrated, coordinated and strategic response and joint development of national policies by the major stakeholders in the European Union. Good safety and health may bring benefits both to society, by helping to improve the health of the workforce, and to the economy, by reducing the costs and boosting the productivity and competitiveness of EU companies.

2.5. Who is affected?

The occupational health and safety challenges are common to all the Member States. The scale of the problem calls for intensified efforts from all players at both European and national levels. Active involvement of all stakeholders, such as the European Commission, the Bilbao

[13] DALYs – Disability-Adjusted Life Years. DALYS for a disease are the sum of years of potential life lost due to premature mortality in the population and the years of productive life lost due to disability for incident cases of the health condition.

[14] Moving Knowledge of Global Burden into Preventive Action, Gerry J.M. Eijkemans, Jukka Takala, American Journal of Industrial Medicine.

Agency, the European social partners, Member States and workers' and employers' organisations, is the key to successful implementation of OSH policies. The ultimate beneficiaries of the better policy action on health and safety at work are European citizens who will benefit from better and higher levels of protection.

2.6. Is the problem in the Union's remit?

Article 137 of the EC Treaty provides the legal basis for Community action to improve the working environment and protect workers' health and safety. The transboundary and Europe-wide characteristics of health and safety at work make a case for policy action at European level.

3. What are the main objectives the policy is expected to achieve?

The goal of the new Community Strategy continues to be to involve all players in achieving modern, effective and efficient health and safety for Europe, which will reduce the accident and ill-health record and be positive for employability and business. The main objective of the new Strategy is to obtain a continuous, sustainable and homogeneous reduction of occupational accidents and diseases in the EU by:

– fostering development and implementation of coherent national strategies;

– keeping the body of legislation suitable for the changing world of work;

– stimulating commitment and motivation on the part of more employers and workers;

– adopting a new approach to occupational health in the context of demographic trends;

– improving monitoring of progress.

The overall objective is a 25% reduction in the incidence rates of accidents at work and occupational diseases at EU level during the period 2007-2012.

4. What are the main policy options available to achieve the objectives?

In order to consolidate a culture of risk prevention and achieve the strategic objectives, it is necessary to combine a variety of policy instruments, such as legislation, social dialogue, progressive measures and best practices, corporate social responsibility, economic incentives and mainstreaming. The new Community Strategy calls for action by players at all levels: European, national, local and workplace. When Member States develop their national strategies they should set targets and priorities for their national action and choose appropriate policy instruments, based on an in-depth multi-dimensional analysis taking into account social, economic and environmental factors.

As comprehensive Community legislation already exists, action at Community level will focus mainly on updating and simplifying existing legislative measures without lowering existing standards of protection. This effort should be accompanied by similar undertakings on the part of Member States to simplify their own legislation on health and safety at work. To make practical implementation of the legislation easier, the Commission will continue its work on providing non-binding guidelines. It will foster stronger cooperation in the field of enforcement with the aid of the activities of the Senior Labour Inspectors Committee (SLIC)

which will continue its exchanges of good practice and experience and focus more on identifying practical implementation problems of significance to different Member States.

To increase the motivation of employers and workers it is necessary to develop policies focusing on bringing about a change of attitudes by making health and safety an integral part of education and training. Targeted support to SMEs should also be provided. It is also necessary to ensure better information and to raise awareness in the workplace by sharing best practice in the field.

A new approach to occupational health in the context of demographic trends should take into account measures ensuring that particular needs of some groups of the labour force are not neglected. Member States are invited to develop OSH policy instruments encouraging reintegration of the disabled into the labour market, valuing the contributions of both older and younger employees and meeting the specific needs of migrant workers.

5. Impact of the Strategy

5.1 Economic impact

The impact of the Strategy in economic terms should take the form of reduction of the direct and indirect costs of accidents and work-related health problems to the worker affected, the worker's family, employers and society.

As a policy action document the Strategy introduces no new specific health and safety requirements, and therefore leads to no additional compliance costs to enterprises. It recommends better implementation and enforcement of the existing legislation. Implementation of the minimum requirements contained in the EU directives across the European Union will establish a level playing field and prevent competition based on low standards for working conditions. This should have positive effects on the competitiveness of the EU economy.

It is difficult to assess the detailed impact since most of the action will be taken downstream and depends on the involvement of stakeholders at different levels. However, as the overall objective of the Strategy is a 25% reduction in the incidence rate of accidents at work, the expected results in economic terms will mainly consist of reduction of the overall costs of accidents, of absenteeism and of the burden of ill health (costs of treatment and hospitalisation). Should this objective be achieved, it would avoid losing more than 137.5 million working days due to accidents at work and occupational diseases. Reducing absenteeism means reducing the costs to employees, employers and insurers. It has a direct impact on national economies, given the medical and social security costs and the loss of output resulting from reduction of the labour force.

Comparison of the estimated costs resulting from work-related illness with the costs of prevention shows huge potential for a positive economic impact from good OSH prevention. According to some studies, the estimated costs as a result of work-related illness per worker are at least three times higher than the costs of prevention.

Estimated total costs per worker in the Netherlands in 2001	**All sectors and services**	
	€ per worker	**% of total**

Costs as a result of work-related illness:	**1 368**	**77.3%**
Cost of resultant absenteeism	527	29.8%
Cost of occupational disability	609	34.4%
Cost of reintegration grants	103	5.8%
Cost of curative health care	129	7.3%
Cost of prevention:	**400**	**22.7%**
Preventive occupational health and safety (OHS) measures	120	6.8%
Company investment and expenses for prevention	157	8.9%
OHS research and development	10	0.6%
Judicial costs	2	0.1%
Administration by companies	102	5.8%
Legislation and inspection	6	0.3%
Subsidies and grants for improvements	3	0.2%
Total costs per worker per year	**1768**	**100%**

Source: The cost of poor working conditions, European Foundation for the Improvement of Living and Working Conditions, http://www.eurofound.eu.int/ewco/2004/12/NL0412NU01.htm

Moreover, good OSH brings many business benefits. Staff motivation, job satisfaction and performance are directly linked to the extent to which staff's needs and expectations (including OSH expectations) are fulfilled. A positive safety culture is therefore an important part of maintaining staff morale and commitment to the enterprise. It also has external effects, helping to build a good image and relations with business partners.

5.2. Social impact

In social terms policy defined in a strategic framework helps to change workers' and employers' perception of risks thanks to the learning process and better awareness of the problems and ways to tackle them. The resultant better understanding of the role of health and safety at work and the true commitment on the part of workers and employers will make it possible to take OSH beyond compliance with legislation and open up an opportunity to create better job satisfaction and well-being at work.

The main social implications of the Strategy on employment and social inclusion for different groups of the workforce and employers are as follows:

- The disabled: good OSH processes could help accident victims or the chronically ill to retain their job or return to work. Rehabilitation and reintegration schemes are concerned primarily with ensuring a safe and healthy return to work following an accident or illness and may involve adapting the workplace or the way work is organised. Good OSH improves rehabilitation and return to work practices and helps to reduce the severity of cases. Timely

rehabilitation combined with early intervention prevent escalation of the condition and loss of skills/motivation on the part of injured workers.

- Migrant workers: the work environment has the potential to be one of the main platforms for integration of migrant workers. It is vital to ensure that this social group benefits from all OSH standards on an equal basis, as this will have a positive impact, such as creating a feeling of equal treatment and participation, and will help to avoid social exclusion of migrant workers.

- Ageing workforce: promoting employment among older workers and delaying their exit from the labour force are key components of the Lisbon Strategy. Good OSH will have a positive impact on extending working life by increasing job satisfaction and reducing stressful and monotonous working conditions that cause early deterioration of health and, hence, an early exit from working life.

- Young workers: raising awareness on the part of young workers who are often less informed about occupational risks will have an impact in the form of better adaptation to and participation in the labour market by such workers.

Since certain categories of workers are overexposed to occupational risks, ensuring a safe and healthy work environment for the entire workforce will bring social benefits and contribute to the goal of combating health inequalities.

5.3. Environmental impact

Occupational health and safety policies could have an impact not only in the workplace, but also on the environment. For example, the measures taken to reduce exposure to chemical agents in the work environment can also have an impact on the ecosystem. The possible interactions will be carefully considered when designing individual policy action or practical solutions and the possible synergies will be harnessed in the policy-making process.

5.4. Impact on the candidate and/or other countries outside the Union (external impact)

The Commission's commitment to worldwide promotion of the preventive principles set out in the Community Strategy by means of closer cooperation with the ILO, WHO and other international organisations should have a positive impact outside the Union by establishing higher levels of protection globally. More intensive cooperation with non-EU countries, in particular provision of technical assistance and enhanced knowledge-sharing with acceding and neighbourhood countries, should make it easier to implement programmes to secure decent standards of work for everyone in these countries.

6. How will the results and impact of the proposal be monitored after implementation?

A comprehensive monitoring system will be established by the Commission to evaluate and measure progress on activities by the Member States and others involved in implementing the Strategy. This monitoring should take place at the different levels of governance at which objectives are set.

The Commission, together with the Advisory Committee on Safety and Health at Work (ACSH), will develop a common system to collect and share information on the content of national strategies, the rate of achievement of their objectives and the effectiveness of the prevention structures.

Moreover, the policy will be monitored by the Commission with the help of the existing statistical indicators used in the framework of ESAW[15] and EODS[16] projects, the Labour Force Survey (ESTAT) and the Working Conditions Surveys (Foundation for the Improvement of Living and Working Conditions). The Commission will also consider the possibility of developing new qualitative indicators to measure the efforts made on implementation of initiatives under national strategies. To foster further harmonisation of the ESAW and EODS statistics the Commission will launch preparatory work on a draft European Parliament and Council regulation on consolidation of methodologies and systematic transmission of statistics by Member States to the Commission.

7. Consultation of stakeholders

The new Community Strategy was submitted for extensive consultation with all stakeholders: Member States, policy-makers and social partners' organisations. Dialogues were held with representatives of the Member States and of workers' and employers' organisations within a working group of the ACSH and by consultation of the Senior Labour Inspectors Committee (SLIC). SLIC endorsed its contribution to the Strategy in Helsinki in October 2006 followed by the ACSH at its plenary meeting in November 2006. Development of the new Community Strategy was also discussed at the meeting of EU Directors-General organised by the UK Presidency in October 2005. Finally, broad consultations of social partners' organisations on the new Strategy have been conducted in parallel with evaluation of the Community Strategy for 2002-2006.

[15] European Statistics on Accidents at Work.
[16] European Occupational Diseases Statistics.