The decision due to be taken on 14 May is a fundamental policy decision that will have a defining long-term impact on occupational health and safety legislation. The new Directive will have to be transposed into our law and will entail a major change to companies' health and safety policies.

"- A weaker classification would mean a lower protection of the health of workers and therefore a higher risk and very likely an increase of the pandemic among the European workforce".

The trade union movement has informed the European Commission of these same concerns. In fact, the General Secretary of the European Trade Union Confederation sent a letter to the Social Rights Commissioner to this effect.

The ETUC's official position can be found in the document I have appended to this letter. You will see that it is in line with my arguments in every key respect.

We will divide my letter into four parts:

1. The current context in which we find ourselves
2. The content of the Directive set to be amended in line with technical progress
3. The classification criteria
4. Flexibility in terms of risk management
5. **The political and social context**

In this section I, feel you free to change, skip, delete or adapt taking into account your national situation

The COVID-19 crisis is probably Europe's most serious public health-related political crisis since the Second World War. That assessment is not based on the number of deaths; after all, the final death toll might not exceed the Hong Kong flu pandemic of 1968-1969. Instead, the COVID-19 crisis has revealed a constellation of inequalities, erroneous political decisions and working conditions that have deteriorated as never before. Never before have such restrictive measures been imposed on the general population with a view to protecting public health. When it comes to public health, the most important matters are decided at Member State level. The European Union's role is relatively limited.

On the other hand, when it comes to occupational health, the European Union's role is often decisive. The vote, which will take place on 14 May, will necessarily have an impact on the organisation of health and safety in our country. If we take into account the extent of the risk, I think it is vital that the Council of Ministers adopts the decision and that Minister Muylle fully exercises her political responsibilities after consulting the High Council for Prevention and Protection at Work.

Since the start of the crisis, extremely stringent health rules have been imposed on the general population. The purpose of this letter is obviously not to discuss those rules, nor to examine to what extent they have increased social inequalities. The important point here is to recognise that they have deemed COVID-19 to be a health hazard of the highest level. On this basis they demanded extraordinary measures be imposed on the public in order to prevent the spread of the pandemic. It is likely that some of these measures are the direct consequence of the austerity policies that have weakened our public health system. The failure to keep masks in stock is just one of many possible examples. However, this must be remembered when trying to correctly classify the hazard level as an occupational risk. In fact, the public health response has been governed in part by the serious deterioration in working conditions seen even before the emergence of COVID-19.

The XXXX government, like most European governments and the European Commission[[1]](#footnote-1), made the political decision not to collect information on the occupations of those who have fallen ill or died. This situation is exacerbated by the weakness of health monitoring provided by health and safety consultants and occupational physicians. It is important that your staff and departments ensure compliance with the obligation to report all occupational diseases, even if an occupational cause is only suspected, and that they take active initiatives involving more than just issuing reminders of legal obligations.

Given this political decision and its wilful ignorance, we currently find ourselves forced to make do with incomplete data. In Spain, according to the Instituto Carlos III, COVID-19 is very clearly an occupational risk in the healthcare sector: the analysis conducted in early May shows that 7,482 men and 23,178 women have been infected due to the lack of effective personal protective equipment for healthcare personnel. In other words, women account for 76% of those infected.

Scattered data are beginning to be collated. The data converge on two points. Among those aged 20-64, working conditions have played a major role, and they have also obviously played an indirect role among other age groups. Anyone infected due to their working conditions is likely to contaminate other people of any age. The very high mortality rates among older people in nursing homes are not due solely to the biomedical fragility factors found in this age group. They are probably linked to the much-deteriorated working conditions that were witnessed even before the emergence of COVID-19 in this sector. Likewise, certain fragility factors that public health experts tend to consider as individual (mainly chronic diseases) are strongly correlated with working conditions, which can play a role both immediately and even more so over the course of an entire career. In the weeks ahead, the European Trade Union Institute will be in a position to publish partial data on this issue.

There is already sufficient evidence to characterise work as an essential vector in the spread of the virus and probably as the central factor in social health inequalities linked to the pandemic.

Getting back to that work which falls within the competence of your Ministry, I would like to draw your attention to a few points.

1. Since the start of the crisis, occupational health has been severely neglected. Instead, public health – or rather a very restrictive version of public health – has taken precedence. Throughout the crisis, this disregard for the part played by work has certainly contributed to less effective health and safety measures. For the sake of brevity, I will give just a few examples. Every day, reports are published informing us of trends in morbidity and mortality. No information has been provided on the occupations of those individuals in the 20-64 age group. To my knowledge, your Ministry has taken no steps to plug this gap. And yet if the aim is a well-targeted health and safety policy, then this is essential information. We should know in which sectors working conditions may have played a major role in the spread of the pandemic. Government decisions regarding essential and critical sectors have not been accompanied by specific measures to protect the health of workers in these sectors. These so-called essential or critical sectors employ a substantial majority of women due to occupational segregation which concentrates women in what are known as 'care activities'. We firmly believe that the spread of the epidemic among the female population aged 20 to 64 is mainly due to occupational exposure. Obviously, this remains to be proven, and that will be all the more difficult as occupational information has not been collected. For the male population in the same age category, working conditions have probably played an important role, but it will be difficult to estimate precisely what their contribution has been due to the greater distribution of men in occupational activities with a high and a low risk of COVID-19. The worker's place in the social hierarchy has played a key role. It is not a question of 'mechanical' causation (for example, many doctors have been infected).
2. Employment conditions cannot be overlooked. Precarious workers are less able to effectively protect their health at the workplace. Certain categories are not covered by the Occupational Health and Safety Act. For example, due to the very nature of their work, domestic workers are highly exposed to the risk and likely to contribute significantly to contamination. Workers for certain online platforms, such as Deliveroo delivery staff, are also highly exposed and likely to contribute to contamination due to the nature of their activities. They work under conditions in which they are extremely vulnerable. They are not covered by the Occupational Health and Safety Act. In a sense, the lack of an appropriate occupational health response is indicative of a number of previous problems. Some may be met with an immediate response, as in the two examples I have just cited. Others require a longer-term strategy and discussion.
3. Government policy is based on a restrictive vision of public health for two reasons. First, social inequalities have been a blind spot in government policy. Second, the work issue has only been examined in terms of 'place'. In other words, the policies were determined by conceiving of work as places where people gather, much as one might envisage a religious ceremony, a sporting event or the screening of a film in the cinema. The only specific measures defined are essentially barriers linked to this view of the situation, such as social distancing, disinfection measures and hygiene rules applicable to specific spaces. This approach is totally at odds with the principles of the Occupational Health and Safety Act that your Ministry should have highlighted. This legislation, which is based on the 1989 European Framework Directive, certainly has room for improvement, but it provides – together with the complementary provisions set out in the Belgian Occupational Health and Safety Code – fundamental and consistent tools for tackling COVID-19 as an occupational risk.
4. By way of example, I will look at just a few mechanisms: the hierarchy of preventive measures, the need for a comprehensive approach that addresses all the work-related activity factors in their interaction, the role of health and safety departments and services and, in particular, the roles played by occupational physicians and ergonomists, the consultation of workers and all the powers of workers’ representatives), the right of withdrawal for workers exposed to serious and immediate danger, etc. In my view, the emphasis placed on barriers (distance, protective equipment, disinfection) seems to reverse the order of priorities. There is no doubt that such barriers are useful. However, they can only work if they are integrated into an overall health and safety plan that takes on board all aspects of work-related activity and the feedback between these barriers and other risk factors (including biocides, psychosocial risks, musculoskeletal disorders and the destabilisation of occupational identities).
5. Work is, of course, a 'place', but it is above all a concrete activity, a permanent process of interaction between people and materials. Effective health and safety measures depend on a real-world analysis of the activity in question. Only through such an analysis is it possible to validate, and – if necessary – to modify, the relevant health and safety measures. Work is also a power relationship: employers determine how work is organised and issue instructions on production and output. General public health measures pertaining to 'spaces' can hardly be applied 'as is' to work as an 'activity'. In spaces like streets and parks, such measures are based on individual responsibilities which depend at least in part on the free choice of individuals (with a significant role being played by social pressure or the threat of criminal sanctions). But this is rarely the case at work. The room for manoeuvre which allows recourse to protective measures/activities is always problematic and very unequally distributed among workers (if only due to 'place' in the division of labour or the presence of a trade union organisation).
6. The basic principles set out in the Framework Directive respond much more effectively to the needs of the struggle against this particular biological risk by taking into account all the principles of the dynamic risk management system. To illustrate this, I will limit myself to one very specific example. A shop steward in the large-scale retail sector described for me the situation in a logistics centre. After a few weeks of disorganisation, much clearer rules concerning hygiene barriers were issued under pressure from the trade unions. However, there has been no change in how work is organised. The workers continue to do their jobs using a voice command system that requires they perform a specific sequence of actions. The order in which operations must be carried out is imposed by management. However, it was predictable that certain products would be in much greater demand and that general activity would increase as retail businesses closed down. What actually happened was that the organisation of work did not change (the health and safety plan was not updated to bring it in line with the current context) but hygiene measures were imposed. As a result, the workers find themselves faced with a paradox: they can either follow orders or comply with the measures designed to prevent the spread of COVID-19. In many cases, they are forced to ignore the COVID-19 measures. As a result, in the store, workers tend to concentrate on those aisles and around those shelves where the products in highest demand are found, inevitably leading to instances of non-compliance with the rules on social distancing.

This long introduction setting out the background to the situation may seem overly detailed to you, and it raises issues that are not directly related to the classification of the virus. However, in my view it is essential to draw your attention to two items.

1. Politically, a classification which categorises SARS-CoV2 as a mid-level hazard (group 3) on the same level as MERS or SARS (if we assume the 2019 Directive will be amended in line with technical progress) would send a wholly inadequate message as regards the priority to be given to occupational health policies before activities resume in companies where work has either been suspended or been continued only in the form of teleworking.
2. Classification in group 3 would represent a serious symbolic attack on the world of work. As citizens, we have been asked to give up fundamental freedoms. As workers, we are told that we are only exposed to a medium-level biological risk. The very heavy price paid by female workers in all phases of the crisis cannot be overlooked. The very high concentration of women in activities with the highest risk levels will continue to be a central occupational health problem until effective treatment or a vaccine is available. When examined in this light, the refusal to take full account of group 4 criteria could be considered a form of indirect discrimination.
3. **Directive 2000/54/EC, set to be amended in line with technical progress**

This Directive is based on three pillars, an approach commonly taken in European occupational health legislation.

1. Classification based on characteristics specific to each biological agent as set out in Annex III to the Directive. This classification was amended by Commission Directive 2019/1833 which must be transposed into national law by 20 November 2021 at the latest. It is based on a scale with four levels, ranging from group 1 (where the hazard to humans is considered non-existent) to group 4 (the highest level of hazard).

Such classification may not, under any circumstances, be linked to risk-management considerations, whether this is due to technical impossibility in one field or high cost in another.

In this respect, a comparison should be made with chemical risks, where the enhanced health and safety measures set out in the Carcinogens Directive play no role at all in the harmonised European classification scheme. The difference is of a different kind. For chemicals, no classification is set out in the occupational health rules. Consequently, the resulting consequences for the protection of public health and for occupational health are not addressed in the same legislative instrument. However, European law takes account of an intrinsic hazard of a certain level which requires, in all sectors, measures of increasing intensity depending on the classification. Accordingly, the classification of a carcinogenic substance as C-1A or C-2 leads, downstream, not to identical responses but to an equivalent level of concern for public health and occupational health. In other words, the principle of consistency must be observed.

In European law, there is no legislative classification for biological agents other than the one for the purposes of occupational health. However, it is up to the Commission and the Member States to ensure a certain level of consistency between the concern raised by a biological agent with respect to public health (which does not result in a formal classification) and occupational health. This requirement to ensure consistency is reflected by the criteria set out in Article 2 of Directive 2000/54. Most of the criteria relate to public health. However, one criterion implies that the classification is also based on the specific impact of biological agents on workers. Thus, in group 3, the agent "can present a serious hazard to workers" while in group 4, the agent "is a serious hazard to workers". In other words, the choice to be made in classification must necessarily be based on two factors: the general concern that this agent raises for public health and the specific aspect of occupational health.

1. Health and safety measures are provided by the Directive itself. Some apply to all biological agents. Essentially, these are Articles 3 and 4 of the Directive which apply to biological risk one of the essential principles of the Framework Directive: risk assessment. Other health and safety measures are assessed on a scale. Accordingly, Articles 5 to 17 do not apply to agents in group 1. The main differences between agents in groups 3 and 4 are revealed in Annexes V and VI. The scope of Annex VI is quite limited in the case of SARSCoV2 (in practice, it would essentially be companies manufacturing vaccines). Therefore, the main differences are found in Annex V. This contains a flexibility clause drafted in very broad terms. The wording in the 2000 Directive (which was not amended by the 2019 Directive) was as follows: "The measures contained in this Annex shall be applied according to the nature of the activities, the assessment of risk to workers, and the nature of the biological agent concerned." In this regard, the changes made to the Directive in 2019 are only of secondary importance. They are limited to explaining the meaning of the adjective "recommended" by specifying: "In the table, "Recommended" means that the measures should in principle be applied, unless the results of the assessment referred to in Article 3(2) indicate otherwise."

The use of the adjective "recommended" generally concerns only agents from group 3. The only exception is the recommendation to take a shower before leaving the contained area, for which the situation is identical for groups 3 and 4.

Other flexibility measures seem possible on the basis of the adoption of asterisks whose meaning is specified in the introductory notes to Annex III.

1. Prevention measures geared to the specifics of the actual work-related activity and based on the assessment in accordance with the principles of the Framework Directive

The Directive's general approach constitutes a solid and coherent basis for organising the prevention of biological risks. On the other hand, this text does not cover the specific characteristics of a pandemic situation. Understandably, back in the year 2000, the European institutions did not pay enough attention to this issue. It is a matter of regret that the assessment of the Directive organised by the European Commission as part of REFIT did not raise this problem. In the meantime, the SARS and MERS experiences could have drawn attention to these issues.

Any amendment to the Directive to bring it in line with the specific problems posed by a pandemic will necessarily take time, as it will have to go through the usual legislative process. Therefore, it would make sense for priority to be given to classification via an amendment procedure to take account of technical progress.

The distinction between the three pillars of the Directive is important. Over the past two weeks, my colleagues in the Workers' Group and I have had numerous informal contacts both with the Commission and with the national authorities. It seems that the discussion on classification has been very much affected by risk-management considerations.

Minister Muylle's statement during the parliamentary debate on Friday, 8 May perfectly illustrates this confusion. She raises two arguments that have some relationship with the legal requirements, the scope of which we will examine later. The third argument calls into question an essential principle of the Directive, the structure of which takes a three-level approach as set out in this section. Classification does not depend on the risk-management measures. Rather, classification is a prerequisite for such measures. When the Minister claims that "the protective measures that a group 4 virus entails would considerably reduce our screening capacity,"[[2]](#footnote-2) not only is this criterion illegal, it also reveals a very shocking policy choice: public health needs could justify an outright violation of occupational health and safety legislation – with this taking place in the healthcare sector, which has been the hardest hit.

In violation of the basic principles of European legislation, it appears that classification often appears to be arbitrary and pragmatic, that the content of Article 2 of the Directive is interpreted with some degree of arbitrariness and that there are informal criteria – never set out in writing – that play a certain role in the decision-making process. As a result, delegated acts are of questionable legality and the transparent discussion of classification decisions is much more difficult than in the context of regulating chemical substances. These observations are confirmed for us by our consultations with epidemiologists who were often surprised by the lack of rigour shown in classification. You will find some important information on this aspect in Professor Unger's report, which I have enclosed with this letter.

1. **Classification of SARS-CoV2 proposed by the Commission and supported by the XXX government**

Classification is a legal act which follows from principles related to policy choices. Recourse to medical assessment is essential, but it must be informed or framed by the rules in force.

This is the main criticism that can be made of the approach taken by your Ministry.

The two reference documents at my disposal are:

* the communication from the Belgian government's expert to the Commission (technical reasons prevented this expert from attending the meeting of experts held on Monday, 27 April);
* the information you sent me in your e-mail of 7 May, which includes more detailed arguments. I will generally be referring to this latter text. In general, these arguments are the same as those used by the European Commission, although certain details may differ.

Within the legislative context, the medical assessment must necessarily be conducted on the basis of higher legal standards. These standards reflect policy choices. Thus, the principle of classification into four groups is neither good nor bad *per se*. This pertains to the political will of Parliament and the Council of Ministers which adopted the Directive in 2000 and intended to assess certain health and safety requirements based on a risk-level scale.

The criteria established by Article 2 of the Directive are composite in nature and list a number of factors to consider. They do not define the specific importance of each factor. The wording is not always particularly precise. This explains in part why, during the meeting on 27 April, several experts expressed doubt, mentioned nuances or indicated that they were not mandated to express a final position. At the meeting of the senior officers of the Luxembourg Committee, the Governments' Group (GIG) came out unanimously in favour of the position defended by the European Commission, namely classification in group 3. This position was unanimously shared by the Employers' Group (EIG). The Workers' Group (WIG) voted for classification in group 4, with the exception of Germany's DGB. This meeting was for advisory purposes only. That same day, the ETUC General Secretary wrote to Commissioner Schmit to inform him of the political importance of the decision to be taken.

Here, I will limit myself to the group 3 and group 4 criteria since the debate concerns this choice.

|  |  |  |
| --- | --- | --- |
|  | Group 3 | Group 4 |
| 1 | Can cause severe human disease | Causes severe human disease |
| 2 | Can present a serious hazard to workers | Is a serious hazard to workers |
| 3 | May present a risk of spreading to the community | May present a high risk of spreading to the community |
| 4 | There is usually effective prophylaxis or treatment available | There is usually not effective prophylaxis or treatment available |

The definition of the criteria is composite. A literal interpretation does not completely resolve the difficulty. The first criterion could lean towards classification in group 3 if the only consideration were the ratio between people affected by the disease and people with severe symptoms up and including death. However, consistency with public health measures adopted should rule out this approach. In the public health arena, there is a recognition of the mass nature of serious illnesses and mortality linked to COVID-19. The notion of causation, as directly indicated by the use of the word "cause", must include a probability factor. Your expert's statement that the agents in group 4 *always* cause serious disease is not based on the Directive's criteria. Nevertheless, criterion 1 is the main argument that appears in your explanation of 7 May. In 80% of cases, the disease causes only mild symptoms. Criteria 2 and 3 are predominantly geared toward classification in group 4. The majority of businesses would not have been closed if there had definitely not been a serious threat to workers. The third criterion leaves no room for any doubt at all: the risk of spread is high. Your expert's assertion that distancing and other barriers reduce the level of risk is absurd. These are risk management measures. The prospect of easing the lockdown indicates its provisional nature. For many occupations these measures are impossible to enforce due to the very nature of the activity. The fourth criterion is also ambiguous due to the use of the adverb "usually". However, your expert's argument that efforts to find a vaccine are under way does not meet the criteria that must be met by the time the decision is made. We are absolutely certain that no vaccine will be available by this Thursday. It goes without saying that a classification can change over time. This is the very purpose of the process of amending directives to bring them in line with technical advances. Perhaps in 2025, SARSCoV2 will meet the conditions for inclusion in group 3. I am amazed at the cursory and casual nature of the expert assessment which is now being used as the basis for making a decision on the current characteristics of an occupational hazard based on data from a hypothetical future.

However, the fact that the wording used for composite criteria leaves room for doubt does not mean that the final decision can be purely arbitrary. Other legal principles tightly govern this decision-making process and make it possible to rule on its legality.

In terms of occupational health and safety law, this question has already arisen with regard to the Working Time Directive. The definition of working time was also based on a composite wording of three factors. The Court of Justice of the European Union has ruled on this question and has provided the necessary legal certainty.

To that end, it supplemented the literal interpretation which made a certain amount of doubt possible with two general principles of interpretation.

In the event of questions or doubt, the matter must be decided on the basis of the objective pursued by the legislation, which in this case is common to both Directives, namely protecting the health and safety of workers. This greatly reduces the risk of arbitrariness. In the event of questions or doubt, the purpose of the Directive must justify Parliament's decision.

The Court also adopted a systematic interpretation of the Directive. It found that this systematic interpretation was based on a dual system: working time and rest time. It does not recognise any intermediate category. This consideration strengthens legal certainty. It requires lawmakers to interpret composite criteria based on what is essential in order to protect the health of workers.

These are fundamental rules of European law which are binding on the Commission in exercising its own legislative powers. These rules are also binding on the Belgian government.

On the basis of current scientific and statistical data, there is little doubt that the information supporting classification in group 4 clearly outweighs the arguments that could be put forward in favour of group 3 (the relatively high number of patients with mild symptoms and the use of the adverb "usually" in the wording of the fourth criterion).

In addition, the Treaty on the Functioning of the European Union requires that a high level of human health protection be ensured in all Union policies (Article 168). Likewise, Article 8 of the same Treaty requires the Union to aim for equality between men and women in all its activities. Even if it is hardly possible at this stage to have detailed figures, there is no doubt that COVID-19 as an occupational hazard affects women more than men. In my opinion, these two cross-cutting provisions reinforce the arguments in favour of classification in group 4.

I refer you to the document by Professor Unger, who has compared the viruses currently classified in groups 3 and 4. While there is a certain degree of inconsistency in the choices that have been made in the past, these conclusions seem unavoidable for the current debate: the only relevant choice including the multiple criteria to be analysed is to assume that the COVID-19 today corresponds to the highest biological risk level.

**IV Flexibility measures and risk management**

Since the start of the crisis, workers have shown a considerably greater sense of responsibility than employers and government authorities. Whether at nursing homes or hospitals, workers as a whole have taken enormous risks. This is not individual heroism. It is the result of a whole set of largely undervalued occupational qualifications, strong professional identities, collective intelligence and solidarity. The many struggles waged against austerity policies and their impact on working conditions have certainly played an important role in the effectiveness of their response despite catastrophic policy decisions such as the failure to keep masks in stock.

From the start of the debate on classification, trade unions have served as relay points for this collective awareness. With a view to protecting public health, should it become clear that certain risk management conditions cannot be implemented, the trade union movement is fully prepared to discuss alternative measures which would offer an equivalent level of protection on the basis of the general principles set out in the framework Directive. Annex V to the Directive already contains a general flexibility clause. Should this prove to be insufficient, other solutions can be envisaged. On the other hand, what is acceptable for covering the public's essential needs ceases to be acceptable when it is a question of other interests, such as productivity or corporate profits.

Through the debate, this position has been repeated and made crystal clear by all trade union organisations at national and European levels.

Yours sincerely,

1. With regard to this issue, it is clear that most of the mechanisms deployed depend on national policies. Eurostat could have played a more active role, but the decisive political responsibility lies with the national governments. [↑](#footnote-ref-1)
2. I have taken this quote from the report published in *La Libre Belgique*, a Belgian daily newspaper. [↑](#footnote-ref-2)