The Europeanisation of occupational health services: A study of the impact of EU policies

Occupational health services (OHS) are part of the social and health policies of the European Union. OHS has been studied mainly as a national system, as part of a system of occupational health and safety, or as an activity-based service unit for employers and employees. The focus has often been on risk assessment and the prevention of diseases, injuries and accidents. OHS has also gained attention among social partners, such as trade unions and employers’ organizations during bargaining and negotiations on compensations for ill health.

This study focuses on OHS in the context of the EU and on OHS as part of the work-based benefits provided to workers in welfare states. The study is a policy study on the impact of EU policies, and uses OHS as a case to demonstrate transnational legislation and governance in EU member states. The main reason for choosing the policy process perspective was an obvious need for empirical analysis of OHS in the contexts of the EU, transnational decision-making, and policy environments.

The study explores the development of OHS in 15 member states of the European Union at the turn of the millennium. The study material included interviews and various types of documents.
The Europeanisation of occupational health services: A study of the impact of EU policies

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This study concerns Framework Directive 89/391/EEC on health and safety at work, which encouraged improvements in occupational health services (OHS) for workers in EU member states. Framework Directive 89/391/EEC originally aimed at bringing the same level of occupational health and safety to employees in both the public and private sectors in EU member states. However, the implementation of the framework directive and OHS varies widely among EU member states. Occupational health services have generally been considered an important work-related welfare benefit in EU member states. The purpose of this study was to analyse OHS within the EU context and then analyse the impact of EU policies on OHS implementation as part of the welfare state benefit. The focus is on social, health, and industrial policies within welfare state regimes as well as EU policy-making processes affecting these policies in EU member states. The research tasks were divided into four groups related to the policy, functions, targets, and actors of OHS. The questions related to policy tried to discover the role of OHS in other policies, such as health, social, and labour market policies within the EU. The questions about functions sought to describe the changes, as well as the path dependence, of OHS in EU member states after the framework directive. The questions about targets were based on the general aims of WHO and the ILO in relation to equity, solidarity, universality, and access to OHS. The questions on actors were designed to understand the variety of stakeholders interested in OHS. The actors were supranational (EU, ILO, and WHO), national (ministries, institutes, and professional organisations), and social partners (trade unions and employers’ organisations).
The study data were collected by interviewing 92 people in 15 EU member states, including representatives of ministries, institutions, research, trade unions, employers’ organisations, and occupational health organisations. Other documents were collected from the Internet, databases, libraries, and conference materials for a systematic review of the policies, strategies, organisation, financing, and monitoring of OHS in EU member states. Different analytical methods were used in the data analysis.

The main findings of the study can be summarised as follows. First, occupational health services is a context-dependent phenomenon, which therefore varies according to the development of the welfare state in general, and depends on each country’s culture, history, economy, and politics. The views of different stakeholders in EU member states concerning the impact and possibilities of OHS to improve health vary from evidence-based opinions to the sporadic impact of OHS on occupational health. OHS as a concept is vaguely defined by the EU, whereas the ILO defines OHS content. The tasks of OHS began as preventive and protective services for workers. However, they have moved towards multidisciplinary and organisational development as well as the workplace health promotion sphere. Since 1989 OHS has developed differently in different EU member states depending on the starting position of those states, but planning and implementation are crucial phases in the process toward better OHS coverage, equity, and access. Nevertheless, the data used for the planning and legitimisation of OHS activities are mainly based on occupational health data rather than on OHS data. This makes decisions on political or policy grounds inaccurate. OHS is still an evolving concept and benefit for workers, but the Europeanisation of OHS reflects contextual changes, such as the impact of the internal market, competition, and commercialisation on OHS. Stronger cooperation and integration with health, social, and employment services would be an asset for workers, because of new epidemics, an epidemiological shift towards new risks, an ageing labour market, and changes in the labour market. Different methods and approaches are needed in order to study the results of integrated services.

In the future, more detailed information will be needed about the actual impact of EU policies on OHS and decision-making processes in order to get OHS into different policies in the EU and its member
states. Further results and effects of OHS processes on occupational health need to be analysed more carefully. The adoption of a variety of research strategies and a multidisciplinary approach to understand the influence of different policies on OHS in the EU and its member states would highlight the options and opportunities to improve workers’ occupational health.

**Key subject headings:** Occupational health services, EU policy, policy-making, framework directive 89/391/EEC.
1. INTRODUCTION

Occupational health services (OHS) became compulsory for employers after the Council of European Communities approved Framework Directive 89/391/EEC\(^1\) in 1989. The framework directive was an attempt to harmonise regulations and to prevent social dumping and using workers as a commodity due to the single European agreement within EU member states.\(^2\) The framework directive was created within the EU context in which the single European market, the creation of the European Monetary Union (EMU), and the social dimension of a unified Europe were developing in parallel. This created the specific drive for the framework directive to be accepted. On the other hand, the creation of the monetary union forced EU welfare states to cut the costs of social benefits and services, including OHS, which might have produced different compliance choices and different tracks of OHS development.

Nevertheless the framework directive and its transposition with the national legislation implied and coincided with significant changes to the financing, organisation, and functioning of OHS. In EU member states, the discussion on OHS has mainly concerned its role in the prevention and protection of workers' health and safety at work, content of the services, and the evidence base of those services. Walters (1997, 2001a, 2002a,b) published studies concerning occupational health and safety systems and small- and medium size enterprises (SMEs) with occupational health and safety systems. Vogel (1994, 1998) published two

\(^{1}\) The framework directive concerns measures to encourage improvements in the safety and health of workers at work and was given by the Council in June 1989.

\(^{2}\) EU member states included into this study were Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom.
1. INTRODUCTION

books on preventive and protective services in EU member states from the trade union perspective. Dotan and van Waarden (2002) compared health and safety at work in different EU member states in relation to the Netherlands. The usual approach is to compare organisational, financial, and managerial issues in addition to services provided by OHS. Cost-benefit and cost-efficiency analyses of occupational health and safety has been conducted by the European Foundation for Living and Working Conditions (Mossink, Licher 1998, Mossink 2000). Also, the Finnish Institute of Occupational Health produced reports on OHS systems in the European countries for the ‘Occupational health for Europeans’ conferences in 1998 and 2000.

This study focuses on OHS in the context of EU, and OHS as part of the work-based benefit within welfare states. The study is a policy study of the impact of EU policies in which OHS is a case to demonstrate transnational legislation and governance in EU member states. The main reason to choose the policy process perspective was an obvious need for empirical analysis of OHS in EU and transnational decision-making and policy environments. OHS has been studied mainly as a national system, as part of an occupational health and safety system, or as an activity- and process-based service unit for employers and employees. The focus has often been on the assessment of risks and the prevention of diseases, injuries, and accidents. OHS has also gained attention among social partners, such as trade unions and employers’ organisations during bargaining and negotiations on compensations for ill health.

OHS is both a practical and an academic issue. From the practical point of view, OHS deals with very fundamental issues of a worker’s life: health and fitness for work; illness and disease; accidents and injuries; pain and suffering; prevention of ill health and promotion of health; and death. The approaches adopted to describe and solve occupational health issues have varied from risk assessment and treatment orientation to workplace health promotion, including work organisation issues as part of OHS. The main approaches of OHS studies have been on the activities of OHS based on World Health Organisation (WHO) or International Labour Organisation (ILO) conventions and recommendations, national occupational health and safety systems and requirements, OHS practices and the impact of OHS on workers’ health, cost-effectiveness and cost-efficiency of OHS, use of evidence-based data in OHS, or
1. INTRODUCTION


Even if the concept of occupational health is to some extent obscure (Westerholm 2004), the definition of OHS used in this study is based on ILO and WHO conventions and recommendations. The framework directive mentions preventive and protective services for workers instead of OHS. The framework directive places health and safety at work within the EU policy frame, in which OHS is a service provider. OHS is an occupation-based social benefit that aims to improve workers’ lives in welfare states. In the political arena, OHS is related to health policy, social policy, and labour, employment, and industrial policies. OHS is affected by all these policies directly, indirectly, and often in an uncoordinated way that has spillover effects.

Between May 1999 and September 2000 a survey was conducted of occupational health services and quality management in Switzerland, Norway, and 15 EU member states. The interviews were conducted between October 1999 and February 2000 and those data have not been updated since. The survey was funded by SALTSÅ and conducted by the author as a principal researcher in the Finnish Institute of Occupational Health. The study was conducted to review the impact of the Framework Directive 89/391/EEC on OHS. Part of this thesis is based on the interviews gathered during that survey. My interest in OHS as part of the welfare state and EU arose during a short research period at the National Research and Development Centre for Welfare and Health (STAKES) in the Globalisation and Social Policy Programme (GASPP), as I prepared a report concerning EU policies in relation to health in the spring of 2003. As I further studied these questions during the scholarship period within the Labournet Research School managed by the University of Tampere, I developed an interest in OHS as one of the benefits of the welfare state system.

4 The changes since the turn of the millennium in OHS have been updated in Westerholm P, Walters D, eds. 2007.
5 SALTSÅ= The Joint Programme for Working Life Research in Europe, Sweden
6 http://www.uta.fi/laitokset/sospol/labournet
1. INTRODUCTION

The data and materials were collected in 1999-2000 and were studied until 2004. The manuscript was given to supervisors for review in October of 2004. The data and materials have not been updated since that time. The long and turbulent review process and the winding and sporadic research process that involved a variety of institutes, funding, and issues has led this thesis to be about OHS as a complex phenomenon within the EU and in its 15 EU member states.

OHS is certainly only a minor dimension of social protection systems, social policies, or the welfare state systems. Nevertheless it is important to have an idea of the OHS systems in EU member states and their solutions and directions in developing OHS. Recent trends have taken OHS as an occupation-based welfare benefit and service in a direction that might erode its original purpose as an antidumping measure of the social dimension in the EU’s market creation aims. The structures of the social protection systems have developed in such a way that the benefit systems depend on each country’s economic and political possibilities. European integration has been evolving for decades, and harmonisation has softened some of the differences among countries, and therefore many similarities can be observed within health, social, and OHS systems. The economic development and timing of welfare development is strong, but the process by which the basic models of OHS spread in Europe is not clear. This is part of a larger discussion on the convergence or divergence of culture, politics, and social structures. However, OHS is only a small part of social structures, and other aspects might also have strong influence on OHS provision and their development. In addition, there is a lack of comparative quantitative data for making a quantitative comparison between EU member states and their OHS.

This thesis starts with a description of policy-making processes, to understand how the OHS and general occupational health policy is made in the EU context and in EU member states (Chapter 2). That is followed by the research tasks, study design, and data analysis. Then the thesis describes the policy environment for OHS (Chapters 3-4). Chapter 5 includes various organisations that influence OHS, competence of the European Community in OHS, and various policies affecting OHS and their interrelations.

Chapter 6 describes OHS and its different appearances in EU member states through different aspects of the OHS system. These aspects are
1. INTRODUCTION

Based on ILO and WHO conventions and recommendations for OHS systems. The majority of OHS aspects and descriptions were collected using interviews and were triangulated using different data sources, documents, and literature. The important issue is that the study is not only based on documents or general written material, but on interviews from each EU member state. The interview subjects include ministerial and political employees as well as professionals from the implementation level of OHS. In addition, workers’ representatives and employers’ representatives were interviewed in most of the EU member states.

Chapter 7 discusses policies, targets, actors, and services in OHS with research questions that look at gained results. Chapter 8 discusses the study’s validity and relevance, and chapter 9 discusses the significance of results. Chapter 10 explains the current impact of EU policies on OHS, making note of the sporadic changes from harmonisation to Europeanisation of OHS and in organising OHS, and of the shifting focus towards quality of work and life instead of occupational health only. Chapter 11 aims to advance knowledge and understanding of OHS in the European context in the near future.
2. POLICY PROCESSES AND POLICY ANALYSIS

Policy analysis is about understanding the formulation and impact of policy (Ham 1990, John 1999) — for example, on occupational health problems. Bureaucrats, professionals, or think tanks can conduct policy analysis, but one can explain the difference between researchers and bureaucrats as the difference between analysis of policy and analysis for policy. Policy analysis is a descriptive activity concerned with breaking down and describing policy formulation, and it is also a prescriptive activity concerned with influencing and changing policy making (Ham 1990, John 1999).

The interests in policy analysis include analysis of the policy process, analysis of policy content, and analysis of policy implementation. Frequently, policy studies are conducted on the influence of pressure groups on policy-making, decision making, the policy formulation process, power structures, and policy content (Ham 1990, John 1999).

2.1 Process of policy-making

The process of policy-making can be divided into the stages of problem identification and issue recognition, policy formulation, policy implementation, and policy evaluation (Walt 1994). Policy development is seen by Milio (1987) as a continuous process of initiation, adoption, implementation, evaluation, and reformulation, but not necessarily a linear social and political process. According to Kingdon (1984), policy process includes testing the agenda, specifying alternatives to choose among, making an authoritative choice from those alternatives, and implementing the
decision. The policy process is often a process of negotiation, bargai-
ning, and adjusting among different interest groups that aim to influence 
policy choices and alternatives. Policies are intertwined together with their 
aims, objectives, and implementation to avoid conflicts. There is rarely 
an optimal policy solution, but politicians often focus on small changes 
in an effort to improve previous policy lines and achievements, and to 
gain maximum acceptance for a policy change (Walt 1994).

The political system uses its values as a base for the selection of 
choices and decision making. The decision makers choose their values, 
which they support or ignore; for example, politicians make collective 
decisions about laws that affect all or part of society. Workplace-related 
social, health, and safety policies are surrounded by numerous values, 
and the government is bound to limit the values it supports. The values 
in relation to OHS might be related to service provision and resources, 
or they might be symbolic. The usual motives to change the situation 
of OHS might be scarcity of funds or moral motives in relation to dif-
ferent values of different importance, which then define the direction 
and degree of government involvement on a policy (Walt 1994). Policy-
making and its outcomes are framed by the self-interest of different 
actors within policy-making circles. Depending on the subject, these 
actors can include professionals, industries, trade unions, and member 
states and their institutions.

Researchers differ on the stages of policy process, but the main 
discussion is whether the policy process follows a logical process from 
identification to implementation and evaluation. Many policies remain 
only as an intention and have no serious effect on public life (Walt 
1994). Success in one process does not necessarily imply success in 
others. Policy is made within a set of shared expectations originating 
from history, sociopolitical conditions, and organisational experiences 
(Milio 1987). Policy building is an important phase in the policy process. 
Policy building can be divided into the stages of policy proposals, policy 
decision, and policy implementation. Policy building occurs in a broad 
political, economic, and social context, and decisions will affect and spill 
over into other policies as well. Various actors enter the different phases 
of policy building at different times. Phases are often intertwined and 
might bring quite unexpected results (Wallace, Wallace 2000). In addition, 
policy spillover can be understood as transferring policies or drawing 
lessons from other policy processes (James, Lodge 2003).
2. POLICY PROCESSES AND POLICY ANALYSIS

2.2 Theoretical frameworks for analysis of policy processes

Different public policies drive change based on social, political, and economic conditions and legitimations. In addition, the shape, pace, and direction of a policy can change during the policy process (Milio 1989). These changes can be studied by several approaches. In policy change studies, the most common of the society-centred approaches is the class approach; decision making is dominated by certain social classes, which also benefit most from the decision. In the pluralistic approach, none of the social classes alone makes the decisions; all classes affect the results, and general public interests are sought. In the public choice approach, the state is not considered neutral, but rather is an actor, which makes alliances with interest groups. In this case, results will not necessarily benefit general public interest. Policy change and policy decisions might reflect the relations among social classes and their advantages and benefits, general public interest, or joint opinions of the state and interest groups. The way policy process occurs affects the process outcomes, the position taken by policy makers, and choices made by policy makers (Walt 1994).

Changes in the welfare state and its provisions have often been studied by viewing the institutions as change agents or as hindering the changes in the welfare state and its provisions. Differences and similarities in provisions have also been explained by the varying political resources among different stakeholders and by globalisation as pressure for change. Previous choices made by institutions bring path dependence as well as dependence on those previous choices and their consequences (Pierson 2001). The focus on institutions as change agents asserts that political power or globalisation influence changes in welfare provisions, but choices, defences, and changes are made by institutions. Path dependence can be explained by economic, labour market, or administrative structures of the nation-state (Esping-Andersen 1999). The explanation for changes or stagnation may be found in the centralisation of decision making, interest in decision-making processes by stakeholders with integrity, or dispersion (Pierson 2001). In the case of OHS, the changes and stagnation can also be referred to an unwillingness of profession-
nals and service providers to change, due to threats to the position of
the profession and services as employers. However, change is difficult
to define because the welfare systems and their services are constantly
on the move. Change also depends on what level is being viewed (e.g.,
financing, governance, human resources, use of services, or impact of
services to health) (Lehto 2003).

Policy change and variation emerges from the interaction of pro-
cesses. Individual views become important when they interact with
institutions. Institutions, interest groups, and networks interplay with
individuals and ideas at different times and places during the process of
making policy (Falkner 2000, 2001). Institutional approaches consider
that formal structures and norms process decisions (Scharpf 1999, 2002,
Julkunen 2003). The institutional approaches--rational choice, organi-
sational institutionalism, and historical institutionalism--explain policy
as strategic choices that are open to individual actors (Schmidt 1999,
Julkunen 2003). In the network approach, patterns of political associa-
tions explain policy stability and variation (Falkner 2000, 2001, Mattila
2000). Socio-economic approaches explain that political processes are
reflected in changes in policy of society and economy (Wilensky 2002).
Ideas-based approaches (Kingdon 1995) explore the salience of argu-
mentation, discourse, and advocacy in the policy process. John (1999)
describes the different methods of policy analysis by combining ideas
and interest into evolutionary theory.

Broader aspects of the institutional role in policy-making include
the role of leadership and expertise, differentiation and fragmentation
of policy-making, the role of policy networks in different areas, the
role of institutions in controlling policies, and policy methods of the
EU. This reflects the understanding of decision making in the EU and
its democratic legitimacy (Andersen, Eliassen 2001). Other theoretical
contributions to policy analysis include institutional analysis and develop-
ment (Marks et al. 1996, Scharpf 1999, 2001), punctuated equilibrium
theory (Baumgartner 1993), multiple streams models of policy change
(Kingdon 1995), and policy diffusion models (Stone 2000). In addi-
tion, relevant policy analysis theories of the EU are regulatory policies
(Majone 1990), policy networks (Peterson 1995, Pappi, Henning 1998,
Mattila 2000), Europeanisation (Radaelli 2000b, 2004), and implementa-
tion analysis (Mazmanian, Sabatier 1989, Sihto 1997). The usual tools
2. POLICY PROCESSES AND POLICY ANALYSIS

and methods of public policy analysis include policy learning (Dolowitz, Marsh 1996, 2000), agenda setting (Kingdon 1995), and policy change (Sabatier, Jenkins-Smith 1993, Sabatier 1999).

2.3 Policy processes for OHS

This study aims to describe OHS as part of a social dimension within welfare states of the EU. The processes of different occupational health policy developments vary in time, topic, and place. The development of the social dimension has been boosted since the accepted single market, and the development of OHS was generally interpreted to receive support from Framework Directive 89/391/EEC. Within policy processes, initiatives are sometimes made by the EU president, sometimes by the Commission or member states, and sometimes by various national or international stakeholder groups.

Policy about health and safety at work is a good way to create safer and more healthy work environments, and it often includes directions for OHS. Building occupational health and safety policies consists of collaborative strategy development involving policies in many sectors--such as health, labour, and social--and many different levels of government and social partners. Experience suggests that the necessary conditions for policy and a strategy for occupational health and safety include institutional responsibility, collaboration within government and between government and social partners, and support by all parties for policy development. The occupational health and safety policy including OHS is successful if funds, authority, expertise, time, information, and education are provided (Walters 1996a, b, 1998, Westerholm, Baranski 1999).

Changes in service provisions can also be measured. Such measurements concern efficiency, equity, and effectiveness (Twaddle 1996). Proponents of efficiency tend to favour market solutions for OHS; those focusing on equity favour democratic control of the OHS system (e.g., workers’ participation); and those focusing on effectiveness favour professional control of the system (e.g., evidence-based service provisions). Also, costs and financing in relation to occupational health outcomes and distribution of OHS are important in measuring the change or reform of OHS.

OHS is sometimes seen as part of promoting the ability to work and
participating in the labour market. This makes the challenge in defining change even more difficult, because other factors affect health more than OHS. Investing in an OHS infrastructure may be less efficient than influencing nutrition, safety, or alcohol policies. Indicators of ill health (occupational diseases, injuries, and accidents) are not the best indicators of the occupational health and safety system or as a measure of change in OHS. However, several initiatives for legislation, policies, and strategies for improvement of OHS are based on ill-health indicators.

The study of these changes in various countries has been limited due to a lack of conceptualisation. Some comparable statistics have been reported, but those have a limited range of theories to make economic and non-economic comparisons. Twaddle (1996) built a global health care reform model to develop comparable information collection and a conceptual frame for the analysis of changes, which has been used as a main frame in this study (figure 1). The hegemonic expert opinion consisted of international organisations, which set limits and controls for social, labour, and health policies and objectives. The International Monetary Foundation (IMF), the World Bank (WB), WHO, and the ILO influence the shaping of national social, labour, and health policies; engage in transnational redistribution and regulation, and occasionally provide for citizens or at least empower citizens to organise the services when states fail to provide such services (Deacon 1999, Deacon et al. 1997). In addition on national and international trade unions and employers’ organisations, such as the European Trade Union Confederation (ETUC) and Union of Industrial and Employers’ Confederation of Europe (UNICE) impact on policy processes. Other important actors are the Organisation for Economic Co-operation and Development (OECD), the EU, and the World Trade Organisation (WTO). These actors have their own increasing role in defining the content of social, labour, and health policies—mainly from market-creation and market-promotion perspectives. In the case of OHS, hegemonic expert opinions are presented mainly by the ILO, WHO, and the EU.

In the national systems, the main areas of importance for OHS development are the history and culture of society; disease, illness, and sickness patterns in relation to responses by the OHS system; the economic situation reflecting the resources for OHS; the nature of the welfare system; and the political system. The most important criterion
2. POLICY PROCESSES AND POLICY ANALYSIS

for OHS is considered to be the relative size of the public and private sectors’ provision for OHS. In addition, importance is given to the bias between specialised care and high technology versus health promotion. Other important criteria are prevention and treatment under different national conditions; and the effectiveness, equity, and efficiency of OHS. These can also be used as values and criteria in assessing the adequacy (coverage, access) of OHS. However, the efficiency of OHS should not be looked at only from administrative or providers’ perspectives, but also from the patient’s perspective (e.g., workers).

<table>
<thead>
<tr>
<th>Worldwide hegemonic systems</th>
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<tbody>
<tr>
<td>ILO</td>
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<tr>
<td>WHO</td>
</tr>
<tr>
<td>OECD, IMF, WTO, WB</td>
</tr>
<tr>
<td>EU</td>
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<tr>
<td>ETUC, UNICE</td>
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<tr>
<th>National systems</th>
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<tbody>
<tr>
<td>political, economic, and social policy system</td>
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<tr>
<td>health system</td>
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<tr>
<td>industrial relations</td>
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<td>history and culture</td>
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<table>
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<tr>
<th>Occupational health system</th>
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<tbody>
<tr>
<td>legislation and policy for health and safety at work</td>
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<tr>
<td>organisation of OHS</td>
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<tr>
<td>financing of OHS</td>
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<tr>
<td>multidisciplinary professionals for OHS</td>
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<tr>
<td>protective, preventive, and curative services</td>
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<tr>
<td>equity, coverage, access, and impact</td>
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<tr>
<th>Economic, social, and political conditions</th>
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<tr>
<td>Reform pressures, plans, and government programmes</td>
</tr>
<tr>
<td>Professionals</td>
</tr>
<tr>
<td>Enterprises</td>
</tr>
<tr>
<td>Trade unions, employers’ organisations</td>
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</tbody>
</table>

Figure 1. Global model for expert opinion formation and policy-making for OHS (applied to OHS from Twaddle 1996)
2. POLICY PROCESSES AND POLICY ANALYSIS

Policy outcomes are not only shaped by the implementation process itself, but are determined by it (Palumbo, Calista 1990). In the case of OHS, the implementation of Framework Directive 89/391/EEC depends on functions of the policy cycles in EU member states.

Implementation is part of a larger policy-making process and is related to other parts of the policy cycle, such as design, problem definition, formulation, and evaluation. The implementation of OHS takes place within the subgovernmental level, for example by the institutions, regional or local governments, or professional organisations. Implementers are a key part of the networks and play a major role in interpreting OHS policy, legislation, and directives. In addition, there is a trade-off between personal relationships among implementers when seeking agreements on how to proceed. Implementers' power is their expertise. The principal source of their power is their influence over policy subgroups or networks, which create policy-making intentions. Public administrators have issues on their agenda that finally define legislative and executive agendas and mostly propose solutions to problems (Palumbo, Calista 1990).

One set of variables, which explains implementation outputs and outcomes, is related to the way organisations alone or interorganisational relationships respond to policy mandates. The implementation output and outcomes are affected by organisational interests and the incentives of the organisations that participate in the implementation process (Winter 1990). Both the EU and EU member states had an interest in defending workers’ rights for health and safety at work as they formulated Framework Directive 89/391/EEC. However, the incentives, interests, and organisations participating in implementation seem to vary widely among EU member states. The implementation processes are systems of pressures and counterpressures, such as between employers’ and employees’ organisations or between institutions and government on OHS issues. Adjustments to implementation are the results of the various participants pursuing their stake in the process. The predominant feature of the process is policy redesign and evolution (Ferman 1990). This can be noticed from several different ways of organising OHS within the existing systems of EU member states.
3. RESEARCH TASKS, AIMS, AND ANCHORAGE

This study focuses on OHS in 15 EU member states using a qualitative research approach that employs comparative policy study in a time of change. The starting point of the study is Framework Directive 89/391/EEC and its impact on the organization of OHS in 15 EU member states. The research task describes the nature and context of the framework directive, specifically articles 6 and 7 and the different views of the stakeholders. The task includes a description of the framework directive's impact on different items of OHS, such as coverage, financing, or organisation in the context of the welfare state and health, social, and industrial relations policies.

The aim of this research is to describe and compare occupational health systems and OHS in 15 EU member states and use it as a case to analyse OHS as part of the European social dimension and enhance understanding of EU policy processes in OHS through social policy in EU and welfare state development.

The research questions are divided into four groups, based on the process of policy-making as described in chapter 2; these groups are policy, targets, actors, and services of OHS. The questions related to policy tried to discover the role of OHS in other policies (e.g., health, social, and labour market policies) or in the social dimension of the EU. The questions on targets were based on general aims of WHO and the ILO in relation to equity, solidarity, universality, and access to health services and specifically OHS. The questions on actors and their role in OHS development sought to identify the variety of stakeholders interested...

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7 Hereafter when reference is made to the framework directive, the main intention is to refer to its articles 6 and 7.
in OHS. The actors are supranational (EU, ILO, and WHO), national (ministries, institutes, and professional organisations), and social partners (trade unions and employers' organisations). The questions related to services aimed to describe the changes as well as path dependence of EU member states to OHS, after the framework directive.

Research questions were divided based on the process of policy-making as described in chapter 2, into four groups as follows.

Policy
1. What was the role of different regimes (welfare state, health and industrial relations systems) and EU policies in the development of OHS?
2. What regulatory impact did Framework Directive 89/391/EEC bring to OHS in EU member states? To what extent did the EU member states adopt and implement the framework directive?

Targets
3. Did Framework Directive 89/391/EEC reach the targets set for OHS in general?
4. Did the framework directive harmonise OHS among EU member states?

Actors
5. What was the role of supranational actors in the development of OHS?
6. Who were the stakeholders in OHS policy development in EU member states and in the EU? What were their opinions and views on OHS?

Services
7. What were the requirements for OHS in EU member states? To what extent did the EU member states implement the principle of multidiscipline in OHS?
8. How did EU member states monitor and evaluate implementation of OHS?
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

The study was designed to look at OHS within the EU and the impact of EU policies on OHS development in EU member states. I examined EU social, health, and industrial relations policies, and I explored their impact on OHS. OHS was interpreted as an issue in the EU and in national or regional policies. Policy-making often refers to the choices in allocating resources. Policy makers are actors in defining the processes, agenda, content, and outcome of any decision and its implementation. The group of policy makers consists of several different types of stakeholders and policy entrepreneurs with a variety of interests to defend and promote. The policy process was limited to studies and literature focusing on the impact that the EU, national governments, or health, social, or industrial relations have on issues about OHS. The need for limitation was based on the interest in OHS from policy process perspectives, which excluded processes, treatments, and workers of OHS units from the study, despite their importance in their own domains. The main reason to choose the policy process perspective was an obvious need for empirical analysis of OHS in EU and transnational decision making and policy environment.

In this comparative study, different EU member states and their OHS systems were compared. The countries formed cases, and different aspects of OHS were compared and their causal combinations explored. The data collection consisted of interviews and documents retrieved from libraries, scientific sources, and sources on the Internet. This formed the empirical analysis of the study. The theoretical analysis consisted of the previous research on OHS and the cognitive processes of the researcher to locate OHS in the EU environment and to look for the impact of different policies on OHS (Figure 2).
The study design is summarised in figure 3. In chapter 5 the policy-making environment and process are described, which is followed by the description of EU social policy, social dialogue, European welfare states, and OHS in EU member states. The comparative studies on the different policies can highlight the internal politics of the political system between the EU and its member states and among the member states themselves (Hix 1994). The study of OHS supported the ideas of health policy studies within the EU framework (Koivusalo 2000, 2003a,b,c, Walters 2001a,b, 2002a,b, McKee et al. 2002, Mossialos, McKee 2002a,b) and relied on the conclusions of the studies related to harmonisation, convergence, and Europeanisation (Radaelli 1999, 2000b, 2004, Börzel, Risse 2000, Knill, Lehmkuhl 2002, Manning, Palier 2003).
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

4.1 Qualitative comparative study of OHS

Qualitative research was chosen to explore and understand the diversity of OHS approaches in 15 EU member states, because quantitative or experimental designs of this type of study are not feasible. Qualitative research is often used to explore and understand a diversity of policy issues. The approach can contribute to the public policy field to understand complex behaviour, needs, systems, and cultures. Qualitative methods are used to meet different objectives, which can be contextual (identifying the form and nature of what exists), diagnostic (examining the reasons for, or causes of, what exists), evaluative (appraising the effectiveness
A comparative method is typically chosen to demonstrate the relationships among values in different countries and to give a deep understanding of these unique phenomena. The qualitative comparative study gives importance to different stakeholders and their views, when collecting and using information for further analysis (Vartiainen 2000). The comparative method was selected as a framework to examine OHS in relation to welfare states and their values, such as coverage, equity, and universality. The study emphasises the importance of understanding OHS and results analysed in different countries. The method was subjective, the results were unique, and the research process was elastic in comparing differences in OHS systems.

The comparative study aims to understand differences and similarities; to build relationships among nations and people, cultures and societies; and to generate empirical scientific knowledge about similarities and differences to form explanatory knowledge of causes or understand influences. In addition, the comparative study contributes to policy formulation by comparing policies among countries and making use of natural experiments (Øvretveit 1998, Smelser 2003).

Comparative studies have grown in number during recent decades, due to increased internationalisation and the export and import of social, cultural, and economic ideas across national borders. People, work, capital, and goods are moving across boundaries. Increased homogeneity and uniformity due to globalisation, however, leaves enclaves of uniqueness, which are also of interest to researchers. For comparative purposes the countries as administrative entities are used as units of comparison, despite the overarching impact of globalisation and the difficulty to trace reasons behind each specific issue (Øyen 1990). However, comparative studies have theoretical and methodological problems, such as biases, aggregation, and disaggregation of results. Cross-national research provides the grounds to develop theories and establish the generality and validity of findings, which have been mainly gained in case studies of individual nations (Teune 1990).
There are several ways of conducting comparative studies. For some researchers there is no difference in research across countries or obstacles to and complexity in the interpretation of results across borders. Some researchers are very aware of interdependencies and complexities and therefore opt for compromises and try to devise tools to make new insights (Øyen 1990). Some researchers distinguish comparative studies from other kinds of studies by using macro-social units to explain and interpret macro-social variation (Ragin 1987). Also, the intent of comparative studies varies. The countries in these studies can fill various roles; they can be the objects of the study, the contexts of the study (in order to generalise phenomenon in two or more countries), the units of analysis (phenomena related to the characteristics of the countries), or transnational items (the nation as the component of a larger international system) (Kohn 1989).

Many of the differences and similarities among countries might be diffused across cultures, nation-states, or societies, but the diffusion itself does not cause the differences or similarities. In some cases, differences within a country are larger than differences among countries. The differences in comparative studies might be cross-national, cross-cultural, or cross-societal (Scheuch 1990).

Table 1. Use of context in comparative studies (Scheuch 1990).

<table>
<thead>
<tr>
<th>Purpose of comparisons</th>
<th>Context is treated as a ‘real’ thing</th>
<th>Context is treated as a set of variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find identicals</td>
<td>Identification of ‘universals’</td>
<td>Show the universality of a statement</td>
</tr>
<tr>
<td>Show differences</td>
<td>Specify the unique property of a society</td>
<td>Specify time-space coordinated for a phenomenon</td>
</tr>
</tbody>
</table>
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

The nation-state and Europe was the geographical frame for the sample of countries in this study. Data were collected from various nation-states, and comparisons were cross-cultural and cross-societal. The researcher understood countries to be systems with varying situations, in which the workforce produced goods under varying conditions. The difficulty was to control other factors affecting OHS, especially the country-specific institutions and processes. The differences were searched for from a set of variables in a country to specify time and space for OHS development in EU member states (Table 1).

In comparative analysis, the concepts of interdiscipline and internationalisation can be applied to information gathering (Smelser 2003). This is an interdisciplinary study in that I used concepts, frameworks, and perspectives from several disciplines to understand and explain OHS. Internationalisation meant that information on OHS, welfare state, or social policy was broadly applicable without reference to specific national or other boundaries.

This comparative study tries to explain and interpret differences and similarities systematically and comprehensively. The goal in comparing is to find generalisations or specificities from the OHS and its aspects. Comparison requires comparability: a process must have sufficient similarities to study differences or sufficient differences to study similarities (Salminen 2000). The comparison of circumstances in different EU member states provides useful information about possible consequences of different political processes. The EU member states were considered comparable based on several administrative, structural, economical, and political similarities and based on similar earlier studies that compare welfare state systems or parts of the systems. A good comparative study is also concerned with differences and demonstrates that what happens in one setting certainly would not occur in another. Finding similarities, different types of propositions, and different types of aspects are not contradictory to each other, but are complementary (Peters 1998). This aspect is well demonstrated in the variety of ways that OHS is implemented in EU member states. However, some diffusion, policy transfer, and learning can occur among EU member states, which increases the similarities.
4.2 Collection of data

The choice of data collection procedures was guided by the research questions and the choice of research design. All interviews were collected between 1999 and 2000, and other data continued to be retrieved until 2004. This information consisted of interviews, and a variety of publicly available documents and literature.

In analysing any public policy, the gathering of policy-relevant information takes place with qualitative data methods. That is followed by an analysis of documents and a description of how the policy was implemented, what influenced the policy-making, how successful the policy-making process was, and what impact the policy had (Milio 1987). A schematic and thematic framework for the scene, data collection, research methods, and approach was developed during the conceptualisation of the research process (Table 2).
Table 2. The thematic framework used to collect data in the study

<table>
<thead>
<tr>
<th>Scene for OHS in Europe</th>
<th>The changing regulatory environment and trends from treaties as an explanation for changes from harmonisation towards Europeanisation of OHS. From the Single European Act and four freedoms towards the trading of welfare services and increasing competition. Developing the social dimension and social dialogue towards Social Europe and Health of Europe through harmonisation of regulations, open method of coordination, benchmarking, and exchange of best practices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, social, industrial relations, and health and safety policies from the 1990s until 2000-2004</td>
<td>OHS requirements for OHS by ILO, WHO, EU, and EU member states</td>
</tr>
</tbody>
</table>

Table 2. continues...
<table>
<thead>
<tr>
<th>OHS policy development phases and major stakeholders</th>
<th>Research approach</th>
<th>Source of information</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legislation and legitimacy of OHS policy, Priorities of the policies, Goals and means of OHS, Decision makers and major stakeholders in OHS, Implementation and stakeholders’ role, Monitoring of OHS</td>
<td>Comparative data and analyses on phases of social dimension, industrial relations, and health policies</td>
<td>Documents, legislation, policy papers, annual reports, evaluations, and scientific articles</td>
<td>Analysis of legislation and policy papers</td>
</tr>
<tr>
<td>Stakeholders and their agendas, goals, priorities, position, authority, and influence on OHS</td>
<td>Interviews of 92 stakeholders in 15 EU member states</td>
<td>Interviews of major stakeholders, Organisational and public document data sources</td>
<td>Comparative case study</td>
</tr>
<tr>
<td>Interpret and analyse interviews and documents</td>
<td>Analyses of qualitative comparative case study based on topic areas</td>
<td>Documents and semi-structured interviews</td>
<td>Systematic and qualitative data analysis using applied policy research and framework method, which is a process to determine meanings and connections as well as to sift, chart, and sort materials according to key issues and themes. This was followed by interpretations and conclusions from the interviews.</td>
</tr>
</tbody>
</table>
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

4.2.1 Literature and document analysis

Literature and document analysis was used to describe OHS systems in EU member states and to make interview protocols, formulate research questions, and contextualise OHS within policy processes. Documents take many forms: scientific journals, in both print and electronic form, were used; information from several Internet pages was retrieved; and publications from seminars, conferences, and other scientific gatherings were consulted. The aim was to get an overview of OHS systems, get theoretical background for the study, and look at the reasons for such diversity in OHS development. A thorough understanding of the overall welfare state development and the EU policy process was needed to understand the OHS development. This ensured the knowledge and understanding of the environment where OHS development occurred, and it was a base for conclusions of the study.

When the context of OHS was understood, the extent and boundaries of the document analysis was decided. The boundaries for the document analysis were laid down, and an effort was made to avoid 'scope creep.' The documents were listed, read, and reviewed; maintained as paper or electronic copies; and kept accessible during the whole process of thesis writing. The documents were filed based on author, publisher (European Commission, Council of Europe, OECD, etc.), or topic (health reforms, welfare state, country-based information, etc.).

In retrieving documents from Internet pages, a series of questions was asked to determine the suitability of the documents. These questions included who the author was, what the institute was, what sources were used for the content, what the publication date was, whether the document was obsolete, who the target audience was (seminar, conference, scientific, etc.), and whether the document was part of a project or programme and if so who funded the project or programme. This analysis provided a phase that specified attributes for further retrieval or discarding of documents and search words. The main determinant for filing was the document's content and questions about it (i.e., what is the content, where or for which topic can the content be used, will the content be used in several occasions, and when will the content be used). All the documents used were open, and no confidential documents were used. The documents were stored in multiple formats, such as Internet pages, CD-ROM, PDF and HTML files, training materials, catalogues, and manuals. Scientific materials also came in several formats.
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

The database for this study was based on notes, legislation, documents from the Internet, documents from interviewees and libraries, tabular materials and scientific reports, and articles retrieved from e-journals and published journals. Notes were the results of interviews, observations, and document analysis (handwritten notes, tapes, transcribed tapes, and files on diskettes). The notes were organised, categorised, and completed for later use. In the case of documents, an annotated list of documents was developed as a reference list and computer files. Several databases (OECD, WHO, HFA, EUR-LEX) were used to retrieve statistics and other information. The main objective was to readily find the right documents when needed. Both qualitative and quantitative data were collected and used to analyse research questions.

4.2.2 Interviews

Qualitative interviewing is a method for discovering people’s experiences, the meaning of events to them, their feelings, and their 'lay theories'. The interviewer aimed to enable the person to reflect on and develop their ideas without introducing the interviewer’s own biases. The challenges of interviews are to recollect properly and avoid a selective view of the events. On the other hand, the interviewees might be more concerned with projecting the right image and with how they appear than with representing the truth. Due to these risks, triangulation and verification were used to confirm the information in the case of different facts between documents and other interviews (Yin 1994, Øvretveit 1998, Britten 1999). Different OHS concepts and variables emerged during the interviews in 15 different countries. I accommodated for those variations I was able to recognise during these interviews.

A procedure for approaching the interviewees was established. A letter was sent to possible National Collaborating Persons (NCPs), who were appointed in 15 countries (Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, The Netherlands, Portugal, Spain, Sweden, and the United Kingdom). The NCPs approached the candidate interviewees with a standard letter in English that included information, details of the purpose and method of the study, and use of results (Appendix I). The NCPs supported and organised the appointments for interviews.
The number of interviewees depended on the timing of visits in each country, availability of interviewees, and selection of interviewees by the NCPs (the recommendation was 5-6 interviewees per country). The interviews were conducted between October 1999 and February 2000. Most of the interviews were recorded, if permitted by the interviewee. The purpose of recording was to increase the reliability and validity of data collected. The researcher was also able to concentrate fully on asking questions and responding to interviewees’ answers. The interviews were transcribed according to the structured interview protocol. Interpretation of the interviews was used as needed. NCPs gave their best possible insight and views about OHS in their respective countries. Most of the NCPs were from research institutes, universities, and professional organisations already experienced in OHS-related research.

Semi-structured interviews were conducted on the basis of a planned structure consisting of open-ended questions from which the interviewer might diverge in order to pursue a response in more detail. The themes were chosen based on the literature review and research questions to clarify the OHS situation in EU member states. The themes were then split into several questions, which were presented to interviewees. The questions were also based on information gained before interviews, such as information on OHS organisation and legislative issues. In general the interviews took from one to two hours.

The themes of interviews follow (Appendix 1).

a. Structure of health service and OHS systems
b. Legislation of OHS
c. Policy of OHS
d. Stakeholders of OHS
e. Planning and implementation of OHS and OHS/QM
f. Monitoring, inspection, and evaluation of OHS
g. Financing of OHS
h. Integration of OHS
i. Promotion of OHS and OHS/QM
j. Training of OHS personnel
k. Indicators for the impact on the OHS (effectiveness and efficiency): health determinants and health outcomes
l. Overall impact of OHS
m. Personal assessment of OHS organisation in the country
The semi-structured interviews were pilot tested through telephone interviews conducted in English in Finland and Sweden. A total of 72 interviews were conducted with the participation of 92 people (table 3). Ten interviews included more than one interviewee.

The interview consisted of six types of questions: background questions at the start of the interviews, experience-based questions, opinion questions, questions requiring knowledge, questions on feelings and values, and questions related to actual participation and experience in OHS development. The interviews started with easy questions about the OHS system in their own country and then moved towards the details of the system, organisation, responsibilities, stakeholders, etc. To promote easy and flexible interviews, the order of questions varied; topics were taken up as they emerged during the discussion. Wording varied, because the interviewer tried to use the person’s own vocabulary when framing supplementary questions, and also because English was the main language used in interviews. Also, during the course of the qualitative study, the interviewer introduced additional questions as she became more familiar with the local topic being discussed.

The researcher took into consideration her perception by interviewees and the effects on the interview of such personal characteristics as class, race, sex, and social and cultural distance. In most cases, it was an advantage that interviewer’s profession was not the same as the interviewees. However, this might have caused some prediction by the interviewer of how the interviewee would answer questions using medical terms. The interviewees also asked the interviewer questions. These

<table>
<thead>
<tr>
<th>Institutes</th>
<th>No of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ministries</td>
<td>29</td>
</tr>
<tr>
<td>Research Institutes</td>
<td>17</td>
</tr>
<tr>
<td>Trade unions</td>
<td>14</td>
</tr>
<tr>
<td>Employers’ organisations</td>
<td>6</td>
</tr>
<tr>
<td>Insurance companies/institutes</td>
<td>8</td>
</tr>
<tr>
<td>Professional organisations</td>
<td>13</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 3. Number of interviewees in different institutes
were answered accordingly but cautiously, in order to avoid imposing the researcher’s own concepts into the interviews. On the other hand, if questions had not been answered, the interviewee’s willingness to answer the interviewer’s subsequent questions might have decreased. In some cases, the questions directly related to the topic were answered at the end of the interview.

The structured interviews were reviewed, discussed, and agreed upon in a workshop with the NCPS and representatives from relevant organizations in September 1999. The report on the results based on interviews was discussed and debated in a workshop in August 2000.

**4.3 Processing and analysing qualitative data**

The data – interviews and different documents – were analysed based on facts found in the interviews and confirmed in documents, or vice versa. In addition, the interviews consisted of opinion-related questions because actual data on OHS are scarce, as are data on the coverage and impact of OHS. Therefore the gathered data on interviews and documents guided the analysis. The analysis of rhetoric or discourse would have been difficult due to cultural differences and the languages used in the interviews. The qualitative data analysis aims principally to detect and define, categorise, theorise, explain, explore, and map the data. The method aims to define concepts (understanding internal structures); map the range, nature, and dynamics of phenomena; create typologies (categorising different types of attitudes, behaviours, and motivations); and find associations between experiences and attitudes, between attitudes and behaviours, and between circumstances and motivations. The ultimate aim is to explain a phenomenon and develop new ideas, theories, and strategies (Ritchie, Spencer 1994).

The process of qualitative data analysis involves identifying a theme and attempting to verify, confirm, and qualify it by searching through the data sources. After all data that matched that theme were located, the researcher repeated the process to identify further themes or categories. The next phase was coding or indexing, where themes were marked up. Indexing produced many categories; these were grouped together, and
the main themes and categories were selected for analysis. This process of rereading the data sources and sorting them into categories meant that the researcher developed an intimate knowledge of the data based on interviews and documents. The process was laborious, despite a word processor’s ability to split, copy, and separate analytical files. The issues were examined, hypotheses were developed, and further issues were examined to test these propositions.

The analytical method process is based on the original accounts and firsthand observations of the interviews and documents. The process is also dynamic and open to change, with addition and amendment occurring during the analytical process (Ritchie, Spencer 1994). The process of analysis for interviews and documents of OHS was systematic, allowing combinations of all similar units of analysis. The analysis was intended to be comprehensive, with a full review of the material collected.

The analytical process is a systematic process of sifting, charting, and sorting material according to key issues and themes (Ritchie, Spencer 1994). The interview scheme was a basis for the analysis of interviews, and documents were analysed in parallel to interviews or in the subsequent phase of document analysis. The analysis has five stages of familiarisation: identifying a thematic framework, indexing, charting, mapping, and interpreting (Ritchie, Spencer 1994). Familiarisation concerned listening to tapes, reading transcripts, studying observational notes, and retrieving documents. The material was selected based on this method; diversity of OHS systems and circumstances was studied; and the research agenda evolved during the study time.

During familiarisation, I identified, abstracted, and conceptualised themes. This phase is heavily descriptive, in that it devises and refines a thematic framework. The meaning, relevance, and importance of issues are judged, and implicit connections between ideas are made. The main aim is to label data into manageable pieces (Ritchie, Spencer 1994).

Indexing is a process where the thematic framework and themes are systematically applied to the data (Ritchie, Spencer 1994). In indexing, different major topics were connected and interwoven. Once the topics were labelled and categorised into themes, the researcher was able to access each reference and see patterns and contexts. In charting, data were lifted from the original context and rearranged according to thematic references and/or cases. Charting was followed by mapping and
interpreting. These are systematic processes to define concepts, map the range and nature of phenomena, create typologies, find associations, provide explanations, and develop strategies. The process continued with analysing charts and notes; comparing and contrasting perceptions or experiences; and searching for internal patterns, connections, and explanations in the data. Unclear themes, questions, or items were cleared up with NCPs, researcher colleagues, or through other documents. Some of the questions were deleted due to lack of answers or opinions.

4.3.1 Evidence-building in comparative multiple case study

A distinctive, though not unique, feature of multiple case study research is the use of multiple methods and sources of evidence to establish and construct validity (e.g., method triangulation). Triangulation was used to maximise confidence in the validity of findings. In triangulation, all data items are confirmed from at least one other source and usually also via another method of data collection. Only using one method can, arguably, produce results with weaker validity than using multiple methods. Using different methods and sources helps to address and strengthen the researchers’ beliefs in the validity of the observations. The use of triangulation in qualitative research tends to provide different sorts of insights. The strength of a case study is its ability to look for several types of evidence, such as documents, interviews, and observations (Yin 1994, Eskola, Suoranta 1998). Patton (1987) divided triangulation into four types: data, researcher, theory, and method. With triangulation, construct validity can be addressed, because the multiple sources of evidence essentially provide multiple measures for the same issue (Figure 4).

The interview material and some of the OHS documents, policy papers, and laws were collected between October 1999 and February 2000, when interviews were conducted in all 15 EU member states. Thereafter the development of OHS was followed through Internet pages and scientific publications. However, many of the documents related to policy processes, EU and national policies, and international organisations were collected until the spring of 2004.
4. STUDY DESIGN, DATA COLLECTION, AND ANALYSIS

The selection and choice of documents was guided by the experience gained and research questions. Hence information available after the framework directive was more important than information available before it. As learning accumulated, more documents were obtained on specific issues. However, the researcher did not get access to all documents sought. The documents were helpful as input for the interviews, and the documents made the interviews shorter because facts were available. The documents were important for tracing some history and stakeholders’ views of the past. The documents were also used to counteract the biases during the interviews. The documents provided most of the input for the study’s analysis and conclusions. The reference list of other interesting documents related to this study is published in Hämäläinen et al., 2001.
Documents and archival records are stable, they can be reviewed later, and they are exact in terms of names, references, and event details. They also have broad coverage and a long span of time with many events and many settings. On the other hand, documents and archival records can be biased; selectivity can lead to incomplete collection, and authors can be biased in their reporting. Also, access to documents can be blocked or restricted, and documents can quickly become obsolete (Yin 1998).

No single source of evidence has an absolute advantage over another. The various sources of information are complementary, and a good case study uses several sources of information (Yin 1998). The researcher had the difficult task of making a judgement about the findings of the study and determining its wider implications. The purpose of the steps followed in designing and building the case study was to maximise confidence in the findings, but interpretation involved value judgements and the danger of bias. Individual cases exhibited common characteristics and were assessed at the same time very differently. In some circumstances, the widely differing opinions of participants were very important and were reflected in the survey report. The case study approach enabled the researcher to gain confidence in both the internal and external validity of the findings, and to make comments with the appropriate level of assurance or reservation.

4.3.2 Analysing evidence in the multiple case study

The case study applied in this context is the combination of a descriptive and an explanatory comparative case study. The aim is to advance knowledge and understanding of OHS in the European context. The main reasons to conduct a multiple case study were that the researcher had little control over events, and the focus was on a contemporary phenomenon: OHS in the EU member states. A case study adds to the repertoire of direct observations of a topic and systematic interviews of stakeholders. The context and its richness created a challenge, namely that the study had more variables than data points, and it collected data from several sources to build up evidence. In searching for the cause-effect relationship in the development of OHS, the study can be seen as an explanatory case study. The aim of explanatory studies is to discover the occurrence of a phenomenon or event by providing causation or by showing the probability of factors influencing the event. A study can also
give an interpretation for an event or phenomenon in a certain context. Explanatory studies always consider context. They use comparison to discover whether a context does or does not explain differences or similarities and also to discover which aspects of context are important. Many such studies seek to explain the presence, absence, amount, or meaning of an item in different places by referring to differences in context and in how the item and context interact (Yin 1994, Øvretveit 1998).

Interviews and documents provided most of the descriptive data for OHS in general and OHS in EU policies. The research questions were related to the form and nature of OHS in the European countries to explain the situation. The research questions also aimed to find reasons for the existing situations. The study aimed to understand the effects and efficiency of OHS in each country. The purpose of some of the opinion-related questions in the interviews was to find new ideas, views, actions, and future prospects of OHS in European countries. Descriptive comparative health research aims to discover the presence of an item or phenomenon in different places, or to describe similarities and differences in comparable items. The descriptive study aims to generate hypotheses or theories. Descriptive comparisons are made where there is little or no previous research and where the aim is to explore and document (Øvretveit 1998). Data analysis consisted of examining, categorising, tabulating, or otherwise recombining the evidence to address the initial propositions. Analytic strategy techniques, such as pattern matching and explanation building, were generally used. As a general strategy, theoretical propositions about the causal relationships guided the case study analysis (how and why questions after the framework directive was announced).

The systematic analysis and open reporting of results facilitated the formulation of conclusions from the original views and observations of stakeholders. It was also possible to add views and research results from national and international researchers, institutes, and stakeholders during the analysing process.

The research aimed to explore diversity in order to generate descriptive conclusions on OHS in the EU member states. The results describe OHS in the complex international setting, where theory is a tool to construct interpretations from the collected material through a scientific method. On the other hand, theory is an aim itself to move from an individual case towards the general interpretation of the material.
5 THE POLICY ENVIRONMENT OF OHS

The policy environment consists of major actors, such as the EU, the ILO, and WHO, and their roles in steering OHS in EU member states (see Appendix II). OHS issues in the agenda of international organisations are shaped by the policy process and policy-making. In addition, policy process and policy-making also influence OHS in EU member states through harmonisation, convergence, and the Europeanisation of issues, processes, and implementation. This chapter gives an overview of the competence of the EU in relation to OHS, policy-making processes, and domestic changes named Europeanisation.

5.1 Contributions of the ILO and WHO to OHS

The ILO and WHO have both been active in promoting occupational health and OHS. The right to health and safety at work has been
stipulated in the Constitution of WHO⁹ (WHO 1946) and the ILO¹⁰ (ILO 1944). The Alma Ata Declaration (1978) emphasised that primary health care services should be located close to people, where they work and live.

The minimum requirements for a national occupational health system are legislation, consultation with social partners, surveillance of the environmental health conditions at work, health examination, first aid, a primary health care approach, curative health services and rehabilitation, special occupational health needs, cooperation and coordination, research, registers of occupational diseases and accidents, OHS, and training for occupational health professionals (Alli 2001).

The Governing Body convened the General Conference of the ILO to adopt the Occupational Health Services Convention 161 (1985). The basis for the convention was earlier documents, such as the Protection of Workers¹ Health Recommendation (1953), the Occupational Health Services Recommendation 112 (1959), the Workers’ Representatives Convention (1971), and the Occupational Safety and Health Convention and Recommendation 161 (1981). ILO Recommendation 112 (1959) defined occupational health service as ‘a preventive service established in or near a place of employment for the purpose of protecting the

⁹ WHO Constitution: Chapter II – Functions: Article 2: In order to achieve its objective, the functions of the WHO shall be: ‘(h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries; (i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; (j) to promote co-operation among scientific and professional groups which contribute to the advancement of health…’

¹⁰ Declaration concerning the aims and purposes of the International Labour Organization: ‘I: The Conference reaffirms the fundamental principles on which the Organization is based and, in particular, that (a) labour is not a commodity; … (d) the war against want requires to be carried on with unrelenting vigour within each nation, and by continuous and concerted international effort in which the representatives of workers and employers, enjoying equal status with those of governments, join with them in free discussion and democratic decision with a view to the promotion of the common welfare. … (a) all human beings, irrespective of race, creed or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom and dignity, of economic security and equal opportunity; (b) the attainment of the conditions in which this shall be possible must constitute the central aim of national and international policy; (c) all national and international policies and measures, in particular those of an economic and financial character, should be judged in this light and accepted only in so far as they may be held to promote and not to hinder the achievement of this fundamental objective…”
workers against any health hazard, which may arise out of their work, contributing towards the workers' physical and mental adjustment and contributing to the establishment and maintenance of the highest possible degree of physical and mental well-being of the workers.'

According to Recommendation 112, OHS should be provided to all workers, and the undertaking (company, organisation or similar) should make arrangements with a physician or a local medical service for administering emergency treatment. Recommendation 112 also underlined the national laws or regulations, and surveillance over hygiene conditions as a prerequisite for the progressive development of OHS.

The OHS Convention 161 made a more detailed description of OHS than earlier. Based on ILO Convention 161 on occupational health, services can be established by laws or regulations or by collective agreements or as otherwise agreed upon by the employers and workers concerned. OHS can also be established through approval of the competent authority after consultation with the representative organisations of employers and workers concerned.

OHS has the following functions, according to the Occupational Health Services Convention 161 and Recommendation 171 (1985).

(a) identification and assessment of the risks from health hazards in the workplace

(b) surveillance of the factors in the working environment and working practices that might affect workers' health, including sanitary installations, canteens, and housing where these facilities are provided by the employer

(c) advice on planning and organisation of work, including the design of workplaces; on the choice, maintenance, and condition of machinery and other equipment; and on substances used in work

(d) participation in the development of programmes for the improvement of working practices as well as testing and evaluation of health aspects of new equipment

(e) advice on occupational health, safety, and hygiene and on ergonomics and individual and collective protective equipment

(f) surveillance of workers' health in relation to work

(g) promotion of adapting the work to the worker

(h) contribution to measures of vocational rehabilitation
5. THE POLICY ENVIRONMENT OF OHS

(i) collaboration in providing information, training, and education in the fields of ergonomics and occupational health and hygiene

(j) organisation of first aid and emergency treatment

(k) participation in analysis of occupational accidents and occupational diseases.

ILO Convention 161 and Recommendation 171 on occupational health services (1985) defined occupational health services as preventive and responsible for advising employers and employees about the requirements for establishing and maintaining a safe and healthy working environment. Convention 161 emphasised the importance of a multi-disciplinary approach and multisectoral collaboration. Recommendation 171 included curative health care and the provision of general primary health care services as part of OHS.

Research conducted by WHO (1990) identified a well-developed OHS as having the following functions: surveillance of the work environment, advice on the control of hazards at work, surveillance of workers’ health, follow-up on the health of vulnerable groups, adaptation of work to the worker, the organisation of first aid and emergency response, health education and health promotion, collection of information on workers’ health, provision of curative services, and provision of general health care services. Both national requirements and OHS units in applying the requirements were key actors in improving health and safety at work.

Other relevant documents for OHS are the Global Strategy on Occupational Health for All (WHO 1995), Health for All 2000 (WHO 1981) and Health for All 21st Century (WHO 1999a,b). The Global Strategy on Occupational Health for All was prepared by WHO Collaborating Centres in Occupational Health in 1995 and emphasised prevention; promotion, adaptation and adjustment of working conditions to the worker; rehabilitation; curative services; and first aid. Occupational health was considered a basic element in social and health development.

\[11\] Occupational health service means services entrusted with essentially preventive functions and responsible for advising the employer, the worker and their representatives in the undertaking on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relations to work and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health and the term 'workers' representatives in the undertaking' means persons who are recognised as such under national law or practice (Art. 1 ILO Convention 161).
OHS was a catalyst for change at worksites to improve the management and control of hazards at work. The Global Strategy on Occupational Health for All aimed to create modern OHS through a multidisciplinary approach to protect and promote workers’ health in the work environment and among workers’ themselves. Health for All 2000 mentioned relevant disciplines for OHS, such as occupational medicine, nursing, occupational hygiene, work physiology, physiotherapy, ergonomics, safety, and work psychology (WHO 1999a,b). WHO also published a booklet about occupational medicine and competencies in Europe to develop the training and discipline of occupational medical doctors to build a new multidisciplinary model for OHS (MacDonald et al 2000). Earlier Occupational Safety and Health Recommendations 14 (1981) of the ILO already defined tasks for competent people in relation to occupational safety and health and the working environment. The recommendation defined cooperation and tasks among workers’ safety delegates, workers’ safety and health committees, joint safety and health committees, and employers. The recommendation also made provisions for the availability of OHS, safety services, and specialists to advise on particular occupational safety and health problems.

In May of 1998, WHO adopted a resolution in support of the new global Health for All Policy (World Health Assembly 1998). The new policy, Health for All in the 21st Century, succeeded the Health for All by the Year 2000 strategy launched in 1977. In the new policy, the worldwide call for social justice is expanded, and all member states are supposed to set their own targets within this framework, based on their specific needs and priorities.

The basic values in the WHO European Region based on HEALTH21 are health as a fundamental human right; equity in health and solidarity; and participation and accountability of individuals, groups, institutions, and communities for continued health development. The European
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Region has put forward 21 targets for health for all\(^\text{12}\). Target 13 refers specifically to a healthy physical and social environment in the workplace. In particular, Target 13 notes that workplace accidents should be reduced and at least 10% of medium- and large-sized companies should commit themselves to practising healthy enterprise principles. In the area of multisectoral strategies for creating sustainable health (Target 14), mention is made of workplaces ‘to reduce exposure to risks, but also to increase employers’ and employees’ participation in promoting a safer and healthier working environment and reducing stress.’ A policy oriented toward health for all should engage individuals, groups, companies, and organisations to agreed targets and an action programme (Target 20) with the support from OHS to address not only the prevention and treatment of accidents and disease, but also broader issues of healthy lifestyles and environment. Better social relationships at work ultimately contribute to higher staff morale and productivity (WHO 1999a,b).

The principles of a ‘healthy company or enterprise’ include a safer working environment, and a safer working environment includes preventing and controlling physical hazards, screening for occupational risks and diseases, healthy working practices, health promotion, and the health impact of company products. OHS can observe all aspects of the relationship of occupation and health and focus on preventive services and work safety. However, OHS should work in liaison with primary care settings (WHO 1999a,b). The targets expand the role of employers and specify health-promoting activities at workplaces. Whether the ‘healthy company or enterprise’ slogan will get support among enterprises depends on the support from regulatory agencies and insurance practices in EU member states.

\(^{12}\) The health for all policy framework for the WHO European Region: Target 1 – Solidarity for health in the European Region; Target 2 – Equity in health; Target 3 – Healthy start in life; Target 4 – Health of young people; Target 5 – Healthy aging; Target 6 – Improving mental health; Target 7 – Reducing communicable diseases; Target 8 – Reducing non-communicable diseases; Target 9 – Reducing injury from violence and accidents; Target 10 – A healthy and safe physical environment; Target 11 – Healthier living; Target 12 – Reducing harm from alcohol, drugs, and tobacco; Target 13 – Settings for health; Target 14 – Multisectoral responsibility for health; Target 15 – An integrated health sector; Target 16 – Managing for quality of care; Target 17 – Funding health services and allocating resources; Target 18 – Developing human resources for health; Target 19 – Research and knowledge for health; Target 20 – Mobilising partners for health; Target 21 – Policies and strategies for health for all
Despite having several conventions and recommendations, the actual impact of the ILO and WHO has remained weak, due to the non-binding nature of agreements. The ILO and WHO make their major impact through tight collaboration with member states, taking the initiatives further to the international level and also exchanging and providing comparative information to make a policy impact.

5.2 Policy-making process within EU

This section aims to contribute to the understanding of the nature of EU policy-making and specifically the policy processes that affect OHS. Both informal and formal policy-making and processes provide an opportunity for OHS actors to influence the direction of different policies, strategies, and activities. The EU represents new types of complex and multilevel decision-making and implementation processes. There are several ways to influence these processes, including informal routes. Since the 1990s the EU decision making and influence in relation to OHS increased in scope, depth, and volume. The monetary union, new treaties with public health aspects, and agreements on social rights have increased interest in the EU as a policy maker and its influence on national policy options and challenges.

The main impact of the Single European Act was that EU machinery became a suitable arena for policy-making instead of member state regulations, especially in the areas of internal market and competition policies (Wallace, Wallace 2000, Andersen, Eliassen 2001). This was encouraged from a distance by national parliaments’ interference in regulation formation. Bargaining processes in the Council of Ministers helped policy makers escape the rigid constraints of national policy-making (Majone 1996, Wallace, Wallace 2000). Contrary to many others, Moravcsik (1998) stated that the EU strengthened the nation-state, and decision making is primarily intergovernmental in the EU. This decision making is dominated by national interests, but governments are more able to manoeuvre decisions in the EU than in the member states themselves. Wallace and Wallace (2000) claimed that transnational public policy processes are embedded in political institutions with unclear definitions, and therefore
political actors have better access to the transnational policy processes than processes in member states and their institutions.\textsuperscript{13}

Another policy-making view is the perspective of multilevel governance\textsuperscript{14} (Marks 1993, Kohler-Koch 1996, Marks et al. 1996, Peterson, Bomberg 1999, Wallace, Wallace 2000). Multilevel governance means that the policy-making process happens in different locations, such as in the member states, EU institutions, regions, or elsewhere. Some researchers state that the multilevel governance within EU reduced the political powers of the states and especially local and regional politics (Wallace, Wallace 2000). The functioning of different institutions, the decision-making, and the implementation processes are agreed in treaties signed by the heads of governments. The European Council, Intergovernmental Conference (IGC), or the European Court of Justice (ECJ) make historical policy decisions at a supersystemic level (Wallace, Wallace 2000, Peterson, Bomberg 1999). The treaties can be changed only in IGC. The process of IGC and the amendment of treaties define the competencies of the European Communities in relation to member states.

The Maastricht and Amsterdam treaties brought an expansion of the European Commission’s role in policy-making. That meant deepening the power and strengthening the competence of EU institutions in relation to EU member states (Nugent 1999). In principle, the processes of reviewing the treaty in Maastricht, Amsterdam, and Nice strengthened intergovernmentalism. However, they also produced a number of policy-making and legislative decisions in the social, health, and occupational health and safety areas. The treaties resulted in action in the public health arena, into which the single European market principles incrementally spilled over; this produced unexpected consequences. In addition, the ECJ made decisions about applying competition law and the four freedoms to health services, which indirectly affected OHS\textsuperscript{15}.

\textsuperscript{13} See Appendix II for the description of major institutions of EU and international organisations.

\textsuperscript{14} Governance refers to the impositions of overall direction or control on the allocation of valued resources. Governance results from a mix of factors, including political leadership, state-society relations, institutional competition, and electoral politics (Peterson, Bomberg 1999).

\textsuperscript{15} For example the following judgements by ECJ: C/120/95 Decker, C-158/96 Kohll, C-368/98 Vanbrackel, C-157/99 Geraets-Smits, Peerbooms, C-385/99-1 Müller-Fauré, van Riet, C-56/01 Iniyan, C-322/02 Weller, C 454/02 Bautz and C-145/03 Keller.
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Typically, the EU and its policy-making has been studied from an intergovernmental approach with international politics perspectives. The main focus has been the policy-making arena in intergovernmental negotiations (Moravcsik 1998). The other approach has been a functional or institutional approach underlining functional relationships, where the political process had a role to play in the way the institutions shape decisions on health strategies (Saari 2003). The third perspective is a descriptive EU legal-administrative-political system in relation to national systems (Raunio, Wiberg 1998, Hix 1999, Goetz, Hix 2001). The development of the modern welfare state concentrates around structures and functions or societies and policies. The structure-functional approach is connected to convergence theory; for example, policies and programmes in different countries become similar as the countries become wealthier (Wilensky 2002). The sociopolitical approach is related to regime theory; for example, policies and programmes vary due to different types of welfare states and adaptation to different sociopolitical circumstances (Pierson 2001, Van Voorhis 1998). Both have their methodological weaknesses, but both have promoted comparative welfare state studies (Van Voorhis 2002).

Formal institutions provide a framework for policy-making, but there are many variations in outcomes. The complex EU structure and heterogeneity of EU member states creates a variety of subsystems for policy-making and policy-processes. Also, actors bring their own styles, strategies, and tactics. The EU as a complex structure refers mainly to transnational policy-making and authority (competence). The EU as an authority and extension of EU scope and policy issues has meant incremental creeping of the EU into national policy-making and Europeanisation of policy-making and policy processes (Andersen, Eliassen 1993, Andersen, Eliassen 2001, Radaelli 2000b, 2004). The scope of national policy-making includes EU institutions, the European networks of national policy institutions, and the actors in EU and national arenas. On the other hand, such global actors as the WTO and United Nations’ specialised organisations have an impact (Andersen, Eliassen 1993). However, the facilitators for the policy-making between EU member states and EU institutions have an established tradition of cooperation and exchange of views. In addition, member states rely on bureaucratic and responsible behaviour among officers, administrative neutrality, and
5.

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respect for expertise. The benefits of cooperation among EU member states are considered higher in the long term, when views and practices are exchanged. This is considered an advantage when issues are diffused to other countries and when issues that are jointly considered to be important build trust among states. However, the intensive cooperation in policy-making seems to be more to manage differences than as an instrument of convergence (Wallace, Wallace 2000).

The EU policy process is in constant flux, and its outcomes are often uncertain. It swings between national and transnational arenas. This fluctuation varies according to policy areas over time and among countries. In addition, the policy process and its strength vary. The EU policy process can also be seen as competition between national and transnational arenas to provide effective or authoritative results. Policy-making in the EU occurs both in formal and informal arenas and is usually sporadic and sometimes unintentional (Leibfried, Pierson 2000, Duncan 2002). This applies to all policy-making stages, levels, channels, and procedures, such as setting an agenda, representing an interest, and implementing a policy. Sometimes there are no solid results in any of these arenas, and sometimes the results are remarkable (Wallace, Wallace 2000).

In this study an attempt is made to look at the EU’s impact on EU member states not as separate entities, but as a complex interplay among actors, stakeholders, policy arenas, and policies causing the Europeanisation of several policies, including social, health, and occupational health and safety policies. EU member states and their national histories and cultures are complex in relation to the welfare state and policy-making (Chamberlayne et al. 1999). A comparison of welfare state typologies is considered as one aspect in explaining differences in OHS provisions. OHS as a social welfare benefit creates a buffer against treating human labour as a commodity to be had for the lowest price. The different welfare states provide varying OHS systems with different coverage, eligibility, inputs, and incentives (or disincentives) to provide OHS and benefit level. This variety is explained by the maturity of the welfare state.

The majority of the work in relation to OHS as an entity was done in the 1980s regarding Framework Directive 89/391/EEC. The 1990s mostly consisted of following up on the transposition and implementa-
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tion of the framework directive and sister directives. However, the main
trend has been that more EU policy responsibilities are given to the Com-
mission and the European Council to decide and implement (Mossialos,
McKee 2002a,b, Hämäläinen et al. 2003). Country variations are vast in
the implementation of directives on health and safety at work; and de-
gree and direction of harmonisation, convergence, and Europeanisation
varies among countries. In social, health, and occupational health and
safety policies, neither the country nor the EU seems to have coherent
and consistent policies or policy outcomes. Policy responsibilities are
divided among different ministries and institutions, but they are intercon-
nected between the member states and the EU through different types
of actions. This means that in the analysis of policies, such as OHS, the
European political system becomes the unit of analysis; and the scope
of national policy-making has to include the central EC institutions,
the European network of national political institutions, and the actors
operating at both levels. The national-level actors were interviewed for
this study on OHS, and the European political system for OHS has been
described based on documents. Also, the transnational institutes, such
as the European Agency for Health and Safety at Work, the European
Foundation for Working and Living Conditions, Advisory Committee
on Health and Safety at work in the Commission, and the Council of
EU, have been taken into consideration.

5.2.1 Formal policy-making

The classical definition of EU policy processes used to be that the Eu-
ropean Commission proposes, the European Parliament advises, and
the Council of Ministers decides. The Single European Act and the
Maastricht Treaty changed the situation when the three pillars of the EU
were formed: Policies of the European Community, Common Foreign
Security Policy, and Justice and Home Affairs. The first pillar includes
the activities related to social, health, employment, and occupational health
and safety policies, for example. The decision making seems to have
been moving to a higher level of supranational authority with majority
voting in the Council and a stronger role for the European Parliament.
Within the first pillar of EC policies, current decision making consists
of proposals from the Commission and joint decisions by the Council
At the European level, such organisations as the Council of Europe, Organisation of Economic Co-operation and Development, and United Nations’ organisations and their European offices (e.g., WHO, ILO) are also working on social, health, and occupational health and safety policies. The role of the Council of Europe has been mainly in human rights mainly due to its lack of resources. WHO and the ILO have roles as leaders of health and social policies within European countries and as producers of policy-relevant documents, which emphasise and originate from the values of human dignity and humanitarianism. The OECD has become the evaluator of health and social services systems and policies among competitive hegemonies (e.g., Japan, the EU and the United States) and has regularly published benchmarks for the development of health, social, and labour market policies.

The Council of the EU and the European Parliament mostly bargain with national preferences and policy-setting decisions at the systemic level. The Council of the EU usually agrees on the minimum standards and the direction of harmonisation, complemented with mutual recognition of national preferences. At the subsystemic level, the policy-shaping decisions are made by the Commission, Council working groups, and EP committees; and this shaping itself determines policy details and policy options (Peterson, Bomberg 1999). Much of the policy-making in the EU occurs below the Council of Ministers and Commissioners. In fact policies are formed by the experts and officers of EU member states, such as the Advisory Committee on Safety and Health at Work. The Commission plays a major role in shaping the decisions of the Council and the European Parliament through implementation. The volume and technical nature of legislation means the Commission staff and the Council are responsible for much of the drafting, decision making, and processes of agreeing on legislation. In addition, economic and societal actors are consulted and have influence on European market rules formation (Majone 1996, Wallace, Wallace 2000). However, the methods of implementation among the directorates of the Commission vary between neoliberalism (competition) and interventionism (environment) (Gini 1997).

EU policies are segmented, and policy coordination is weak and fragmented. Social policy is divided into social, health, labour market, and consumer affairs; and each of these has several subpolicies, such as health and safety at work. There is coordination among the Direc-
torates General, the Committees at the Council, and the Commission, but further development of efficiency and effectiveness is needed. This reflects the challenge of different political levels of decision making and ways and levels of influencing decision making. Experts usually participate in the Committees of the Commission, whereas political decision makers participate in the Committees of the Council (e.g., representatives from the EU Representation or political decision makers from the ministries) (Cini 1997). Administrators play as great if not a greater part of all stages of the policy-making process as do executives and legislators. Implementers won’t always be winners despite tactical and strategic advantages (Palumbo, Calista 1990). Courts, such as the ECJ, have come to play a more active role in interpreting EU treaties about implementation. Because of this, administration and courts have sometimes become rivals.

The formal institutions in EU member states play a crucial role in the changes, reforms, and reorientation of OHS systems. However, the increasing interaction among countries and the creation of new entities for collaboration among countries also bring new institutions to direct the change or stagnation on international and national levels. Policy-making, decision making, implementation, and compliance are challenging, because interaction can occur in so many forms (networks, working groups, committees or clubs for joint actions in promoting health and safety at work) and frames (intergovernmental, supranational, multilateral). The norms produced in interactions shape the national social and health service systems, but compliance with these norms varies among countries due to differences in enforcement, sanctions, structures, and capacity of the countries to deal with the issues (Linos 2003).

The role of institutions, their autonomy, and the nature of the EU systems modify the interpretation of the decision-making processes and openness to present interests in various policy areas (Wallace, Wallace 2000, Anderson, Eliassen 2001). The actors, such as EU member states, EU institutions, and interest groups, play different roles in different policy areas; and formal decision-making procedures apply differently in different sectors. Also, the values differ among policies and sectors; there is more of a free market orientation in negative integration and more of an intervention orientation in positive integration (Scharpf 1999). Competition policy has also become increasingly supranational (McGowan, Wilks 1995).
5. THE POLICY ENVIRONMENT OF OHS

Ministries, national occupational health and safety institutes, and professional organisations all play an important role in any changes, usually in implementing issues that have been agreed on internationally. The interests and focus areas of the member states are not always easy to establish within countries. Interest satisfaction plays a crucial role in national and international policy processes, and the same actors are often involved in bargaining at different locations for political action. Location might be regional, national, or European, and there might also be different policy domains (Walt 1994, Peterson, Bomberg 1999, Elgström, Jönsson 2000). Besides the political orientation of governments, national institutions exert an influence on the scope, character, and style of policy-making, policy processes, and change implementation. They create the political incentive, the structure of policy-making, and the degree of influence and power. Policy actors can bring these to the policy processes. The national institutes share the structures of political debate, mediate preferences, and alter policy choices. The administrative capacities, implementation and delivery, and decentralisation of the government vary among countries. Industrial relations also affect individual policy areas, depending on their independence from state interventions, self-regulations, and involvement of social partners in the management of welfare programmes (Hemerijck 2002). In the case of occupational diseases, injuries, and accidents, most countries have representatives of trade unions and employers’ organisations on the boards of insurance companies. If unions share institutional roles with governmental institutions, they cannot be ignored when making reforms. Political institutions might limit the repertoire of feasible policy options, but they also act as a resource for decision making (Hemerijck 2002).

5.2.2 Informal policy-making

Informal policy-making has several locations, means, actors, and influencing powers in the EU policy-making and policy processes. It is a complex system, and in some cases informal policy-making is more important than its formal counterpart. Major choices, issues, and contents are sometimes decided in informal negotiations, bargaining processes, and lobbying activities. To understand informal policy-making, one has to know how ideas reach the policy agenda. The characteristics of the EU
negotiation process are a diversity of negotiating contexts, occasions, and levels; a diversity of actors and preferences; a diversity of strategies, negotiation styles, and communications; and a diversity of outcomes in bargaining and problem solving (Peterson, Bomberg 1999, Elgström, Jönsson 2000, Elgström, Smith 2000).

5.2.2.1 Negotiation and bargaining

Ideas are important in shaping policy process and can come from different policy areas, stakeholders, interest groups, member states and their institutes, and the private sector. When ideas have been accepted, policy formulation and negotiation of policy content begins. The bargaining and compromising process to resolve conflicts includes defining problems, finding ideas for solutions, and designing policy to seek solutions. Identifying problems and their solutions depends on the ideology of individuals or groups, and a perfect fit is seldom reached (Palumbo, Calista 1990, Greenwood 2003). However, EU negotiations include bargaining as well as problem solving, which means that there is a strong desire for consensus, which in turn leads to lowest-common-denominator solutions. The negotiation and bargaining depend on politicisation, type of policy, and stage of the decision-making processes (Walt 1994, Peterson, Bomberg 1999, Elgström, Jönsson 2000). Therefore, policy issues and the impact of events test the capacities of negotiating partners and reveal many of the key features of the European policy process. The ways of achieving consensus vary over time and according to topics. Sometimes an idea moves quickly due to outside pressures, such as the media or an emergency situation, and sometimes an idea ‘pops in’ several times without any larger step forward, but nevertheless gets accepted and moves smoothly and slowly forward.

Both procedures and practice are important in policy processes and may initiate or close the option for new policy openings (Kingdon 1995). Several policies have an impact on policies close to them through diffusion, exchange of ideas, and peer pressure. In moving ideas towards becoming policy, building a consensus is often the key to the policy process, but this has its own rules, procedures, policy processes, and requirements for cooperation. The willingness to get certain policy outcomes has built clientelism—for example, lobbying around the EU
5. THE POLICY ENVIRONMENT OF OHS
	policy processes—and has made the acceptance of ideas, the decision making, and the policies somewhat distant from ordinary people. On the other hand, the EU process both constrains and multiplies the options of ideas, policy approaches, and ways of proceeding for collective action among EU member states (Wallace, Wallace 2000, Andersen, Eliassen 2001). The ideas in the area of OHS might appear in social, labour, health, or industrial relations policies by the different stakeholders and their lobbying of committees, advisory groups, and key people.

Negotiation can be considered a process, system, or order that all contribute to the understanding of European integration and policymaking (Elgström, Smith 2000). Wallace and Wallace (1996) noted that the European policy process depends on negotiation as a predominant mode of reaching agreements on policy and of implementing policies once agreements are reached. The negotiations occur in different committees, advisory groups, Council of Ministers meetings, and between the Commission and social partners or social and economic committees.

Because issues in the EU are complex and require a high level of expertise, the working groups in the Council of Ministers, as well as Rapporteurs and Committees in the Parliament and in the Directorates General are gaining influence. This has strengthened the power of policy networks with a variety of more or less permanent structures. This might signify that informal networks could have more influence than the formal ones (Greenwood 2003). This is the case when the Commission is obliged to consult social partners on social policy proposals. However, the approach is more one of 'negotiate or we will legislate' than real consultation (Andersen, Eliassen 2001).

Elgström and Smith (2000) considered the EU to be a negotiation system with three fundamental properties: interdependence of actors, regulation of interactions, and the presence of rules or institutions. Negotiations are also influenced by an informal principle in which all member states are supposed to gain something from the negotiation. EU negotiations are permanent, linked, and continuous; and member states expect to get long-term favours from them. Concessions are gained in the negotiation processes, but reciprocation of favourable behaviour is expected sooner or later. This has implications for the evolution of expectations and the generation of negotiation strategies. Negotiation parties are important. The multilevel governance considers that the EU
decision-making process involves a multitude of players at different levels; these include private and public actors, expert groups, working parties, and committees, in addition to informal networks. Network coalitions typically emerge to govern sector policies, and leadership and mediator roles are played by the Commission, the president, and individual member states (Richardson 1996, Peterson, Bomberg 1999, Elgström, Smith 2000). The formal negotiation process is closely related to informal negotiations, in that they both involve expert groups, working parties, comitology committees, and informal networks (Peterson, Bomberg 1999, Elgström, Smith 2000). Networks and informal contacts are viewed by the Commission as major instruments to promote effectiveness and flexibility (Greenwood 2003). EU negotiations include links between levels and sectors internally, as well as links between internal and external negotiations (Elgström, Smith 2000).

5.2.2.2 Concessions and lobbying

EU negotiations include tough bargaining and strong consensus norms in different committees. On the other hand, evidence exists of very confrontational behaviour that often leads to lowest-common-denominator solutions. The day-to-day negotiations in the EU are to a large extent a problem-solving exercise. Under certain circumstances, however, conflictive bargaining occurs. The pattern varies according to the level of politicisation, the type of policy, and the stage of the decision-making process. The spread of decision making by majority voting promotes coalition-building behaviour. Coalition patterns depend on policy interest, cultural affinity, power, and ideology (Elgström et al 2001). Processes of learning have resulted in changes in the EU’s negotiation style: problem solving has become increasingly institutionalised within the EU machinery (Elgström, Jönsson 2000).

Lobbying brings informal influence to shaping and making decisions. Several stakeholders, of whom some have more influence and impact than others, express their views in the policy-making process. EU lobbying includes activities aimed at gathering information and establishing oneself as an actor (Greenwood 2003, Elgström, Jönsson 2000, Andersen, Eliassen 2001). Lobbying concentrates on the initiation phase of any policy. The major lobbying actors in occupational health
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and safety are insurance companies, professional organisations, public health organisations, and some networks, organisations, and institutions that receive funding from EU programmes. Direct lobbying of EU institutions--such as members of the Commission and the Council, and their different Committees and officers--form an important part of the decision-making process (Elgström, Smith 2000, Andersen, Eliassen 2001, Greenwood 1997). In addition, the process of social dialogue between employers’ and employees’ organisations forms a platform for negotiating and forming consensus for occupational health and safety issues, including OHS.

5.3 Competence of the European Community in OHS

The European Community may use several instruments in the area of social policy to enforce actions. According to the Presidency Conclusions of Nice (2000), the methods can be coordination, regulation, social dialogue, structural funds, support programmes (such as a public

16 Following the treaties of Paris (1951) and Rome (1957) there were three distinct communities: the European Coal and Steel Community (ECSC), the European Economic Community (EEC), and the European Atomic Energy Community (EURATOM). Each had its own separate legal identity until the signing of the Merger Treaty in 195. This established a common set of institutions for all three communities, but it did not get rid of the distinctive legal and policy-making identities of each community. Nonetheless, the term European Community (or more precisely European Communities), abbreviated to the EC, came into accepted usage.

The matter became complicated with the drafting, negotiation, and ratification of the Maastricht Treaty on the European Union of 1992. This renamed the EEC as the European Community and created a three-pillar structure for the European Union (EU) - the new umbrella term. Pillar I was the EC, pillar II the Common Foreign and Security Policy (CFSP), and pillar III was Co-operation in Justice and Home Affairs (JHA). The procedures for decision-making under pillars II and III were quite distinct from pillar I, giving very little input to the supranational institutions (Commission, Parliament, and the Court of Justice).

Attempts were made in the negotiations for the 1997 draft Treaty of Amsterdam to give legal personality to the EU and thereby make the consistent use of the term ‘EU’ much more accurate. For many reasons, this development – which would have meant that the EC was superseded by the EU – did not make the final draft. Roughly speaking the EU includes, but is not identical to, EC & ECSC & EURATOM & pillars II and III. Areas such as the single market are still EC, not EU. The Commission is not the Commission of the EU, but still the Commission of the European Communities (Translator Saarelainen 2003 in personal communication).
health programme), integrated policy approach, research, mainstreaming, directives, and cooperation. Both hard and soft methods are used in the area of occupational health and safety. Hard methods generally include treaties, regulations, directives, and agreements, while soft methods consist of open coordination, reflection groups, advisory committees, and communications as an initiative from the Commission. Instruments of EC law (treaties, regulations, and directives) bind states to uphold labour and social standards (Rhodes, Cass 1996, Knill, Lehmkuhl 1999, Knill, Lehmkuhl 2002).

Instead of hard legislation, soft methods (e.g., recommendations, observations, benchmarking, best practices, and other non-binding documents) facilitate policy exchange and promote policy learning and diffusion of ideas among EU member states (Majone 1993, Savio 1995, Wallace, Wallace 2000, Anderson, Eliasssen 2001). The impact is indirect policy-making by the EU machine without necessarily any political or legal mandate. On the soft law side, the EU has expanded to an open method of coordination among member states in several social policy areas (de la Porte et al. 2001). The structural funds provide substantial monetary incentives for policy-making to benefit poor regions, sectors, and individuals (Anderson 1996, Wallace, Wallace 2000). There has been a move from governance based on hard regulation towards the use of soft methods for exchange practices, information, and benchmarking.

5.3.1 From treaties to the new treaty in 2009

Treaties form the base and legitimation of the EU activities in OHS. Activities in occupational health and safety are based on articles about social policy in the Treaty of Rome, later altered by the community treaties (the Single European Act (SEA), the Maastricht Treaty, the Amsterdam Treaty, and the Nice Treaty). The Treaty of Rome established the European Economic Community in 1957 and laid the groundwork for the creation of a large market area. Since then, health and safety at work

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17 The 1956 Treaty of Rome restricted imports and exports to protect human health (Article 36) and guaranteed the free movement of services and the right of establishment, which included the health professions (Article 52-59). Health and safety at the workplace was mentioned in the 1951 European Coal and Steel Treaty (Article 2) and in the 1956 European Atomic Energy Community Treaty (Article 30-39), and was applied to the workers in those specific industries. The Treaty of Rome extended these health and safety provisions to cover other industries.
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has been in the core area of action for the European Community. Treaties have emphasised workers’ rights and conditions in order to facilitate the free movement of labour among EU member states. Article 117 of the Treaty of Rome introduced the harmonisation of social systems of EU member states and directed the European Council to act in relation to the free movement of the labour force and social protection. This was a significant beginning for the development of health and safety at work as a work-based benefit among EU member states.

The Single European Act (SEA) in 1987 sped up the passage of regulations about workers’ health and safety. The SEA\(^{18}\) provided the basis for a specific occupational health and safety policy to be developed for the first time, and it became part of the social dimension of the EU Single Market (Belcher 1999). The SEA defined more specifically the ‘four freedoms’ (free movement of goods, people, services, and capital) for the European Single Market. The SEA\(^{19}\) advanced the social protection rationale. The five important developments for social policy were the principles of subsidiarity, citizenship in the Union, amendments to the social policy title of the treaty, economic and social cohesion, and the social policy protocol and agreement (Nielsen, Szyszczak 1997). The provisions were by nature binding, such as the approximation of national provisions in relation to health, safety, environmental protection, and consumer protection,\(^{20}\) the working environment, the health and safety of workers,\(^{21}\) and the economic and social cohesion of the Community.\(^{22}\) Non-binding provisions concerned the social dialogue between employers and employees.\(^{23}\) The SEA confirmed that qualified majority voting\(^{24}\) would govern occupational health and safety issues as well as environmental and consumer protection issues. This increased the ability of the Council of Ministers to make decisions without member states using veto rights to withdraw proposals of directives from the agenda (Walters 2002a). The nature and scope of action in the field of health and safety has been based in part on the interpretation of the Treaty.

\(^{18}\) Article 118a
\(^{19}\) SEA was accepted in 1986 and in force in 1987
\(^{20}\) Article 100a
\(^{21}\) Article 118a
\(^{22}\) Articles 130a to 130e
\(^{23}\) Article 118b
\(^{24}\) Article 100a
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The occupational health and safety entity of the Treaty originated from a proposal by Denmark, where the concept of the workplace was broad and dynamic and included ergonomic measures, psychological factors, and training in health and safety in addition to the health and safety of workers (Venturini 1989).

The Maastricht Treaty and the Agreement on Social Policy was signed in 1992 by member states, except the United Kingdom, and set out European policy in the areas of working conditions (Savio 1995, Kari 1997, Nielsen, Szyszczak 1997). The Maastricht Treaty defined new action areas of social policy, but it did not give a wider spectrum for action. However, attention was given to employment, which was important for social policy and financing of social security and protection (Pakaslahti 2001). The social dimension of the EU also faced a shift away from uniformity towards such aims as coherence, coordination, cooperation, mutual recognition, and convergence--instead of a legislative route to harmonise social policies. This is also an important shift in relation to Framework Directive 89/391/EEC and OHS. In the Maastricht Treaty, the social chapter and its articles formed the actual social policy articles. The social chapter referred to social dialogue among labour market organisations and demonstrated the objectives of the EU in developing working and living conditions, occupational safety and health, social dialogue, and equal pay, for example. Other entities concerned the free movement of labour and professionals, and the cohesion entity emphasised underdeveloped areas to support their social policies. In addition, public health, vocational training, and consumer protection can be considered part of social policy in the EU. First time in the Treaty appeared public health article emphasising health promotion and prevention of diseases and attainment of a high level of health protection, but emphasised that harmonisation of national laws and regulations was not the aim. A further public health article

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25 also called the Treaty on European Union
26 Articles 117, 118, 118a, and 119
27 Article 118c
28 Articles 48-59
29 Articles 130a-130e
30 Article 129
31 Articles 126-127
32 Article 129a
aimed to ensure a high level of human health protection by encouraging cooperation between EU member states.

The Amsterdam Treaty (1999) paid further attention to employment, environment, and public health. Following the Luxembourg Employment Summit of 1997, the creation of jobs dominated the social policy area. Health and safety at work, occupational health, or public health became subordinate to labour market and employment issues. EU member states agreed to add the Employment Chapter to the Amsterdam Treaty to support the European-wide activities. The treaty represented a victory for the pro-market centre-left policies associated with the United Kingdom (Belcher 1999). The treaty also set out the specific public health\footnote{Article 152} competence of the Community. The treaty underlined that a high level of health protection must be ensured and taken into consideration in the implementation of all other Community policies and activities. This is also called the mainstreaming of public health into other policies (Koivusalo 1999a). In addition, the treaty emphasised that the Community should take action to improve public health, prevent human illness and diseases, and obviate sources of danger to human health. However, the EU member states kept their responsibility for the organisation and delivery of health services and medical care. Several other EC laws already affected health services; such laws were in areas including medical qualifications, insurance, pharmaceuticals, and the functioning of a single market (Koivusalo 2000, 2003b, McKee et al. 2002, Mossialos, McKee 2002, Hämäläinen et al. 2004).

The Nice Treaty of 2003 kept the competences of the EU as in the Amsterdam Treaty. The only difference in social protection and social security was that the Council of the EU was able to give directives with minimum requirements and with unanimous decisions. Unanimity means that decision making is difficult but possible for minimum requirements for social protection and social security (Kari 2003). The Nice Treaty established the Social Protection Committee in the Council of EU.\footnote{in Article 144}

Due to several revisions of the treaty, the Convention on the Future of Europe was established to write a draft Treaty establishing a Constitution for Europe, which was planned for adoption in 2006 after the ratification of a draft Treaty on a Constitution in the EU member states.
states. However, following the negative referendum of France and the Netherlands in May of 2005, the process proceeded towards a new reform treaty to be in force in 2009.

Table 4 describes the development of treaty-based action in the areas of coordination of social protection, health and safety at work, social policy programmes, health policy, and social dialogue. OHS is not a matter in the treaties, but it is influenced by the entities mentioned in table 4. The coordination of social protection includes compensation for injuries and accidents, the influence of health and safety at work on OHS through social dialogue or directives, the influence of social policy programmes’ on working and living conditions, and the influence of health policy on the scope of provisions and public health aspects. Table 4 can be used as a reference for a more detailed look at the articles in the treaties and their use as a justification for activities in the areas of health and safety at work and OHS.
### Table 4. Legitimation of policy areas for the EU after the Amsterdam Treaty (Modified from Kari 1997, Pieters, Nickless 1998).

<table>
<thead>
<tr>
<th>Coordination of social protection</th>
<th>Health and safety at work</th>
<th>Social policy programmes</th>
<th>Health policy</th>
<th>Social dialogue</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before the Amsterdam Treaty</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article 51: Coordination of social protection for free movement of workers; <em>Unanimous decision by the Council</em></td>
<td>Article 118a-c: Working and living conditions, occupational safety, and health and social dialogue <em>Qualified majority in cooperation with European parliament</em></td>
<td>Article 235: Common market</td>
<td>Article 129: Public health <em>Qualified majority</em></td>
<td>Article 100: Approximation of laws to fulfil common market <em>Unanimity or qualified majority voting</em></td>
</tr>
<tr>
<td>Article 235: Common market <em>Unanimity after consultation of the European Parliament</em></td>
<td>Article 100: Approximation of laws to fulfil requirements for common market <em>Unanimity or qualified majority</em></td>
<td>Social Agreement <em>Co-decision based on qualified majority</em></td>
<td>Article 100: Common market <em>Unanimity or qualified majority</em></td>
<td>Article 118c: Social dialogue</td>
</tr>
<tr>
<td>Articles 48-59: Free movement of labour and professionals</td>
<td>Article 117: Social policy</td>
<td>Article 129a: Consumer protection</td>
<td>Articles 126-127: Vocational training <em>Qualified majority</em></td>
<td></td>
</tr>
<tr>
<td><strong>Amsterdam Treaty in force since 1 May 1999</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Article 42: Free movement of people, services, and capital; coordination of social protection <em>Co-decision and unanimous decision by the Council</em></td>
<td>Article 137: Social policy: workplace health and safety, working conditions, information and consultation of workers, labour markets <em>Co-decision and qualified majority</em></td>
<td>Article 137: Social policy: workplace health and safety, working conditions, information and consultation of workers, labour markets <em>Co-decision with qualified majority</em></td>
<td>Article 152: Public health <em>Co-decisions and qualified majority</em></td>
<td></td>
</tr>
<tr>
<td>Article 308: Common market <em>Unanimous decisions</em></td>
<td>Article 95: Internal market <em>Co-decision and qualified majority</em></td>
<td>Minimum requirements of directives were enlarged</td>
<td>Article 308: Common market <em>Unanimity</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Article 13: Common policies <em>Unanimity</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.3.2 Agreements on social rights and social policy

In addition to treaties, separate agreements have been used to build the European social dimension and to make content for the policy objectives. Workers’ rights as part of the human rights movements have been highlighted in the development of working conditions. The human rights of health and safety at work were enshrined in the UN Declaration on Human Rights in 1948. The rights of workers to have decent living and working conditions have continuously been in the agenda of the Community. The rights of workers have progressively expanded to include health and safety at work (encompassing OHS), working hours, employment contracts, conditions governing collective redundancies, the environment, and public health (Hantrais 1995).

In the 1990s the two most influential agreements in EU were the Community Charter of the Fundamental Social Rights of Workers and the Agreement on Social Policy. The Community Charter of the Fundamental Social Rights of Workers was born in 1989 after several rounds of collective bargaining over issues of worker participation and consultation over changes in working conditions. The Charter gave the Community the role of supporting activities of EU member states and had an implicit relevance to health matters (Mossialos, McKee 2002a). The Charter stated that ‘every worker must enjoy satisfactory health and safety conditions in his working environment. Appropriate measures must be taken in order to achieve further harmonisation of conditions in these areas while maintaining the improvements made.’ According to the Charter, everyone has the access to preventive health care and the right to benefit from medical treatment under national laws. The objectives of harmonisation of working conditions were made explicit. According to Hantrais (1995), the Charter confirmed the general aims presented in the Treaty of Rome and the competence of the Community to act in the area.

The Charter served to highlight particular areas, which then were implemented under the Treaty of Maastricht. Further details on living and working conditions were given in the Agreement on Social Policy annexed to the Maastricht Treaty (1993). The agreement referred to the need to promote proper social protection, taking into consideration the diverse forms of national practices. However, the Commission’s
role was limited to encourage cooperation between the member states and facilitate the coordination of their action in all social policy fields under the agreement. The agreement underlined a high level of health protection and encouraged cooperation among member states. On the other hand, the agreement confirmed Community competence in the area of social policy law and in social policy as part of economic objectives of the treaty.

The adoption of the social agenda in the Nice Summit made social policy part of economic and employment policies to reach the set goals of competitiveness and full employment of the Lisbon strategy. The social agenda urged undertaking social responsibility and anticipating and capitalising on changes in working environments by creating a new balance among flexibility and social security, social dialogue, and health and safety at work.

The charter, agreement, and social agenda did not specifically mention OHS, but they indirectly influenced the development of OHS as part of health and safety at work.

5.3.3 From regulations and directives to open method of coordination

Of the several instruments used by the EU, the strongest are regulations and directives. Regulations are binding and have direct legal force in EU member states and may supersede national legislation, if necessary. Regulations concerning coordination of social security, especially in relation to the free movement of labour and social benefits, have been implemented. Coordination means consistency of social protection for employees, entrepreneurs, and their family members, so that they would get social protection from one and only one member state. This means that earned social protection rights could be moved to another member state. The EU member state should provide health care, medical treatment, and welfare services for migrant workers just as it does for nationals. These ‘benefits in kind’ are provided and paid for by the member state in which the migrant is living and working (Hervey 2002).

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35 Council Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community

36 Council Regulation (EEC) No 574/72 of the Council of 21 March 1972 fixing the procedure for implementing Regulation (EEC) No 1408/71 on the application of social security schemes to employed persons and their families moving within the Community
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Individual entitlements to medical treatment are determined according to national law. Patients’ rights to health care within EU member states are mediated by several EC measures. Two regulations ensure that migrant workers who are nationals of a member state, for example EU citizens and their families, are entitled to health care services in the host state. Migrant workers from non-EU states do not have the same rights in Community law. Regulations concerning the free movement of workers are an EU harmonisation measure based on the principle of non-discrimination for migrant workers. It entitles migrant workers to ‘the same social advantages as national workers, including access to national health services’ (Hervey 2002).

In general, the system set up by Regulations has not generated many disputes. The state providing the health service usually receives contributions from the patient (in the form of taxes or social security contributions) or can claim compensation through transfers between member states as set out in the Regulation concerning the coordination of social security.

5.3.3.1 Directive

The Single European Act elaborated further the four freedoms within EU member states, namely the free movement of services, people, goods, and capital. The need for the protection of workers led to the creation of Framework Directive 89/391/EEC as based on the Regulation aiming to coordinate national social security schemes. Directives lay down objectives to be achieved and are legally binding, but individual states are free to select the most suitable form of implementation in their own legal systems.

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37 Citizenship of the Union: Article 17:1. Citizenship of the Union is hereby established. Every person holding the nationality of a Member State shall be a citizen of the Union. Citizenship of the Union shall complement and not replace national citizenship. The Consolidated version of the Treaty establishing the European Community. 2. Citizens of the Union shall enjoy the rights conferred by this Treaty and shall be subject to the duties imposed thereby.

38 Regulation 1612/68/EEC of the Council of 15 October 1968 on freedom of movement for workers within the Community.


40 Article 189 of the Treaty
In relation to legislative work in the EC and in EU member states, a framework directive is a method to provide a general overview of a broad problem area. This method was new when Framework Directive 89/391/EEC was created (Frösén 1993). The issued directives can be divided into the harmonisation and the minimum standard directives. Harmonisation\(^{41}\) and minimum standard directives\(^{42}\) are based on the Treaty of EC in SEA. The treaty permitted the European Council to adopt directives in the area of health and safety at work based on qualified majority voting in the Council of EU in cooperation with the European Parliament.

The purpose of the directive is to reconcile the dual objectives of both securing the necessary uniformity of Community law and respecting the diversity of national traditions and structures. What the directive aims for, then, is not the unification of the law, which is the regulation's purpose, but its harmonisation. The idea is to remove contradictions and conflicts among national laws and regulations or gradually iron out inconsistencies so that, as far as possible, the same material conditions are obtained in all the EU member states. The directive is one of the primary means deployed in building the single market (Lampinen, Uusikylä 1999).

The disadvantages for the citizen are that member states do not implement the requisite measures to achieve an objective set in a directive, or that the measures taken are inadequate. The ECJ has a long list of cases in which the member states have not implemented the measures. The decisions of the ECJ concerning direct effect on the national level are based on the general view that the EU member state is acting equivocally and unlawfully if it applies its old law without adapting it to the requirements of the directive or recommendation. This is considered an abuse of workers’ rights by the state. The directive should be recognised by the states and not be seen as seeking benefit or violating Community law. Nevertheless, when the period allowed for transposition has expired, the directives acquire full legal force and effect in that all state institutions are obliged to interpret and apply national law in accordance with the directives. That means the interpretation of a directive must be in line with Community law (Raunio, Wiberg 1999).

\(^{41}\) Article 100a of the Treaty of Rome
\(^{42}\) Article 118a of the Treaty of Rome
1996, about 74% of EU member states had transposed the directives adopted under Article 118a, and the transposition reached 95% in 2000 (www.europa.eu.int 5/2000).

5.3.3.2 **Framework directive 89/391/EEC**

The development of Framework Directive 89/391/EEC was based on three fundamental concepts: the need to push on with improving the safety and health protection of workers on a broad front; the obligation to ensure that workers have adequate protection from the risks of work accidents and occupational diseases; and the need to ensure that the competitive pressures of the single market did not jeopardise the safety and health protection of workers (Vogel 1994). Its quick development was related to the standardisation of products and procedures to increase trade in the internal market. Health and safety at work directives are also related to directives on environmental issues, more specifically to the working environment and the improvement of living and working conditions. The making of the framework directive has been extensively discussed in two volumes published by Vogel in 1994 and 1998. The broad consensus from drafting the directives went to widespread opposition at the time of transposition. In the Council of the EU the framework directive was drafted in vague terms, which allowed member states space to make their own interpretation and make only minimal changes on national legislation (Vogel 1994).

In the 1990s many new directives concerning health and safety at work were adopted. The second half of the 1990s brought deregulatory pressures due to liberalisation and a decreased ability of social welfare states to respond to the funding needs. The working time directive, the protection of young people at work directive, and the pregnant workers directive are weaker than the directives adopted earlier, and several other directives have never been passed. In addition, the European Agency for

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Health and Safety at Work and funding for the health and safety initiatives have faced delayed and lower funding than expected (Kari 1997). Also, the change of EU methods towards coordination, benchmarking, and mutual recognition decreased the interest in promulgating directives as a tool for harmonisation.

The Commission has published its description of the framework directive, where the objectives are stated as ‘ensuring a higher degree of protection of workers at work through the implementation of preventive measures to guard against accidents at work and occupational diseases, and through the information, consultation, balanced participation, and training of workers and their representatives.’ According to the Commission, the framework directive ‘should be applied to all sectors of activity, both public and private, with the exception of certain specific activities in the public and civil protection services’ (European Commission 2000a).

The framework directive concerns minimum safety and health standards for the workplace and for workers using machines, tools, products, and installations. The Commission also sought adequate trade union participation in the European standardisation (Venturini 1989, Belcher 1999). However, the European Trade Union Technical Bureau for Health and Safety (TUTB) is the only body to have taken a comparative look at how the framework directive has been implemented (Vogel 1994, 1998). TUTB’s concerns about the framework directive were how to enforce the rules, how to address changing patterns of work, and how effective the prevention policies of recent years had been. The important factors to jeopardise the adoption of the framework directive were deregulation, decreasing enforcement systems, and lower employee representation in SMEs. As a result, the framework directive updated the legislation in the member countries, but left national prevention policies and services untouched in many countries in Europe (Le Monde Interactive 1999, TUTB 2000).
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5.3.3.3 Protective and preventive services based on the framework directive

The preparation of Framework Directive 89/391/EEC included debate about the content, scope, and role of public authorities; preventive services; information dissemination; workers’ participation; and employers’ obligations. The Luxembourg Advisory Committee, its ad hoc group, and the Commission worked out proposals for the framework directive. The discussion on how safety should be organised in the workplace culminated in the idea of preventive services. Employers were mostly critical towards framework directive, and their amendments were related to the composition of preventive services, freedom to use more than one service, training requirements, and the relations between the preventive services and occupational medicine. The Council watered down the training requirement in the framework directive by replacing it with capabilities and made it optional for the member states to decide the number of the workers in the preventive service (Vogel 1994). The final framework directive referred to ‘the necessary capabilities and the necessary means’ for in-company services, and ‘the necessary aptitudes and the necessary personal and professional means’ for external services. These expressions are unclear, and their interpretations in member states have been difficult and lacking proper guidance from the framework directive, so the member states have made their own interpretations.

The framework directive left occupational health services and health and safety at work as separate entities, despite ILO Convention No. 11 concerning OHS and empirical experience that these services should work together and integrate services to give best benefits to the workers at large. Preventive and protective services are not defined in the framework directive, but norms are given for the personnel and employer to be responsible for such services. Prevention comprises all the steps or measures taken or planned at all stages of work in the undertaking to prevent or reduce occupational risks.

The framework directive changed the focus from regulatory policies of prescriptive measures to goal-setting regimes, where the directive was an instrument to fulfil the goal. According to Walters (2002a), the framework directive gave employers an opportunity to concentrate on risks, using tools and experts to prevent risks; it also allowed workers to participate in the health and safety decisions made in their workplace.
In the framework directive, the preventive and protective services are defined as follows.

"Article 7

Protective and preventive services
1. Without prejudice to the obligations referred to in Articles 5 and 6, the employer shall designate one or more workers to carry out activities related to the protection and prevention of occupational risks for the undertaking and/or establishment.

2. Designated workers may not be placed at any disadvantage because of their activities related to the protection and prevention of occupational risks. Designated workers shall be allowed adequate time to enable them to fulfil their obligations arising from this Directive.

3. If such protective and preventive measures cannot be organized for lack of competent personnel in the undertaking and/or establishment, the employer shall enlist competent external services or persons.

4. Where the employer enlists such services or persons, he shall inform them of the factors known to affect, or suspected of affecting, the safety and health of the workers and they must have access to the information referred to in Article 10 (2).

5. in all cases:
   • the workers designated must have the necessary capabilities and the necessary means,
   • the external services or persons consulted must have the necessary aptitudes and the necessary personal and professional means, and
   • the workers designated and the external services or persons consulted must be sufficient in number to deal with the organization of protective and preventive measures, taking into account the size of the undertaking and/or establishment and/or the hazards to which the workers are exposed and their distribution throughout the entire undertaking and/or establishment.

6. The protection from, and prevention of, the health and safety risks which form the subject of this Article shall be the responsibility of one or more workers, of one service or of separate services..."
whether from inside or outside the undertaking and/or establishment. The worker(s) and/or agency(ies) must work together whenever necessary.

7. Member States may define, in the light of the nature of the activities and size of the undertakings, the categories of undertakings in which the employer, provided he is competent, may himself take responsibility for the measures referred to in paragraph 1.

8. Member States shall define the necessary capabilities and aptitudes referred to in paragraph 5. They may determine the sufficient number referred to in paragraph 5.

The terms ‘worker,’ ‘employer,’ ‘workers’ representative,’ and ‘prevention’ were defined in the framework directive. Prevention means ‘all steps or measures taken or planned at all stages of work in the undertaking to prevent or reduce occupational risks.’ According to the framework directive, ‘employers are obliged to ensure the health and safety of workers in every aspect related to the work, primarily on the basis of the specified general principles of prevention, without involving the workers in any financial cost.’ In addition, employers should ‘evaluate the occupational risks, inter alia in the choice of work equipment and the fitting-out of workplaces, and to make provision for adequate protective and preventive services.’ The employer is also responsible for keeping ‘a list of, and draw up reports on, occupational accidents and to take the necessary measures for first aid, fire-fighting, evacuation of workers, and action required in the event of serious and imminent danger.’ The employer should also ‘inform and consult workers and allow them to take part in discussions on all questions relating to safety and health at work and ensure that each worker receives adequate health and safety training throughout the period of employment.’

According to the framework directive, workers are obliged ‘to make correct use of machinery, other means of production, personal protective equipment, and safety devices, give warning of any work situation presenting a serious and immediate danger and of any shortcomings in the protection arrangements, and cooperate in fulfilling any requirements imposed for the protection of health and safety and in enabling the employer to ensure that the working environment and working conditions are safe and pose no risks.’
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The implementation of the framework directive was scheduled to be the beginning of 1993. The Maastricht Treaty in 1993 and the Amsterdam Treaty in 1999 strengthened the position of public health and health protection. In addition, the impact of the Single European Act spread to policies beyond those originally intended, namely to health and social services. Similar occupational health and safety levels had to be reached, because otherwise countries would be at a competitive disadvantage. Framework Directive 89/391/EEC introduced a minimum level of occupational health and safety measures to be implemented in all EU member states. In addition, new daughter directives were accepted from 1989 until the mid-1990s. Since then, far fewer directives and regulations have been adopted.44

5.3.3.4 Open method of coordination

Directives have been used as the main tool to harmonise health and safety at work among member states. However, burdensome harmonisation was replaced by mutual recognition and coordination. Better methods to exchange information and best practices were needed when the member states’ systems converged, and the open method of coordination (OMC) responded to this need. The open method of coordination is a ‘soft’ method of policy-making and governance because its implementation is non-binding. OMC is regarded as a middle ground between the standard ‘hard’ acquis method of integration (directives, legislation), and the member states’ spontaneous but uncertain harmonisation of policy-making (Ahonen 2001). Lönnroth (2002) described OMC as a complementary method to legislation to improve the quality of policies.

The OMC was defined at the Lisbon European Council in 2000 (paragraphs 37-40) as spreading best practices and achieving greater convergence towards the main EU goals. This new method of governance got the name of OMC. Social pillars (employment, social inclusion, and pensions) and economic pillars (macroeconomic and economic reforms, and Broad Economic Policy Guidelines) were integrated under this method, but with different, albeit related, processes (Larsson 2002).

According to the Lisbon European Council, OMC was designed to help EU member states develop their own policies towards defined targets. At the EU, fixed guidelines and specific timetables for achieving the goals have been set in the area of employment strategy and social inclusion, for example. OMC also includes the establishment, where appropriate, of quantitative and qualitative indicators and benchmarks for member states. These European guidelines are meant to be integrated and implemented into national and regional policies by setting specific targets and adopting measures, taking into account national and regional differences. OMC involves periodic monitoring--evaluation and peer review--organised as mutual learning processes among EU member states (European Council 2000a,b, Larsson 2002).

OMC was planned as a fully decentralised approach in line with the principle of subsidiarity in which the European Union, member states, regional and local levels, social partners, and civil society would be actively involved under a new method of governance (Larsson 2002). Even though the method is not legally binding and lacks sanctions, peer pressure and peer reviews give it weight for decision making within the European Union. Whereas legislative regulations set a minimum standard, the OMC encourages governments to compete to establish the highest standards possible and to be open to feedback and recommendations to improve their performance. OMC has restrained the initiatives of the Commission somewhat, because member states and the Commission have to work together. But it may in fact decrease democratic control and move governance towards processes led by experts from various ministries or other institutions. According to Savio (2001; also Savio 2003, Palola 2003), OMC is governance that involves regulation without the name of regulation. OMC goes beyond previous EU norms and EU cooperation.

The Feira European Council in 2000 extended the policy areas in which OMC is implemented to include social policy area, such as OMC in pensions. The Nice European Council decided to use OMC to implement the European Social Agenda (European Council 2000d). OMC became a new model of cross-national policy-making through monitoring and benchmarking, which launched a new mode of European governance. OMC is located between intergovernmental negotiations and mutual adjustments. Government competencies are not entirely national, but
are no longer pursued in isolation. OMC depoliticises issues and makes policy-making a problem-solving exercise. EU member states seem to be more willing to accept initiatives of Community actions, although the EU does not have legally binding powers. Hemerijck (2002) has called this the self-transformation of the European social models. New policy procedures for the implementation of EU-wide programmes, as well as the new processes of benchmarking and best practices are considered methods for obtaining a high degree of policy convergence in the context of institutional diversity in national social policy and employment (Teague 2000). OMC might also make some of the challenges of OHS more explicit, if occupational health and safety and OHS are included in any of the OMC processes. So far, health and safety at work and OHS actors are taking more direction from other policies, which make them more proactive than reactive and excluded from the processes.

5.3.4 Creation of the internal market in the European Union

The principal aim of the EU was to create an internal market. The SEA sped up the development of the four freedoms: free movement of goods, people, services, and capital. The main aim was to increase the economic growth of the European countries, but the spillover effect has brought internal market, competition, and implementation of the four freedoms to OHS and health and social services as well.

5.3.4.1 Internal market, competition law and the ECJ

The expansion of the EU regulations and judgements by the European Court of Justice (ECJ) has eroded national sovereignty. The ECJ has delivered several judgements concerning compensation for health services and service provisions. In principle, the nature of the ECJ is non-political; however, it does help form EU health policies. The building of the EU’s social dimension has supported market-building processes, which have spurred the demands for ECJ decisions and expanded the significance of EU law in the national health systems (Leibfried, Pierson 2000).

ECJ judgements have confirmed that medical activities, including hospital services, fall in principle within the scope of the freedom to
provide services within the Community. However, all member states still have the mandate to decide on their social security systems, and a member state may restrict access to health care and hospital services abroad in order to keep the financial balance of national social security systems, to ensure a wide range and accessible health care and hospital services, and to ensure sufficient capacity and knowledge in the member state itself for necessary protection of public health (Hämäläinen et al 2004).

The ECJ also passed judgement on the conditions under which authorisation to receive treatment abroad should be given under existing EC legislation. According to the judgement, the treatment can be authorised if it is regarded as ‘normal’ in international professional circles, and if the patient’s condition requires it. Authorisation can be refused only if the same or an equally effective treatment can be obtained in the patient’s member country without undue delay at an establishment that has a contract with the insured person’s health insurance fund. The ECJ did not adequately define ‘undue delay,’ but some member states with lengthy waiting times (for patients to receive treatment for a number of medical conditions) might find it difficult to justify refusing authorisation for their citizens to receive treatment abroad (Nickless 2001).

These rulings occurred in two different insurance systems: Luxembourg has a reimbursement system (Cases Decker and Kohll) while the Netherlands has a benefits-in-kind system (Cases Geraets-Smits, Peerboms and Müller-Fauré, van Riet). The interpretation of the Decker and Kohll cases would be different, therefore, in the Netherlands or in other EU member states. The Commission, however, is reportedly of the opinion that the single market can contribute to a high level of social protection in the health care sector through a more effective use of infrastructure and know-how, a greater range of choices for patients, and improvements in cost transparency and cost effectiveness due to increased competition in the health care sector (Belcher 1999). The Commission therefore wishes to enhance competition and market forces in health care and to seek further competence in health matters so as
to implement this policy direction. Current evidence on competition and market forces in health care suggests that such a trend is unlikely to be in the interests of member states or their citizens (Paton 2000, Koivusalo 2003a). It would also complicate further the principles of solidarity and universality in health and social services (European Commission 2003).

The health insurance industry, however, has welcomed these decisions and is providing more voluntary health insurance packages in several EU member countries. The funding of health care by voluntary health insurance raises questions of equity and efficiency. Rocard (1999) points out that regardless of the type of insurance organisation or decision-making procedures (mutual societies, provident schemes, or insurance companies), there is an urgent need to make rules that increase options (i.e., risk-based voluntary health insurance is not the only option) and increase the affordability of high-quality care, preventive treatments, and treatment in general. Mossialos and McKee (2002a) suggest that the market for voluntary health insurance suffers from significant information failure, which limits the potential for competition, efficiency, or higher equity. The deregulation of the voluntary insurance market in the EU has decreased the power of regulatory bodies to protect consumers. This decreased power has direct implications to increase national regulations of the insurance market. This kind of increase would ensure more efficient and equitable allocations of resources for health services (Mossialos, Thomson 2002).

The ECJ passed a judgement on compulsory membership in a statutory work accident insurance body: Cisal di Battistello Venanzio versus INAIL (Italy) 49 concerned a worker who had taken private insurance instead of paying INAIL contributions. The concern was whether or not the compulsory membership was against the Community competition law. The ECJ gave its ruling in 2002 and reaffirmed that Community law does not affect the power of the member states to organise their social security systems. The judgement underlined the social aims of work accident insurance and solidarity applied by the Italian scheme. Compulsory affiliation is essential for the financial balance of the scheme, and INAIL has an exclusively social function and is not an undertaking.

49 Case C-218/00 Cisal di Battistello Venanzio
within the meaning of Community competition law. This meant that the creation of a market based on private insurance for occupational risk compensation was not started in Italy (Vogel 2002). In the case between Belgium and the Commission, the ECJ judged that in the countries with a free market in work accident insurance, the market should be open to insurance companies established in other Community countries. Belgium had contested the ruling on the grounds that Belgium could not control and supervise the activities of such insurance companies if they have activities in or outside Belgium (Vogel 2002). Figure 5 shows the possible aspects of the single European market influencing OHS.

5.3.4.2 Free movement of occupational health professionals

The freedom of EU citizens to work in another member state was established by the Treaty of Rome. The rights for certain professionals in the health sector (doctors, dentists, pharmacists, nurses, and midwives) to practice their professions with minimum standards of training in other countries were laid down in separate directives. These professionals have an automatic right to mutual recognition of their qualifications throughout the EU. Other health professionals outside these directives may practice their professions using the ‘general system directive’ for the recognition for their qualifications.

All EU member states regulate the practice of health care by professionals. Usually professional regulation is undertaken by quasi-public bodies, which grant entitlements to utilise medical professional titles and to practice branches of the medical profession. Professional regulation is the key component in regulating national health policies by ensuring that competent professionals with appropriate training are giving safe treatment to patients. The EU Health Policy Forum (2003) supported the collaboration between professional organisations and regulatory authorities to control the quality of migrant professionals, that is, to avoid mobility of disqualified or underqualified health professionals.

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50 Case C-206/98 Belgium
51 Articles 49, 57, and 66 of the Treaty of Rome
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OHS are the means by which EU member states supply occupational health and safety to workers and impose duties to employers. Few individual workers can afford to pay doctors directly for their treatment. Through regulations, the state demands that employers organise and cover OHS costs. The supply of doctors is controlled by the states, often by the number of intake of medical students. Paradoxically, the earning and autonomy of doctors are endorsed by the state (Freeman 2000). On
the other hand, some countries regulate the use of a doctor’s time per employee for OHS, which places restrictions on a doctor’s income.

However, the state expects that OHS plays its role as part of the distributive function of welfare state benefits. But doctors decide ‘who gets what, when, and how,’ because OHS is based on the contract between OHS and employers. The spending in OHS is depoliticised, because decisions are made in the enterprise or professional domain. Such issues as absenteeism and occupational diseases become OHS problems, which means that OHS must seek solutions for them. The employees see their interests protected through certifications of sickness by the medical profession, which means that occupational hazards become individual problems rather than general workers’ problems to be tackled more broadly by society. Doctors are dependent on states for their legal monopoly of medical practices, and employers are dependent on doctors due to requirements that regulate professional practices. When providing care, doctors also assume responsibility for making rational decisions and for making enterprises comply with legislation. Therefore, medicine is threatened by the loss of autonomy, government is threatened by the social and political conflicts between employers and employees (Freeman 2000), and enterprises are threatened with non-compliance and sanctions for not taking care of their employees.

Doctors make significantly different payments for occupational health in different countries, and this affects the political power of the medical profession. The interest organisations for occupational health doctors practice self-regulation through registration, licencing, education, and training. The professionals' interest organisations influence policies by national and international representations and by lobbying. Internationally, the most important professional organisations are ICOH and UEMS. UEMS gives opinions on occupational health and safety issues in the EU framework. The members of UEMS are national medical organisations. While diverse bodies carry regulatory and representative roles, their leadership seems to be in the hands of small groups of doctors, which leads to greater cohesion than expected (Freeman 2000). State or employers’ interests are weakened by fragmentation between payers (funds) and providers of OHS (OHS units). In Denmark, however, OHS units have formed their own interest organisations.

54 ICOH = International Commission of Occupational Health; UEMS = European Union of Medical Specialists
Despite the free movement of health professionals that is facilitated by the directives, several cultural (language), administrative (work permission), and economic (salary level) factors prevent them from seeking employment in other countries. In practice, the number of EU health professionals working in another EU member state is relatively small. The free movement of health professionals within the EU offers advantages and disadvantages. For example, a surplus of health professionals in one country (e.g., Germany) could provide trained workers for another country that does not have enough of their own (e.g., the United Kingdom). In some member states and regions (Belgium, France, the Netherlands, the United Kingdom), the recruitment of health professionals from other member states has become routine. This practice has changed the labour market for health professionals, opened up new career opportunities, and given health services the opportunity to select their staff from a larger pool of workers. One disadvantage, however, is that the increased movement of professionals might complicate human resource planning (Belcher 1999, Tjadens 2002).

When highly trained health professionals are recruited abroad (Germany to Austria, Belgium to the Netherlands, Ireland to the United Kingdom) or trained abroad (Greece), their country of origin or country of training could be left with a lack of trained staff or without compensation for the training. One country carries the training costs, but another country enjoys the benefits of that training by way of immigration or emigration. The directive allowing the free movement of doctors requires professionals to have acquired all their qualifications and competencies during their training before they move abroad. This means that doctors working in different health systems might not in fact be competent to a satisfactory level in their new home country and might not meet its requirements. It also means that assuring the quality of patient care has been subordinated to the free movement of health care professionals. Medicine was long isolated from economic and political decision making and placed out of competition. Professional dominance of the health sector above the state and market might have served personal and professional interests. The health care reform of the 1990s could be read as countervailing actions undertaken by EU member states against their medical professionals (Freeman 2000).
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5.3.4.3 Free movement of services

Generally speaking, the Commission is of the view that competition law and the free movement of services applies to health services. At issue is whether EC law defines those who provide health care services as commercial undertakings, which must comply with competition rules, or as public bodies, which are exempt from such rules. If they are commercial undertakings, then health service providers should be able to offer their services in another member state without being discriminated against by the local providers (McKee et al. 2002). There is little evidence that this has happened to any great extent throughout the Community, but mobile services could more easily be provided in border areas to patients in other countries (Palm et al. 2000, Coheur 2001, European Commission 2001, Belcher 1999). The extension of competition law to include health care systems or OHS has been a result of legal interpretations within the member states concerned, rather than a result of specific EU regulations (van der Grinten, de Lint 2001, Ollila et al. 2003). But the EU has in fact had an indirect influence on health systems including OHS because of the introduction of European competition law in the national law (Akyurek-Kievits 2001).

Nonetheless, the requirement that service providers from other member states cannot be discriminated against has the potential to interfere substantially with European OHS systems. This is the case when the OHS are organised with a mix of public and private provisions and by means of various financing arrangements, ranging from direct outsourcing to third-party payments and reimbursement of costs. This applies to OHS differently in different EU member states. Another issue is the decision about when state subsidies are used to provide OHS across populations and areas. All of these aspects could be disturbed or jeopardised by the principle of non-discrimination among different providers.

There is little evidence, if any, that the commercialisation of health services leads to lower costs and better quality health services for all (Freeman 1998, Ollila et al. 2003), which presumably would apply in similar terms to OHS. If the aim of OHS is to make a profit, that the profit might be used for shareholders’ benefits or transaction costs rather than quality improvements and service expansion. When a health
market is implemented, one can question whether a market approach is cheaper—even when medical technology and pharmaceutical costs are already driven by markets and are a major part of health service costs (Freeman 1998, Ollila et al. 2003). For OHS, this applies to health and safety technology and pharmaceuticals that are mostly on the market created for goods. This could increase or decrease costs, depending on the market partners.

The competition law is important as a regulator of the internal market and for the interpretation of application of internal market rules to OHS. There are three exemptions for EC competition law not to be applied to services. These exceptions are services without economic activities, purely social activities, and mere coverage of needs (Mossialos, McKee 2002a, Belcher 1999).

Competition law applies if an organisation is considered to be an undertaking. For OHS this means that cartels and the abuse of dominant positions are forbidden in the market. Cartels can be prohibited forms of cooperation among undertakings (e.g., agreements that disturb competition), limits on competition (e.g., preventing, restricting, or distorting competition by means of a price agreement among different undertakings), or limits on trade among EU member states (Belcher 1999, Mossialos, McKee 2002a). However, it can take years for OHS chains to form or for any individual OHS enterprise to get a dominant position in the market. But this could forecast the future: large OHS units might have benefits of scale for the provision of services and goods, but within the limits of the market.

The European Community also considers subsidies a barrier to the development of the single market. In principle, both health insurers and health providers can be involved in subsidies (Mossialos, McKee 2002a). Within publicly financed services, the contracting out of services is considered to be part of government procurement. While defined classes or services are set under national legislation, European procurement law applies to a broad range of public contracts, such as OHS for public sector workers, if contracted to an OHS unit. Even in situations in which government procurement rules would not interfere with the contracting out of OHS, they still have important implications for the supply of medical goods and equipment, and the building of hospitals and other infrastructure (Hämäläinen et al. 2004).
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In relation to free movement of OHS, an interest in marketing and trading health and OHS has increased in recent years, partly because of their overall impact on economic profits and the sheer size of the potential OHS market. Many conflicts, however, may arise between occupational health policy priorities and commercial interests, such as the common aim of universal coverage and solidarity in access to OHS.

5.4 Policy environment affecting OHS

In this chapter OHS is contextualised from the points of view of social policy, welfare states, health services, and industrial relations. All these policies are intertwined and have close connections to each other, both in EU member states and in the EU itself. However, many researchers, officers, administrators, and others have different specifications for the connections and interactions among these different policies, which are mostly described and explained as separate entities and policy processes. In the case of OHS, several policies have a major impact on the operation of OHS activities.

Increased European economic integration has raised the importance of social policy, the so-called social dimension, as a balancing factor in European integration, economic development, growth, and global competition. The EU has an increasing influence on national social policies, practices, and benchmarks through several means. One of these means is the OMC and its processes in different policy areas, such as economic coordination, employment, social exclusion, pensions, and research.

5.4.1. The role of social policy in the EU

In EU policies, occupational health and safety and OHS belong to the social policy and employment directorate. In EU member states, the occupational health and safety issues belong under several different ministries. The concept of social policy, social protection, social security, social services, and the content of the concepts varies in EU member states. However, the OHS belongs to occupation-based social benefits instead of health or social benefits. Despite the fact that the EU has an impact on social policies, the member states continue with their social policies according to national objectives and targets.
Social policy as a term reflects the time of its use; for example, the content of social policy has expanded during recent decades. Titmuss defined social policy as choices among conflicting political objectives, goals, and how they are formulated. That definition of the good society is one that distinguishes between the needs and aspirations of social man and the needs and aspirations of economic man. The influence of these decisions would be vested in and anticipated by interested social groups and other social agencies. Redistribution, universality, and inequality are mentioned as driving social policy decisions (Alcock et al. 2001, Titmuss et al. 1974). According to Wilensky (1975), social policies are the ‘essence of the welfare state.’ Contemporary social policies are welfare programmes designed to provide sufficient income, remove insecurity in case of a social risk, and provide social services. One of the aims of social policy is to redistribute resources among the needy population, and for this purpose social policies can be collective redistribution mechanisms guided by overall social policy and priorities (Korpi, Palme 1998).

Social policy originated from several development trends and activities of different stakeholders. Credit can be given to party pluralism, corporatist pluralism, state capacity, and neo-Marxism as promoters of social policy development. Party pluralism promoted social policy; both right and left parties were in parliament, and pressure groups and electorates of both parties pursued social policy issues. Corporatist pluralism promoted social policy in general through negotiations among government, capital, trade unions, and other corporate bodies. In implementing social policy, the civil service and public administration have also increased its credibility (Ginsburg 1992).

The role of government in social policy is to regulate, finance, and provide subsidies and direct provisions for the implementation of social policies and programmes. Social policy concerns both workers and all citizens in society. Different social policies can be characterised by their goals, activities undertaken, and effects or outcomes. All these characteristics vary among EU member states, such as mechanisms to achieve goals, institutional framework to formulate and deliver social policy, and functional relationships among the private sector, the public sector, and individuals (Kleinman 2002). The grounds for intervention can be grouped into categories of efficiency, equity, and solidarity argu-
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ments (Kleinman, Piachaud 1993). On the other hand, social policies are claimed to be based on investments in human and social capital and to be conducive to higher economic efficiency to improve the labour force's productivity and quality of life. In the EU context, social policy is often considered a productive factor and a counter factor to competitive and market-oriented factors. The costs of social programmes are generally visible in the short term, while the benefits are often only apparent in the long term (Fouarge 2003).

The content of social policy varies among countries. Kleinman and Piachaud (1993) divided social policy into ‘Anglo-Saxon’ and ‘continental’ approaches. In the Anglo-Saxon countries, social policy includes a collective provision of social services: education, health care and personal social services, social security, and housing. The main issues in the development of Anglo-Saxon social services are efficiency and effectiveness of services, who provides services to whom, and to whom are service providers accountable. The continental European social policy is more related to institutions, the labour market, and rights of workers. In a broad sense, social policy includes government interventions designed to affect individual behaviour or command over resources to influence the economic system in order to shape society in some way (Kleinman, Piachaud 1993). The southern European social policies are less coherent in social security provisions and rely heavily on traditional forms of support from families, kinships, networks, and the Church. The state bears the majority of the social protection costs, because the coverage has been extended during recent years (Hantrais 1995). Esping-Andersen (1990) argues that countries have qualitatively different types of social policies that to a large extent result from diverse social structures, as well as historical and political processes within differing state traditions. Welfare states developed differently due to variables and welfare state determinants that appeared at different times in the societies. Different determinants of welfare state institutions form country-specific configurations, which result in different configurations of institutions and their outcomes (Esping-Andersen 1990). In the EU framework, social policy can be defined as modifying market outcomes, for example, through policies on industrial relations, education, or social security (Leibfried, Pierson 1995).
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5.4.1.1 Phases of social policy development in the European Union

The development of social policy can be divided into different phases. According to Venturini (1989), the first phase was 1958-1972, the second was 1973-1984, and the third was from 1985 onwards. According to Blanpain (1992), the second phase can be divided into two phases: harmonisation took place from 1974 to 1980, and the move towards deregulations was from 1980 to 1989. The third phase (from 1985 onwards) included the adoption of the Community Charter for Fundamental Social Rights for Workers in 1989 and the Social Action programme (later also called the Protocol and the Agreement on Social Policy). Mosley (1990) divided the European Community social policy into two phases: 1958-1973 was a phase of gentle neglect and 1974-1985 was the phase of social activism. Since 1986 there has been the social dimension phase of the internal market and economic liberalisation.

The development of EU social policy can be also divided into the following phases: a period of neoliberalism from 1957 to 1972; a period of social action from 1972 to 1980; a period of stagnation or crisis from 1980 to 1986, and a period of optimism from 1986 to 1993. A fifth phase emerged after the publication of the Commission’s white paper ‘European Social Policy: A way forward for the Union’ (COM(94)333). This led to the involvement of social partners in making decisions and also led to a shift away from the harmonisation of social rights towards their coordination. Emphasis moved towards the principles of subsidiarity, technological support, and the use of softer methods (such as coordination), to influence social policy in EU member states (Nielsen, Szyszczak 1997).

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this study, the development of social policy has been divided into three phases: before 1986, between 1986 and 2000, and after 2000. These are described in a time-based table in Appendix V, showing the most important issues in social policy development in each phase.

5.4.1.2 Social policy in EU context

The development of social policy reflects the different phases of EU integration. Since the Treaty of Rome (1957), there have been two different views about the social policy: one for growth of economy, and the other for social development and cohesion. However, the social dimension has usually been a secondary objective in relation to priorities of and the development of the economy. The differences in social security and its effect on competition have raised differences due to the variety of investments in social security.

The Treaty of Rome did not have a specific social provision, and the main task given to member states was cooperation. When Denmark, Ireland, and the United Kingdom joined the European Community in 1973, a more active phase of social dimension development started with the community social action programmes. However, the Council of Europe had been active in social policy. Already in 1961 the Council of Europe had adopted the Social Chapter, which guaranteed fundamental rights for workers and citizens.

The Social Chapter was a model for the creation of the Community Charter of the Fundamental Social Rights of Workers in 1989. The concept of the social dimension appeared for the first time and was originally intended and reserved for planning of EU social policy. The action programmes that applied the Community Charter as a direct method of legal enforcement were absent. The principles set out in the Community Charter of the Fundamental Social Rights of Workers were taken up in the Agreements on Social Policy annexed to the Treaty on European Union (Maastricht). The Agreement on Social Policy laid down the basis for collective agreements at the European level. The concept of the social dimension described the EU social policy objectives derived from the SEA and expressed later in the Green and White Papers on the European Social Policy (1994). The European Commission published the Community Social Policy in 1996, which described the content of social
policy of the EU. The Community Social Policy consisted of the basic agreements, such as the Social Charter, green and white papers of social policy, and Social Action Programme of 1995-1997. The Community Social Policy included the employment and social fund, occupational education and training, European labour market, coordination of social protection, work conditions and occupational health and safety, equality between men and women, social policy and social protection, public health, connections to other countries and international organisations, social dialogue, and research in social policy (Kosonen 1995, Kari 1997, Kleinman 2002).

After the Maastricht Treaty, the focus was dominated by the transition to economic and monetary union and the single currency through the Stability Pact, which committed the participants to fiscal strictness and transition to the common currency euro in 1999. Vanhercke (1998) expected that in economic shocks, labour and social protection become the instruments to regulate competitiveness; this causes lower wages, increased flexibility, lower taxation, and lower social protection. The member states had to adjust their budgetary procedures, and EMU criteria were used in many countries to legitimise the reforms in public expenditures and social protection systems (Pochet, Vanhercke 1998).

The Commission published three reports on social protection in Europe, followed by several communications paving the way towards modernising social protection in the European Union. In March 1999, the European Parliament called on the Commission 'to set in motion a process of voluntary alignment of objectives and policies in the area of social protection, modelled on the European employment strategy.' The Commission felt that it was time to deepen existing cooperation at the European level in order to assist member states in modernising their social protection and to formulate a common political vision of social protection in the European Union.

The strategy to achieve this aimed to exchange experience, policy discussion, and monitoring of ongoing political developments in order to identify best practices. Based on the Communication on 'Modernising and Improving Social Protection in EU,' the Commission proposed a
number of broad objectives to the European Council to guide future action, such as making social protection systems more employment friendly, tackling demographic ageing, tackling social exclusion, and providing high quality health care while containing overall costs.

In its conclusions in December of 1999 (Helsinki), the European Council endorsed these broad objectives as identified by the Commission and underlined the need for enhanced cooperation in modernising social protection. The Lisbon European Council of March 2000 adopted an integrated approach to employment, economic reforms, and social cohesion. The Lisbon European Council stressed that social protection systems need to be reformed so as to continue to provide good quality health services. The Lisbon Summit of 2000 suggested a move from harmonisation, convergence, coordination, and mutual recognition to an open method of coordination (OMC) in several policy areas, including social and health policies. The key issues in the social policy agenda were promotion of employment, tackling unemployment, social inclusion, making work pay, pension reforms, and health care for the elderly in the 2000s (European Council 2000a). The OMC provided instruments to monitor and direct policies.

The adoption of the Social Agenda by the Nice Summit of 2000 made social policy manage structural changes and undesirable social consequences. The Nice summit stated that ‘reinforcement and modernisation of the European social model is characterised by the indissoluble link between economic performance and social progress’ (European Council 2000d).

The Social Agenda of Nice provided a political basis for the consolidation of a comprehensive strategy of mutually reinforcing economic, employment, and social policies. The EU set goals for competitiveness, full employment, living standards, and quality of life. The driving forces in achieving these goals were the quality of social and employment policy. The European social model was to be strengthened by promoting synergy and positive interaction among economic growth, employment, and social cohesion. The European Union, Directorate General of Employment and Social Affairs as well as Eurostat were asked to publish annual reports on social trends in the EU to describe progress in the social arena (European Council 2000d). The various reports and established OMC processes form a constant movement towards con-
verging and enhancing cohesion in social and health policies among EU member states, which might bring several fundamental changes into social protection systems in EU member states.

A high quality social policy provides a high level of social protection, good services to all, real opportunities for all, and a guarantee of fundamental and social rights. The EU’s Social Policy Agenda published in 2000 included an improved form of governance and the means for social protection with clear and active roles assigned to all stakeholders, including European Union institutions, member states, regional and local institutions, social partners (trade unions, employers’ organisations), civil society, and companies.59

After the Treaty of Maastricht (1993), the concept of the social dimension has not been adequate to describe the future-oriented social objectives of the EU (Savio 1995). The most striking feature has been the straight impact of EU economic policies on social policies in the member states through stability pacts and monetary policies. The spillover effects of the single market features are also evident in social and health policy areas of EU member states. The competition and EMU in the economic policy area are both causing greater similarities in various policy areas and institutional arrangements (Streeck 1995, 1996, Scharpf 1999, Leibfried, Pierson 2000). The spillover from other policies, for example further integration, requires commitment from the political and economic elite to drive social and health policy issues further to reach the original goal of the single market. The limitations may only arise if national identities, economics, or values hinder or strengthen integration (Hix 1994).

On the other hand, the concept of a European model of the welfare state gives EU member states a mandate to continue developing a chosen social policy. In the European model of the welfare state, it is considered necessary to promote EU regulations concerning minimum income security and social rights for all. The welfare state model concept is promoted to respect the member states’ decisions concerning welfare, but on the other hand the input of the EU policies has an impact on the welfare of the member states (Savio 1995).

59 COM (2000) 379
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The Commission uses its various functions to promote its role as a supranational policy entrepreneur. As such, it persuades and manipulates opinions and interests to defend its positions. The Commission plays a decisive role in gradually pushing integration in various areas, as well as shaping EU governance in the EU social policy area. The administrative failures in the institutional connections among the EU member states and the EU centre and others reflect opportunities for new forms of pan-European policy collaboration. The socialisation between national actors and interest groups within the EU has created political and social processes where national actors can exchange and try out their preferences, expectations, and behaviours in the interaction of European political and economic forces. Socialisation works to increase the legitimacy of EU social policy through social dialogue, comitology, focal points, and networks leading to a permissive environment for pan-European collaboration in various social and health policy areas, for example Europeanisation (Teague 2000).

5.4.1.3 Health and safety at work

The European Agency for Safety and Health at Work, the spring 2001 Swedish presidency of the EU, and the European Commission organised a joint workshop to develop the new Community Strategy on Safety and Health. One of the priority areas of the Swedish presidency was the ‘Quality of Work.’ The new strategy was requested by the EU Social Policy Agenda adopted at Nice 2000. The focus on quality of work produced a Commission Communication in June 2001 on the contribution of employment to the quality of work (COM (2001)313). This document put forward a plan based on the idea that ‘quality of work’ depends on a careful balance between job characters and work environment/labour market characters. During the Belgian presidency, a European conference called 'For a better quality of work' was organised in September of 2001. The conference included such topics as time, work and personal life, changes in work organisation, and labour market flexibility. The aim of the conference was to draw concrete and practical conclusions as to how to achieve a better quality of work (European Foundation for the Improvement of Living and Working Conditions 2001, Noortje et al. 2001). The European summit in Laeken in December of 2001 called
attention to the close links between quality of work and productivity. One of the challenges in the European debate was to arrive at a definition of what constitutes job and employment quality.

The results from the Bilbao 2001 workshop contributed to the formulation of a new strategy for safety and health at work (European Agency for Safety and Health at Work 2001a). Another workshop in May of 2001 was organised to update an earlier Agency report on Priorities and Strategies in Occupational Safety and Health in the Member States of the European Union published in 1996 by Walters and Piotet. The workshop also provided information for the preparation of a new Community Strategy on Safety and Health at Work (European Agency for Safety and Health at Work 2001b).

The Commission published a new strategy on health and safety at work 2002-2006 in March 2002. The Council of the EU passed a resolution on the strategy. Several stakeholders expressed their opinions in relation to the new strategy, emphasising inclusion of health promotion, access to preventive and multidiscipline services, additional efforts to reach SMEs with preventive services, and increased cooperation among stakeholders.

In a broad sense, health and safety at work in the EU frame has developed through the modest coordination among member states of benefits in action programmes that will improve health and safety at work in EU member states. Thereafter the aim was to harmonise health and safety at work to defend workers’ rights and prevent social dumping, using Framework Directive 89/391/EEC as a tool. The strategy adopted in 2002 brought health and safety at work to new policy level by integrating issues to other policies and by giving a mandate to the European Agency for Health and Safety at Work to follow and implement the strategy. In 2001 the Advisory Committee on Safety, Hygiene, and Health Protection at Work adopted an opinion on the promotion of multidisciplinary OHS in EU member states. Although OHS has not been the focus area in the process of social policy development, a

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60 Council Resolution of 3 June 2002
61 The Advisory Committee on Safety, Hygiene, and Health Protection at Work; European Parliament: Committee on Employment and Social Affairs Working Document; Economic and Social Committee; European Trade Union Technical Bureau for Health and Safety; UNICE; European Centre of enterprises with public participation and of enterprises of general economic interest (CEEP); and Standing Committee of European Doctors (UEMS)
tangible impact on OHS can still be recognised. The social policy was renovated in 2006 as well as the health and safety at work strategy, which integrated health and safety at work towards social policy issues and the use of OMC within several other social policy areas.

The new Advisory Committee on Safety and Health at Work replaced the Advisory Committee on Safety, Hygiene, and Health Protection at Work (ACSHH) and the Safety and Health Commission for the Mining and other Extractive Industries at the beginning of 2004. As a standing body, the Advisory Committee assists the Commission in the preparation and implementation of activities in the area of safety and health at work. It facilitates cooperation among national administration, trade unions, and employers’ organisations. This is performed in collaboration with the European Agency for Safety and Health at Work in Bilbao.

The tasks of the Advisory Committee include exchanges of views and experiences on existing or planned regulations, support for the creation of a common approach to problems in the fields of safety and health at work, and identification of Community priorities and the measures necessary for implementing them. The Advisory Committee will also highlight for the Commission areas in which there is an apparent need for new knowledge and suitable training and research measures. Additionally, the committee will define the criteria and aims for preventing accidents at work and health hazards within companies, suggest methods enabling companies and employees to evaluate and improve protection levels, and give opinions on proposals for Community initiatives (Decision by the Council 2003).

The committee covers both the public and private sectors. The composition of the committee should reflect the various economic sectors and the proportion of women and men in the working population. It will act as a tripartite body and will consist of three full members for each member state, comprising one representative for each of the national governments, trade unions, and employers’ organisations. Two alternate members may be appointed for each full member (Decision by the Council 2003).

The Commission’s Directorate General for Employment and Social Affairs will chair the committee, and the chair has no vote. The European
Foundation for the Improvement of Living and Working Conditions will act as an observer for the new committee. A foundation representative will report to these meetings on ongoing work (COM (2003) 346 final), thus ensuring the continuation of the established cooperation between the Advisory Committee on Safety and Health at Work and the foundation.

The Council of the EU makes the major decisions concerning EU social policy and OHS. Under the unanimity rule in the core area of social policy, one country is able to block EU decision making. The important issue is which decisions on social, health, labour, or other policies are made under unanimity, qualified majority, or co-decision procedures. Different processes give possibilities and opportunities to influence the content of policy, directives, or recommendations. The majority of the influence occurs during the process of preparation in different committees, expert groups, or work groups in the Council or under the chairmanship of the Commission. The Commission makes initiatives and coordinates different expert and working groups in the Directorates General for Social Affairs and Employment or for Health and Consumer Affairs.

5.4.2. European welfare states

The welfare state is about shared risks that cut across generations, localities, classes, ethnic and racial groups, and educational levels. Welfare as a term refers to well-being and things people choose to have. Welfare can also refer to the range of services provided in a variety of circumstances in a welfare state. These services, such as OHS, are usually paid for by social protection. Welfare is associated with needs, and people should have a range of choices that will allow them to achieve their personal goals. In the EU member states, welfare is based on the principles of solidarity and rights for such welfare benefits according to circumstances, such as family and work situations. The welfare provision might be universal for all or selective for some, redistributive from poor to rich or vice versa, or a variety of welfare provisions (social services, provided fiscally different ways or based on employment status) (Flora, Heidenheimer 1981, Kosonen 1995, 1998).
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The development of welfare states was necessary and possible as industrialisation increased the pressure to organise social protection for those who were not able to work or sustain their life due to different risks in life. Industrialisation facilitated urbanisation, mobility of the workforce, and a weakening of family networks. Wage-based work caused dependence on employers and created the need for social security. Competition among industrial producers caused unequal opportunities and outcomes for different groups of people and destroyed traditional social institutions, such as kinship support. Social protection by the state was created as a combination of complex interplay among economy, politics, and the civil society. As prosperity and economic growth continued, resources were available for the development of social security and the advancement of social protection programmes (Uusitalo 1992, Amoroso 1996, Scarborough 2000). Another alternative view for the birth of welfare states was the reconciliation of the contradictions of capitalism and democracy. A third set of theories points to the welfare states as part of nation-building processes (Scarborough 2000). That was a project of the elite and their willingness to integrate workers into the capitalist economy and nation-state (Alber 1988). According to Amoroso (1996), industrial relations played a central role in forming European societies, because of the perception of the relationship among economic growth, social welfare, and democratic growth. The welfare states in Europe developed according to the economic, political, or cultural situation in each country. Several cultural and structural determinants describe and differentiate the welfare states, even if they have adopted similar health and welfare programmes (Amoroso 1996).

Titmuss defined the welfare state as promoting the welfare of citizens (Alcock et al. 2001). The welfare state needs the support of economic policy and full employment to fund social security. Titmuss felt that the welfare state should provide education, health, social security, housing, and social services, and should also provide strategy and delivery of these services within a wide economic context. According to Titmuss, fiscal welfare through tax relief and tax allowances, as well as occupational welfare (benefits through employers in cash or in kind, such as OHS), should be alongside state provisions. Both these provisions form collective interventions to meet individual needs. Amoroso (1996) defined this as a functional welfare system. According to Kleinman (2002), Titmuss’s
approach mainly looks at the provision of services and values of social policy. Nevertheless Titmuss affected the organisation of social policy and also promulgated the discussion on comparative welfare state models (Abrahamsson 1999).

The welfare state in a broad sense means a democratic state that devotes the majority of its fiscal resources to serving the needs of the welfare of the population (Esping-Andersen 1990, Amoroso 1996). According to Kosonen (1995), in the welfare state, the state is responsible for the major part of welfare services or is a principal promoter of welfare services. In a narrower sense, the welfare state devotes the largest share of tax resources to social policies, such as cash transfers and services aiming to provide security against social risks (Kautto 2001). However, direct state provisions of services are not the necessary or defining characteristic of welfare states. It is necessary to understand the social and political rules that are taken for granted in apparently similar as well as widely different systems. The same term might have quite different meanings in different places and systems. There is no coherent and universally accepted definition of what a welfare state is, nor is there even common agreement about why the welfare state developed (Greve 1996).

According to Kosonen (1995), the differences in welfare states in EU member states are related to social expenditures in pensions, unemployment benefits, social income transfers, and health and social policy. With benefits, such as OHS, the differences can be found in the differences in universal services versus limited services for citizens, coverage of services, and accessibility to social and health services. There are also disparities in relation to equality, which implies income comparison, level of poverty, and equality between men and women. The basic differences are in the financing arrangements of health and social services; the services may be financed by taxation, employers’ social benefits contributions, or out-of-pocket payments by insured people. A welfare mix in welfare services has developed based on public, private, and non-governmental actions and collaborations. The interactions of social movements, organisational development, and general voting rights have created democracy and welfare distribution. Different social classes, unions, and parties have influenced the development of benefits and rights (Wilensky 1975, 2002, Flora, Heidenheimer 1981, Castles 1982,

Occupational health as part of welfare state policy emphasises the importance of work on social protection and funding arrangements of OHS and statutory accident insurance. Improvements in working conditions and the working environment make contributions to national development and make up part of successful economic and social policies. In addition, OHS and employers make up an important part of protection, prevention, and promotion of health as part of health policy and public health. Employers cover the costs of OHS and make a necessary contribution to cover the costs of ill health and to improve the health and safety at work in enterprises.

5.4.2.1 Welfare state models and classifications

Since the 1970s, countries have been classified into groups based on their welfare systems. The major discussion about the welfare state models started after Esping-Andersen (1990) published his classification of welfare states into three groups. This led several other authors to criticise and classify countries based on similar or different criteria. As European integration was proceeding with the Single European Act and retrenchment of welfare states appeared to squeeze the welfare state provisions, discussion about the ‘European social model’ started as a counterforce to market-oriented liberal economic policy. The welfare state modelling can be considered a simplification of circumstances. When EU member states are classified into groups, however, the purpose is to follow the impact of different EU policies on welfare programmes and policies. The EU plays an increasing role in social policy in European welfare states. It is very important to acknowledge the differences among the welfare states and the distinctive features that reflect their historical, political, economical, and cultural backgrounds, when different actors interchange information in international connections and try to build up common aims and joint activities.

The first recognised classification of welfare states was presented by Titmuss (Alcock et al 2001). His models were the residual welfare
model, the industrial achievement-performance model, and the institutional redistributive model of social policy. In the residual welfare state, individuals’ needs were fulfilled by the private welfare market and the family. Only when these ‘welfare providers’ broke down should the social welfare institutions play their role, and that role should only be temporary. In the industrial achievement-performance model, social needs were based on the individuals’ merits, work performance, and productivity. This model was based on incentives, effort, rewards, and the formation of class and group loyalties. The institutional redistributive model of social policy provided universal services, outside the market, based on needs. Theoretically it was based on multiple effects of social change, the economic system, and social equality. All these models emphasised the role of family and work differently in securing the welfare of citizens (Alcock et al 2001).

After Titmuss presented his welfare state models, comparative welfare state research moved in the early 1970s from the structural and functionalist approach underlining similar welfare states towards the politics and institutions of welfare states. This approach emphasised qualitative differences and divergent development among welfare states. The focus was changed from expenditures to social rights and permitted more detailed reporting of variation. By the 1980s, the viewpoint of institutional divergence became a common approach to interpretation of variation among welfare states; and linear development and convergence of welfare states were less common approaches (Kautto 2001).

The modelling of welfare states was presented by Esping-Andersen in 1990. He ranked welfare states using a combination of de-commodification and stratification. His analysis included such welfare programmes as old-age pensions, sickness benefits, and unemployment insurance. The typologies of welfare states were born around certain clusters of variables, which differentiated certain distinct regimes. Titmuss’s approach to classification was value driven, whereas Esping-Andersen’s (1990) was more means oriented.

Esping-Andersen divided countries into three groups: Anglo-Saxon countries, Scandinavian countries, and continental western European countries (Table 5). De-commodification referred to ‘the degree to which individuals or families can uphold a socially acceptable standard of living independently of market participation.’ For example, in principle
individuals can use the social benefit system, instead of employment, for their living. De-commodification is a feature of all welfare states, but to differing degrees. Each type of welfare state also gave rise to a particular type of stratification, for example, the division of people into classes or social strata. Economic development seemed to have a negative correlation to de-commodification. The political factors offered significant correlation with benefit systems’ performance, political left power in the government, electoral support for Catholic conservatism, and the extent of absolutism. For example, authoritarian rule supported the benefit system. Three political regimes were established: strong liberal, strong conservative (Austria, Belgium, France, Germany, and Italy), and strong socialist (Denmark, Finland, Netherlands, and Sweden) regimes.

Table 5. Common characters of welfare states in some European countries (Esping-Andersen 1990).

<table>
<thead>
<tr>
<th>Welfare state model</th>
<th>Countries</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative-corporatist</td>
<td>France, Germany,</td>
<td>social rights deeply enshrined to preserve status differences; private insurance</td>
</tr>
<tr>
<td></td>
<td>Italy, Austria</td>
<td>and occupational fringe benefits are marginal; family policies stress traditional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family arrangements; social insurance excludes non-working wives; church and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family play important role</td>
</tr>
<tr>
<td>Anglo-Saxon welfare states</td>
<td>Ireland, United</td>
<td>dominance of social assistance; low level of benefits and means testing decrease</td>
</tr>
<tr>
<td></td>
<td>Kingdom</td>
<td>de-commodification; the effect might be to strengthen the market by increasing the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>desirability of private welfare for those who can afford it</td>
</tr>
<tr>
<td>Social-democratic regimes</td>
<td>Denmark, Sweden</td>
<td>universality; de-commodification extended to middle classes; services and benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>relatively high; full employment; compulsory state social insurance; good benefits; no substantial de-commodification</td>
</tr>
</tbody>
</table>
5.4.2.2 Criticisms of the three welfare state models

After Esping-Andersen (1990) presented his typologies of three welfare states, several authors criticised and added one or more types to the classification. The most common criticisms include the exclusion of Mediterranean welfare states and the neglect of gender dimensions in social policy. Of the Mediterranean countries, only Italy was included and classified as a corporatist welfare state regime; whereas Spain, Greece, and Portugal were not classified by Esping-Andersen’s typologies. In addition, Australia and New Zealand were considered to be part of the liberal welfare state regime, something on which many researchers do not agree (Arts, Gelissen 2002). Katrougalos (1996) classified the southern European countries in a subcategory of the continental model due to their immature social protection systems and some similar social and family structures.


Appendix VI presents some of the typologies of welfare states in EU member states. It also presents dimensions used in categorisation, which is important for analysis and reflects the applicability of categories and typologies in different welfare state programmes.

Even if different indicators classify welfare states, some countries become standard models (Appendix VI). The United Kingdom is the Protestant, Anglo-Saxon, or basic security welfare model; Germany is the Bismarckian, continental, and conservative model; and Sweden is the social-democratic Nordic model. The differences appear in relation to southern European countries. Some authors define Italy as a corporatist, continental, and conservative welfare state. Most authors assign Italy to the same Mediterranean group of welfare states as Greece, Spain, and Portugal. Most authors also categorise the Netherlands as a corporatist, continental, and conservative welfare state. In some cases it belongs to the social-democratic type or liberal type (Arts, Gelissen 2002).
The question about why different welfare state models emerged was explained by Esping-Andersen (1990) as a result of different class coalitions within a context on inherited institutions. The newly elected regimes were not able to change the policy and approach, due to earlier history and long-term development. Institutional inertia (i.e., institutions stay as they are) and path dependency were factors in defining the persistence of welfare state regimes. This is related to the relationship between power and resources within each welfare state. Castles (1993) argued that policy similarities and differences among the welfare states depended on circumstances and diffusion. Circumstances led countries to seek solutions from other countries due to economic, political, or social reasons, for example to get rapid responses to the problems faced (Castles 1993). In the 1980s, Flora and Alber presented their arguments about the diffusion of welfare systems to countries through imitation and the adoption of pioneering institutions. They recognised that socio-economic problems and political mobilisation had to be taken into consideration when welfare states were developing (Flora, Alber 1981).

According to Kasza (2002), variations in the policy-making process affect the substance of policy, and borrowing from foreign models introduces diverse practical and normative elements into each country’s welfare package. Incoherence should increase with the age and size of each country’s welfare programmes. On the other hand, diffusion of best practices via the OMC practised in the 2000s among EU member states, and the exchange of expert groups etc. among EU member states might converge social policy issues more than any regulations, such as a directive, would.

The critics of welfare state regimes and typologies ignore relevant factors—for example, not only the difference between work and welfare, but also the differences among paid work, unpaid work, and welfare. Other issues that are left out in typologies are gender and the role of women in welfare generation. Depending on which variables are compared, the results and typologies vary although the classification might be the same, approximately the same, or similar. In selecting the variables, it is important to make judgements, and various typologies include a set of ideal types of welfare regimes (Arts, Gelisssen 2002). According to Anttonen and Sipilä (1996), a basically similar typology emerges even if countries are classified according to their social care characteristics.
5.4.2.3 Welfare state in flux

Nation-states are more interdependent due to globalised markets and supranational political cooperation (e.g., United Nations, World Trade Organisation, World Bank, OECD). Both globalisation and European integration have reduced the intervention possibilities of governments (Ferrera et al. 2000, Taylor-Gooby 2001, Kleinman 2002). The internal effects and challenges for the welfare states are the ageing of the workforce, changing labour markets, changing family patterns, social exclusion, and the new needs and expectations of the population towards society. This also leads to an increased focus on employment and the functioning of the labour market due to the interdependence of the welfare state funding and contributions to social protection. Some welfare states experience pressure more than others to make welfare policy solutions compatible with economic competitiveness and globalisation. This may lead to convergence, which is a process of declining variation among welfare states (Kosonen 1995, Pierson 1998, Ferrera et al. 2000, Kautto 2001, Kleinman 2002). However, convergence is hindered by the heterogeneous consequences of economic openness, national resistance, and innovation. Greater openness increases the demand for social protection against the ravages of the world markets (Saari 2001). On the other hand, export competition has not been the cause of retrenchment (Huber, Stephens 2001a,b, Pierson 2001). In addition, internal pressures due to increased contacts and political integration cause policy education and diffusion. Convergence occurs as a result of changes in the global environment (Deacon et al. 1998, Kautto et al. 2001, Kautto 2001). The results of globalisation are that differences in welfare states decrease and variety among states declines (Kosonen 1994, Rhodes 1996, Streeck 1995, 1996, Scharpf 1999, 2000).

Political, economic, social, and historical reasons affect welfare states differently and in different time spans. The reforms based on the national economies facing high unemployment rates, decrease in economic growth, and the need to lower the expenditures in welfare programmes in the 1980s and 1990s reduced entitlements to social benefits. The welfare states expanded to an extent of the status quo, which was called a frozen landscape of welfare states by Leibfried and Pierson (1995). The reduction of benefits and entitlements has been called retrenchment or the
dismantling of the welfare state (Ferrera et al. 2000, Taylor-Gooby 2001, Kleinman 2002). It has been explained by a type of convergence called ‘the race to the bottom,’ for example, the convergence of retrenchment in which nation-states had to adapt to the demands of the free market, deregulation, and globalisation due to economic, technological, and ideological pressures (Bouget 2003). However, there is more evidence on convergence to an intermediate level of social expenditure rather than ‘a race to the bottom’ (Wolf 2002). Another economic explanation of convergence is based on domestic fiscal constraints and their economic and political consequences (Pierson 2001). Convergence is also a consequence of maturation in European welfare systems. This consequence is based on economic growth and demographic change, as well as the countries’ increasing similarities in social, institutional, and cultural aspects (Wilensky 1975, 2002, Pierson 2001).

At the same time, support for the welfare state continues to be strong. From an attitude survey of some EU countries (Austria, France, Germany, Portugal, Spain, Sweden, and the United Kingdom) Taylor-Gooby (2002) concluded that there is strong support for the welfare state. This is also true in the countries with different levels of spending on social protection. There is no clear pattern of difference among the various welfare regime types (Taylor-Gooby 2002). Cuts in welfare spending have been fiercely opposed, because public support for welfare state programmes is large, intense, and able to fight to sustain benefits (Ferrera et al. 2000, Pierson 2001, Taylor-Gooby 2001, Kleinman 2002). The welfare state faces pressures for austerity and enduring popularity. Social and economic transformations produce pressures in mature welfare states. Social policy does not centre on dismantling the welfare state, but rather centres on renegotiating, restructuring, and modernising it. The interests exist in settings that facilitate such reforms in certain countries and in the terms of these reforms (Pierson 2001).

In the 1990s the reform of the social welfare system was no longer only a national task, but it also depended on international economic and political circumstances. Welfare reforms were created by at least three distinct sets of causal factors: relevant policy challenges, differences in structures of political decision making, and variations in welfare state design (Scharpf, Schmidt 2000, Hemerijck 2002). The Scandinavian welfare states faced a ‘flexibility’ problem in creating appropriate conditions.
for private welfare services. The Anglo-Saxon countries faced increasing social exclusion of both the working and non-working poor even if work were available. The continental countries suffered from low employment rates. The Mediterranean countries were in trouble due to weakening traditional family support. The first wave of retrenchment in the early 1990s concerned health care insurance and unemployment insurance in continental welfare states (Palier 2003). The Netherlands, Ireland, Denmark, Spain, and Italy negotiated social pacts with important reforms in welfare states (Rhodes 2001). The centre-left governments implemented reforms through experimentation with social services, whereas social democrats were bound to the idea of social protection as a productive factor. The past policy legacies (e.g., path dependence) and institutional structures framed the decision making but also the policy makers’ capacity to innovate (Crouch 2001). Governments are able to make welfare adjustments through international and national policy learning. They have to adjust the goals taking into consideration the consequences of past policy and new information to get more effective and legitimate policy solutions for the challenges they face (Hemerijck 2002).

The retrenchment debate has been dominated by arguments about formal political institutions, party systems, and policy dynamics. Social class, modernisations, and democratisation dominated the debate on the expansion of the welfare state (Green-Pedersen, Haverland 2002). Despite similar challenges in welfare states in Europe, the policies in the countries are not uniform. It seems that policy choices in the past become difficult to reverse, and path-dependent solutions are common; therefore, radical change in the European welfare state is institutionally ruled out (Hemerijck 2002). However, path dependence can be seen as national resistance to the international convergence process, keeping national systems stable (Bouget 2003). Today’s policies are the cumulative work of different forms of government that represent responses to a variety of historical circumstances (Kasza 2002). Theories of convergence have predicted that fiscal competition, social dumping, and social tourism would cause a race to the bottom and that social protection would be adopted through retrenchment and structural adjustment policies. In addition, ECJ decisions would affect monopolies of services and goods, for example OHS. This is referred to as negative integration (Leibfried, Pierson 1995, Scharpf 2000).
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Institutional arrangements become resistant to reforms, because of high costs, reduced coordination and transaction costs, and popular expectations. National welfare state reforms are guided by innovations, which might be accumulating due to policy failures. Institutionally bound policy changes have been possible in the EU in the 1990s, although common socio-economic problems do not necessarily imply convergence in policy-making due to institutional arrangements among countries (Bonoli et al. 199). The social justice, equity, and economic competitiveness in relation to political institutions and negotiated reforms have been in favour in European welfare states and have had a good response. Welfare policy adjustments have depended on the capacity of policy makers to innovate and use normative, cognitive, and institutional resources (Crouch 2001). The tension between path dependence and innovations has been evident in several countries (Bouget 2003, Hemerijck, Visser, 2003). Policy innovation might remain within the bounds of principles, content, and institutional format of a previous policy; innovation might also include changes in institutional rules of the game or goals or principles of policy (Hemerijck, Visser 2003).

During the second half of the 1990s and the early 2000s, the welfare state and its funding base have focused on employment, employability, and proportion of age group at work. This has been noticeably reflected in the aims of improving working and living conditions, and in only slightly embracing OHS and occupational health and safety. Economic and political reasons seem to be responsible for a shift from standards of protection towards prescriptive measures of employment. The employability and percentage of employed from the working-age population is a straight link to social welfare and welfare state retrenchment, which strives to reduce public expenditures and demands more flexibility in labour market and employment issues.

5.4.3 European health services under reforms

In the 1990s the European member states faced health care and welfare state reform in several areas of the health system and its services. Reform can be defined as a purposeful, dynamic, and sustained process that results in systematic structural changes (WHO 1996).

The major reasons for health sector reforms originate from reforms of the welfare state and from fiscal pressures. Health care is a major
entity, and it is important to the electorate. For these reasons, health care reforms are prone to conflicts, which politicians try to avert because of blame avoidance and loss of support. Health reforms are also attractive due to power relations among various stakeholders. The industrial dimension of health reforms is important owing to the large impact on employment, medical technology, and pharmaceuticals (Moran 1998, Freeman, Moran 2000). Most health care reforms in the 1990s were intended to reduce costs, to improve performance and outcomes of health care services, and to orient services more towards customers. These reforms increased the value for money in relation to services provided. Most of the countries focused their reforms to ensure high quality services, enhance health gain through health care, and provide appropriate regulation for care providers. The countries also tried to achieve equity, balance between public and private provisions and inputs, and involve consumers to determine priorities for health services. However, the reforms focused mainly on supply-side changes to improve efficiency and effectiveness of health care delivery (Hunter 1996, Ranade 1998, Moran 1999).

In addition to fiscal constraints, organisational reforms originated from the new public health management, which emphasised rational policy-making in the health sector. The new public management concept included professional management in the public sector, standard setting, and performance measurements in relation to quality and target settings. The emphasis was on output controls in relation to resource allocation. The ideas of provider/producer functions and contracting standards to provide health services were introduced into the public sector. Private sector management styles were brought in and greater flexibility was introduced—instead of formal and inflexible services, which were said to characterise the public sector. The scarcity of resources or reduced allocation of funds to the health sector meant cutting costs, doing more with fewer resources, and controlling labour union demands. The new public management brought market principles into the health sector. Health services with market principles signified competition among different services to improve performance and raise efficiency. These reforms caused confusion, instability, and low morale in health care staff due to the clash between the public health sector’s values-based ethos and the private sector’s market-based commercial ethos (Hunter 1996, Ranade 1998, Moran 1999). The management, competition, and market
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Approaches have been questioned as their legitimacy may be questioned. The dominance of the approaches in policy-making are based more on the economic values than other values.

Several general options have been implemented in health sector reforms. The first option is the decentralisation of health services. This moved the power to make regulations to lower levels; it also gave the power to implement regulations or monitor applications to agencies, regional or local authorities, and social insurers. This can be seen easily in Finland, where municipalities are responsible for providing health and social services and OHS for enterprises. In Spain and Italy, regions or semi-independent communities are responsible for health services and OHS in local health units. The second option is enforced self-regulation in relation to a professional or enterprise-based set of standards for members. This was implemented in Sweden, where internal control in enterprises is the self-regulatory means to control health and safety in the workplace. A strong self-regulatory approach is also used in the United Kingdom. The third option is to give accreditation and licensing of health services or professionals to independent or semi-independent agencies. Denmark and the Netherlands gave quality certification of OHS to independent agencies. The fourth option of health reform is to build independent regulatory agencies and intersectoral cooperation among different policies (Saltman et al. 2002), such as occupational health institutes or the European Agency for Health and Safety at Work. Also, there is an attempt to implement safety and health areas through joint management systems in enterprises.

Van de Ven (1996) recognised several trends in market-oriented health reforms. These trends included increasing the role of primary health care physicians to coordinate all needed care, contracts between third-party purchasers and the care providers, continuity in pro-competition policies, cost containment, and choices in health care. All these trends can also be seen in OHS. The market orientation is related to the outsourcing of OHS from companies to private OHS centres or private OHS units that provide services for companies. This has created possibilities for health professionals to extend services, but it has also given them new requirements to manage, monitor, and evaluate several companies and their health and safety issues. In countries where primary health care services provide OHS, the situation can bring challenges to competition
issues, but it can also bring a variety of services for companies. However, as public health services face constraints, the priorities of the public system might differ from those of enterprises. Insurance companies contract OHS to provide services for employers, which also creates competition among different insurance companies and different OHS providers. This creates pressures for cost containment and inclusion or exclusion of OHS into the contracts. Many enterprises are minimising the costs of OHS to provide only the minimum services in occupational health, even though some companies offer OHS provision as an employee fringe benefit in a competitive package of an employment contract. Often, public sector employees are left out of these types of choices in OHS provision or even of any OHS provisions.

The health care reforms have underlined the importance of improved management to achieve efficiency and better accountability among health professionals and closer performance monitoring. The processes of corporatisation, proletarianisation, and deprofessionalisation have progressively eroded professional autonomy. In addition, public expectations for professional performance have increased (Hunter 1996).

A variety of skill levels can be found in health settings and in OHS. It is unclear, in terms of outcomes and efficiency, what impact this variety of skill levels has on standards. The skill mix and demarcation of professional boundaries raise important questions about training. Different professionals form different tribes within a health system. There is interprofessional tribalism and intraprofessional tribalism. Training is both a consequence and a cause of tribalism. Most professionals are trained in specialised courses and are given few management skills or competencies to work in teams or to manage change. In a real work situation, there is a great need to be able to work effectively across organisational and professional boundaries. Technology patterns and care provisions require a more flexible approach than different professions. Teamwork, collaboration, and an ability to work in competitive and market circumstances are important attributes. In addition, professionals benefit from good political, negotiation, and communication skills (Hunter 1996).

Regulation, deregulation, and reregulation have occurred in all EU member states in a variety of ways in the area of health and safety at work. These measures are subsidies paid for certain services of OHS in
specific risk sectors, allowing OHS to set their own fees and minimum standards for OHS, for example. The reforms of health services have also affected OHS and medical professions. The economic interest towards the efficiency and impact of OHS culminated in cost-effectiveness studies conducted by several research groups in the 1990s. Employers’ organisations requested an accounting of the costs of all regulations. The introduction of managerialism to public health care brought with it a demand for health and safety management systems to companies, and it also brought the integration of general management with health and safety management. The ILO and WHO/EURO further developed such approaches.

In addition, outsourcing and cost cutting in the companies brought new types of organisation to OHS. Many of the OHS units were privatised or formed as independent external OHS units. Some of the OHS units formed non-profit associations with companies and provided OHS as external services. In Denmark and the Netherlands, quality management certification became obligatory; and in many other countries, certification is recommended or quality guidelines are provided. All these reforms have also created management positions in OHS units to draft and manage contracts among employers, authorities, and insurance funds. Both management and doctors have an interest in sustaining OHS units (positions, profits, and employment), but the major impact is felt among occupational health nurses and other occupational health professionals, especially in large OHS units. Other policies than occupational health policy, such as employment policy and economic policy, have had a profound impact on employees’ provision and access to OHS.

### 5.4.3.1 Impact of reforms on requirements for quality of OHS

The demand for quality OHS emerged at the same time as reforms and the reorganisation of health services. Diminishing resources for OHS in enterprises and public sector increased the expectations and demand for quality OHS. Governments announced legislation and regulation-based or recommendation-based quality requirements. These laws and requirements were intended to ensure the acceptable level, coverage, and effectiveness of OHS and health service provisions. The governments changed the administration and regulation of OHS towards more of
a market orientation (the Netherlands and the United Kingdom); or they withdrew support to OHS (Sweden), which affected workers’ and companies’ decision making in the allocation and use of resources for OHS.

According to a framework proposed by a group of authors in WHO in 2001, the quality of health systems is defined as the level of attainment of health systems’ intrinsic goals for health improvement and responsiveness to legitimate expectations of the population (Evans et al. 2001). Quality policy is the overall intention and direction of an organisation with regard to quality as formally expressed by top management. Quality management includes all the activities of the overall management function that determine quality policy, objectives, and responsibilities and that implement them by means of quality planning, quality control, quality assurance, and quality improvement within the quality system. However, quality is significantly different for occupational health professionals, employees, OHS management, enterprises, and society (Westerholm, Baranski 1999).

The quality of OHS is often debated by users, providers, and purchasers (e.g., workers, OHS units, and employers or insurers), but overall occupational health depends more on the quality of the whole health system including the country’s social, economic, educational, and cultural environment. But the quality of OHS provided to the population is also largely determined by models of financing, legislation, and other regulatory mechanisms. There is general agreement that quality should be assessed from the viewpoints of major stakeholders (such as users/workers, care providers/OHS units, payers/employers, politicians, and health administrators/inspectorates) and against explicit criteria reflecting the values of EU member states.

Both OHS providers and payers (e.g., employers and insurance companies), have increased managerial functions, quality norms, and standards for OHS units; and competition among OHS units has also increased. The interest to apply an enterprise type of management in health care systems brought contracts among service providers, demands for productivity, efficiency and performance ratings, and the creation of an internal market within health services (OECD 1992). In addition, health and safety management systems have been developed at international (GPHESME) and national levels (such as TQM) to integrate oc-
occupational health and safety issues into general management systems, or to view health and safety at work as part of public health (Baranski et al 2003). The quality management systems were expected to decrease costs, increase productivity of OHS units and enterprises, reduce ill health and personnel costs in enterprises, and improve services of OHS units (Zwetsloot, Baranski 1998a). For the follow-up of health, environment, and safety management (HESM), criteria and indicators were developed for evaluation and monitoring (Zwetsloot, Baranski 1998b). OHS is important in capacity building, expert support, and provision of consultancy and training in HESM. WHO also produced guidelines, based on HESM, for quality management in multidisciplinary occupational health services (Westerholm, Baranski 1999). The governing body of the ILO adopted technical guidelines on occupational safety and health management systems in April of 2000 (ILO 2001).

Although the delivery of OHS is clearly the responsibility of EU member states, the common agenda of transparency and consumer protection increasingly brings social if not legal pressure for European standardisation in order to ensure the free and safe movement of goods, services, professionals, and patients (Cucic 2000). Health ministers agreed in 1998 to collaborate on quality in health care, and the Austrian Federal Ministry published a summary of quality policies in EU member states in 1998. In 2000 the Commission published a health strategy (COM (2000) 285) that included the concept of spreading best practices in health care.

5.4.4 Social dialogue in EU member states

Social dialogue and collective bargaining are defined by the ILO to include all types of negotiation, consultation, and exchange of information among representatives of governments, employers, and workers, on issues of common interest relating to economic and social policy. The concept of social dialogue, which is still evolving, varies from country

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63 Social dialogue reflects the ILO constitutional principles of tripartism.
64 Collective bargaining is a means to determine wages and work conditions that apply to the workers covered in the ensuring agreements through free and voluntary negotiation between the two independent parties concerned.
65 ILO. Right to organise and collective bargaining convention No. 98. 1949.
to country and from region to region. The enabling conditions for social dialogue are strong, independent workers' and employers' organisations with the technical capacity and access to the relevant information to participate in social dialogue. In addition, political will and commitment from the parties to engage in social dialogue, and respect for the fundamental rights of freedom of association, are essential conditions. Social dialogue requires appropriate institutional support. Social dialogue takes many different forms in a tripartite process, with the government as an official party to the dialogue; or it might consist of bipartite relations only between labour and management (or trade unions and employers' organisations), with or without indirect government involvement. Concentration of tripartite powers can be informal or institutionalised, and often it is a combination of the two. It can take place at the national, regional, or enterprise level. It can be interprofessional, intersectoral, or a combination (ILO 1949).

The European social dialogue has been an instrument for EU member states and the social partners to smooth out cultural differences in industrial relations. Social dialogue and mutual agreements in the EU have been practised through the Economic and Social Committee, the Standing Committee on Employment, the tripartite conferences, the joint sectoral committees, and many commissions, committees, and joint or tripartite working groups. The Treaty of Rome is the basis for social dialogue. Industrial relations develop along the lines of regulations adopted in intergovernmental bargaining. The European Commission has been a policy actor and promoter of alliances exploiting its competences. This has meant that the EU has regulatory impact on national sovereignty, traditional interest group activities with increased transnational nature, and Europeanised labour market and industrial market policy (Rhodes 1995).

The Treaty of Rome established the Economic and Social Committee (ESC). From the mid-1980s the Delors Commission started a social dialogue (Val Duchesse intersectoral social dialogue) with the highest level of the representatives of trade unions and employers (Spyropoulos 1990). According to Streeck (1995), the intention was to strengthen the position of business and raise its role in supranational institutional growth. The framework for European industrial relations was also laid down in the Community Charter on the Fundamental Social Rights of
Workers. The charter has two brief references to transnational aspects of rights, namely on European social dialogue. The article refers to the Treaty of Rome, adding that contractual relations can take place at either the interoccupational or the intersectoral levels. In addition, reference is made to information, consultation, and worker participation—in that they must be developed according to practices of member states.

The Maastricht Treaty established the consultation process and the possibility of social partners to open negotiations on any topics on industrial relations. According to Delors, ‘the Commission would like to see the social dialogue leading to Community-wide framework agreements to which employers and unions could refer during collective negotiations at national, industry or company level’ (Spyropoulos 1990). This type of declaration from the Commission revitalised the social dialogue, and several joint opinions were given by employers’ and employees’ organisations (UNICE, CEEP, ETUC). The policy steering groups were created in 1989 and consisted of representatives from UNICE, CEEP, ETUC, and the Commission. Social dialogue served to organise action on various topics and to evaluate joint opinions and their impacts. The joint opinions were given on education and training, the future of the European labour market, occupational and geographical mobility, and the improvement of the labour market in Europe. But because UNICE opposed supranational political and institutional development to keep the competitiveness of enterprises high, the development of the social dimension deceased to the level of the beginning of the 1980s. However, UNICE supported worker mobility, education and training, health and safety at work, and equal opportunities at work (Spyropoulos 1990, Streeck 1995). On the other hand, ETUC supported the establishment of an area for social relations at the European level and the institutionalisation of social relations (Spyropoulos 1990).

The Treaty of Amsterdam enforced the role of the Community Charter of 1989 and the Social Charter of the Council of Europe, due to a new chapter of fundamental rights and principles. The Amsterdam Treaty gave purpose to European social dialogue by incorporating the

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66 Articles 11-14, 17-18
67 Article 12, paragraph 2
68 Article 17, paragraph 1
69 In Article 138
Maastricht Treaty Protocol’s Agreement on Social Policy into the Treaty of Rome. It formally established that the social partners of the EU needed to formulate and implement EC labour laws (Gabaglio, Hoffman 1998). The Commission published a communication concerning collective bargaining.\(^{70}\) Under the Social Policy Agreement, a directive was adopted to establish the European Works Council at the Community level.\(^{71}\)

Social dialogue occurs among ETUC, UNICE, and CEEP (plus, more recently, UEAPME and the EUROCADRES/CEC liaison committee). Social dialogue has created some positive actions, such as joint opinions on the establishment of a cooperation strategy for economic policies, the completion of the internal market, the implementation of the Social Charter of the Fundamental Rights of Workers, and the progress towards economic and monetary union. The social partners in Europe have been able, at Summit meetings or through the adoption of opinions and recommendations, to influence and play a part in establishing policies. Three framework agreements have been signed since 1995: parental leave (December 1995), part-time employment contracts (June 1997), and fixed-term employment contracts (March 1999) (COM (2000) 113, Carley 2002). In the Laeken summit in December of 2001, the European social partners (UNICE, UEAPME, CEEP, and ETUC) undertook to carry out an autonomous work programme 2003-2005 and identified common topics, such as employment, enlargement of the EU, and mobility. Before the Spring European Council 2002, the employers’ and employees’ organisations hold a high level meeting and give the conclusions of the meeting to the Spring European Council. This was expected to strengthen the bipartite social dialogue in the EU and give employers’ and employees organisations a change to influence and make initiatives.

In July 2002, a framework agreement on telework was concluded, which was to be implemented by the members of the signatory parties, rather than by means of a directive. However, concrete pay and conditions of employment are not subject to collective agreement at European intersectoral or sectoral levels (Carley 2003). UNICE’s approach to social dialogue has been not fully refusing social dialogue, but neither commit-

\(^{70}\) COM(96) 448 final  
ting itself to any goals. UNICE wants to keep autonomy of the social partners and considers that the Commission should not mix with the work programmes of the social partners (Arcq et al. 2003).

5.4.4.1 Labour market regimes

Different western European trade union systems have concentrated on collaborative relations. Homogeneity of the structure of the society and political system promotes a concentrated trade union system, whereas a heterogeneous society leads to a dispersed and decentralised trade union movement. Trade unions can be centralised or decentralised, depending on how much they compete and how many of their functions overlap. Labour market systems have been classified as bilateral (employers and trade unions), state centred, and corporatist (capital, labour, and states). Nordic countries have centralised and corporatist labour market systems. In Sweden and Denmark the labour market system is formally bilateral, but the state has an important role in cooperation. In the southern European countries, such as Spain and Portugal, labour market systems are decentralised, conflict oriented, and state led. In the United Kingdom and continental Europe, labour market systems are decentralised and bilateral, but corporatist countries also exist (Austria). Germany’s labour market system is central and bilateral. In Belgium and the Netherlands trade unions are separated, but labour market systems have strong corporatist elements (cooperation among capital, labour, and state) (Kosonen 1995, Nieminen 2004, 2005).

Rhodes (1995) categorised countries into different labour market regimes according to state and legal traditions. In the Roman-Germanic system (Belgium, France, Germany, Greece, Italy, Luxembourg, and the Netherlands), the state plays a central role through the constitutional provision of basic workers’ rights and through comprehensive labour market legislation. In the Anglo-Irish tradition (the United Kingdom and Ireland), the state has abstained from regulating the industrial relations system by legislation or labour code. In the Nordic labour market system (Denmark and Sweden), the role of the state is less formal than in the Roman-Germanic systems, but industrial relations have been regulated by agreements between employers and unions. The agreements serve the same function as the constitutional and legislative frameworks of the
Roman-Germanic countries. The state mediates between the two parties, creating a tripartite or corporatist element in the system. Denmark and the United Kingdom often resist the extension of regulations in labour market systems because their systems are based on a voluntary system. On the other hand, labour market management and organisations often create the national regulatory systems. The labour market’s flexibility—for example, external flexibility to hire and fire, types of contracts, and internal flexibility within companies—varies from country to country, which creates different approaches to labour market relations (Rhodes 1995).

5.4.4.2 European industrial relations and welfare benefits

Industrial relations regulate and determine the relationship among enterprises, employees, and the government. There is pressure to modify industrial relations more favourable towards market integration, transnational unions, and business structures. Labour relations’ issues include salaries and wages, working time, employment rules, and the functioning of the labour market. The social partners negotiate agreements on labour relations and make partnerships in some countries in negotiations on welfare state reforms, policies, and initiatives with the government (Elvander 2002).

Industrial relations are diverse in EU member states. The most important differences are the level of unionisation, the degree of centralisation, the role of legislation, and ideologies (Kosonen 1995). Trade union membership is low in some countries, such as France, and high in the Nordic countries and Belgium. Trade unions are decentralised in Italy and the United Kingdom, whereas Ireland and Belgium have centralised trade unions. In Germany and the Netherlands, decisions are made at the national, sector, and enterprise levels. Legislation plays a crucial role in industrial relations in Belgium and France, because many employment conditions are statutory provisions. Law plays a relatively small role in Denmark, Ireland, and the United Kingdom in industrial relations. In Belgium, Denmark, Germany, and the Netherlands, trade unions seek consensus, and there is a high level of common values and beliefs among employers, unions, and governments. In Ireland and Spain, trade unions and employers’ organisations consider themselves as having opposing
views and interests. In Portugal and the United Kingdom, the industrial relations system has been adversarial between business organisations and trade unions. Other differences among member states are related to legislation concerning working hours, employee participation, and the termination of formalities, holiday entitlements, and employment contracts (Teague 1993).

The link between social policy and industrial relations lies in the concept of bipartite employment-based contributions to the social insurance funds from which employment benefits, sickness and accident benefits, and retirement pensions are paid (Crouch 1999). Social insurance developed mainly as a male system. Family dependents were often built into benefit scales. In addition, entitlements were tied to years of employment. The high number of women in the Nordic labour market created different conditions for the functions of the labour market and welfare state in Nordic countries than elsewhere. In addition, the institutional arrangements, social pacts, and histories of nation-states influenced the variety of ways to the development of welfare states (Kosonen 1995, Rhodes 1995, Crouch 1999). In countries with strong occupational training and identity (Austria, Germany, and to some extent Denmark), the social insurance systems of different occupations were kept very separate from each other. The benefit levels varied drastically from one occupation to another (Crouch 1999). In the Nordic countries, independent farmers and early cultural uniformity explains the expansion of social protection to all citizens. In addition, high union membership and social democratic political power promoted the Nordic welfare state (Kosonen 1995).

The insurance systems in Scandinavian countries and the United Kingdom moved to political or universal citizenship so that benefits did not depend on being at work or without work. In general, occupation-based schemes implied the maintenance of occupational inequalities within social policy, while a universal scheme implied redistribution and equality. Labour movement parties and trade unions primarily developed Scandinavian social policy. However, social policy heavily linked to participation in employment, such as that of the Bismarckian traditions, developed differently. Employment-based contributions increased the costs of the social insurance system and the contribution levels (Crouch 1999).
Trade unions are often involved in administering the national social protection system, such as pensions and social insurance. In Austria, Belgium, Germany, and the Netherlands, union participation in running social insurance seemed to be part of the neo-corporatist and co-determinative models of the industrial relations system. In France and Italy, formal union involvement in the management of pension and social security schemes seemed totally at odds with the prevailing industrial relations context. Union participation in the reform process has become fundamental in all welfare systems, where unions and employer organisations have a formal role. Unions cannot be marginalised or excluded from national discussions, despite decreasing membership, resources, and engagement in collective bargaining. British voluntary exclusion from administration of the welfare states has contributed to a weakening of unions, whereas in many other countries the role of unions has been intensified. French unions have extraordinary capacity for social disruption despite their low formal strength (e.g., low union membership). The British social insurance systems have presented far fewer barriers for flexibility than most of the rest of western Europe, and reforms are fairly easily achieved (Crouch 1999).

Shalev (2000) concluded that a politically strong reformist labour movement strengthened the growth of the welfare state in Europe. According to Scarborough (2000), there is no decline in union density throughout Europe. It has declined severely in France, modestly in the Netherlands and the United Kingdom, and marginally in Germany, but it has risen in Italy and Denmark and modestly in Sweden. However, the overall number of union members has increased. In the United Kingdom and France, both union members and densities have declined. In France, Italy, Spain, Portugal, Austria, and even Germany, unions have been able to mobilise large protests against government efforts to curtail welfare provisions (Scarborough 2000). According to the ETUI reports, the Europeanisation of industrial relations continues slowly in the 2000s. ETUI has also published recommendations and guidelines on the coordination of collective bargaining. The principal aim is to prevent wage dumping and to harmonise living and working conditions through upward convergence (Fajertag 2001, 2002).
5.4.4.3 Collective bargaining

Multinational companies affect industrial relations in several ways. It is difficult for a country to maintain a strong national regulatory regime in the presence of internationalised industrial relations and cross-national economic integration (Streeck 1992). Trends of decentralisation and flexibility in industrial relations can also be observed during the 1990s. Companies have been split into smaller units to respond better to flexibility and fast-changing markets. For example, decisions are being made at lower levels in industry agreements in Germany and the Netherlands. In France, Spain, Italy, and the Netherlands, higher level coordination can also be observed. The disorganised decentralisation of industrial relations is marked only in Britain. In other European countries, decentralisation has occurred in a coordinated way. Some institutions and national systems have been more vulnerable than others to the internationalisation of industrial relations (Ferner, Hyman 1998).

Collective bargaining unarguably plays a key role in industrial relations in all the EU member states, although national systems differ widely in terms of the level, coverage, content, and nature of bargaining. In terms of the level of bargaining, despite national differences and a widely observed trend towards decentralised bargaining, it can be said that most EU countries currently have relatively centralised systems. Bargaining usually takes into consideration macroeconomic variables, for example inflation, the interoperation among levels of national collective bargaining in neighbouring countries, and the consolidation of labour market flexibility to respond to economic shocks (Streeck 1992, Pochet 1998).

The models of collective bargaining in European Union member states vary. Since the beginning of the 1990s, social pacts have been negotiated among social partners--notably in 1992-1993 in Belgium, Italy, Spain, and Ireland; in 1995 in Portugal, Finland, Germany, and Ireland; and later in Belgium, Italy, and Spain. Substantial agreements were signed covering wage moderation, reduction in social charges, and flexibility of working conditions. Centralisation of wage bargaining has taken place, as well as recourse mechanisms in case of inflation. Room for options in bargaining can be found only on the regional or company levels after the introduction of the single currency (Pochet 1998).
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Competitive social pacts with strong centralised agreements have been signed since the single currency on the grounds of competitiveness, employment, and job creation (Pochet 1998). The government has intervened in wage formation in several countries. Social security’s funding and its role in job creation have been main topics in discussions since 1995. In three countries (Belgium, Finland, and Ireland), the intersectoral level is currently the dominant wage-bargaining level. In eight countries (Austria, Germany, Greece, Italy, the Netherlands, Portugal, Spain, and Sweden), the sectoral level remains the most important level of wage bargaining. There is no predominant bargaining level in two countries (Denmark, Luxembourg). Only in France and the United Kingdom is the company level the dominant wage-bargaining level, while it is also important in Luxembourg. Collective bargaining is centralised in the current EU (Zegelmeyer, Schulten 1997, Carley 2003).

Bargaining coordination is currently most developed in Belgium, Germany, and the Netherlands. This applies to employers’ organisations as well as trade unions. Indeed, the current central agreement in Belgium is the main instance of explicit coordination of bargaining. Bargaining cooperation in the form of information exchange and mutual discussion of bargaining developments at the sector level is well developed among the Nordic countries, and particularly among the trade unions concerned. By contrast, bargaining coordination would appear to be less well developed among the southern countries (Zegelmeyer, Schulten 1997, Marginson, Schulten 2000).

Devolution and differentiation, as well as new strategies and structures in many countries for articulating interests, can be noted among trade unions and employers’ organisations. Trade unions are for collective bargaining, but they also have other important functions at lower levels, such as providing legitimacy and vocabularies of motives of representation. Trade unions are not only concerned about salaries and wages, but also taxes and other deductions, social benefits, and entitlements that their contributions provide. In Belgium and the Nordic countries, the institutionalised role of trade unions contributes to membership stability due to the administration of the welfare system. In general, trade unions have a legitimate role in representing employee interests over social policy agendas (Ferner, Hyman 1998).
5.5 Interrelationship among different systems and regimes

Welfare states, health services, and industrial relations systems vary among EU member states. Placing each system or regime into one of several categories simplifies the situation in each country and makes each country an idealised version of a certain system or regime. However, the classification of systems and regimes makes the comparison easier to some extent. In the Scandinavian countries, with a Beveridge health care system and strong national institutions, the coverage by health services is relatively universal and relatively well institutionalised. Also, trade union density is high. In Bismarckian countries, health services as a benefit is related to the position in the labour market. Trade union density varies, but trade unions are also powerful, especially in Germany and France. The southern European countries have mixed health systems, due to reforms in health care and the decentralisation of administration towards regions and local communities. In Italy, Spain, Greece, and Portugal the devolution of power has not been completed since the start of reform (Guillén 2002). Also, the trade union density is low in three of these four countries (Italy is the exception) (Broughton 2003). The approach in Anglo-Saxon welfare states can be characterised by universal health services. Trade union density is low, and their interests in and influences on OHS is low. In relation to the financing of welfare systems, most of the welfare or health care benefits are covered by taxation or insurance.

The most uniform groupings are between Nordic countries and Anglo-Saxon countries. Scandinavian welfare states have Beveridge health care systems and a bilateral corporatist industrial system. Anglo-Saxon welfare states (the United Kingdom and Ireland) differ in health and industrial relations systems. Bismarckian welfare states, with insurance-based health care systems, include the founding members of the EU and Austria. In terms of industrial relations, countries vary among corporatist (Austria, the Netherlands, Belgium), bilateral (Germany, the Netherlands), and state-centred industrial relations (France). Southern European welfare states have a mixed health care system with state-centred (Portugal, Greece) and bilateral (Spain, Italy) industrial relations (Table 6).
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Table 6. Relations among welfare state, health care, and industrial relations systems

<table>
<thead>
<tr>
<th>Scandinavian welfare state model</th>
<th>Beveridge health care system</th>
<th>Bismarck health care system</th>
<th>Mixed health care system</th>
<th>Industrial relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark, Finland, Sweden</td>
<td></td>
<td></td>
<td></td>
<td>bilateral, corporatist (DK); corporatist (FI); corporatist, bilateral (SE)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bismarckian welfare state model</th>
<th>Beveridge health care system</th>
<th>Bismarck health care system</th>
<th>Mixed health care system</th>
<th>Industrial relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria, Germany, Netherlands, France, Belgium, Luxembourg</td>
<td></td>
<td></td>
<td></td>
<td>corporatist, bilateral (DE, AT); bilateral, corporatist (NL); state-centred (FR); corporatist, corporatist (B, LU)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anglo-Saxon welfare state model</th>
<th>Beveridge health care system</th>
<th>Bismarck health care system</th>
<th>Mixed health care system</th>
<th>Industrial relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td></td>
<td>bilateral (GB); corporatist (IE)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Southern European welfare state model</th>
<th>Beveridge health care system</th>
<th>Bismarck health care system</th>
<th>Mixed health care system</th>
<th>Industrial relations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spain, Portugal, Italy, Greece</td>
<td></td>
<td></td>
<td></td>
<td>bilateral (ES); state-centred (PT); bilateral (IT); state-centred (GR)</td>
</tr>
</tbody>
</table>

In table 7 the features of EU member states are combined in relation to different regimes. Ideology, goals, functions, financing, benefit structures, access, provisions, and relation to regimes vary fundamentally. However, the market economy and competition shapes each country differently and affects the provisions provided to people. Ideologically Anglo-Saxon countries provide residual services, Nordic countries provide redistributive services, and Mediterranean countries provide rudimentary services (e.g., OHS). It is important to recognise that the regimes rest on an empirically fuzzy foundation upon which other empirical analyses are often built (van Voorhis 2002). The regimes and systems are built on ideal simplified situations. The Netherlands has been considered a social democratic model in some analyses and a corporatist model in other analyses. In some analyses, Finland is considered corporatist, in others social democratic. Austria and Belgium are most often considered corporatist.
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<table>
<thead>
<tr>
<th>Geographical and historical reference</th>
<th>Anglo-Saxon welfare state; Beveridge health care system</th>
<th>Continental welfare state; Bismarck health care system</th>
<th>Nordic welfare state; Beveridge health care system</th>
<th>Mediterranean welfare state; Mixed health care system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideology(^{72})</td>
<td>Residual Liberal Residual</td>
<td>Industrial-achievement Conservative-corporatist Institutional</td>
<td>Institutional-redistributive Social-democratic Modern</td>
<td>Semi-institutionalised Rudimentary Corporatist(^{73})</td>
</tr>
<tr>
<td>Goals of social policy</td>
<td>poverty and unemployment alleviation, individual choice, market</td>
<td>workers’ income maintenance, occupation-related benefits and services</td>
<td>equality, an income for all, egalitarian distribution, network public services, state dominated</td>
<td>family- and church-based welfare producers and supporters, resource mixing</td>
</tr>
<tr>
<td>Functioning principles of social policy</td>
<td>selectivity contributions</td>
<td>universality</td>
<td>universality and contributions</td>
<td></td>
</tr>
<tr>
<td>Technique of defining provisions of social services</td>
<td>targeting social insurance</td>
<td>redistribution</td>
<td>mixed/decentralised</td>
<td></td>
</tr>
<tr>
<td>Methods of financing social services</td>
<td>payroll contributions</td>
<td>payroll contributions</td>
<td>taxation and user charges</td>
<td>payroll contributions and user charges combined</td>
</tr>
<tr>
<td>Benefit structure; compensations of OHS</td>
<td>means tested, flat rate; employer</td>
<td>contribution and earnings related; employer</td>
<td>flat rate; employer and national social insurance</td>
<td>contribution and earnings related; employer</td>
</tr>
<tr>
<td>Access to welfare services; OHS</td>
<td>need; work-related benefit</td>
<td>work-related benefit</td>
<td>citizenship, residence- and work-related benefit</td>
<td>work-related benefit</td>
</tr>
<tr>
<td>Provision of OHS</td>
<td>employment related; employers contribute to OHS units</td>
<td>employment related; employers contribute to insurance funds or OHS units</td>
<td>employment related; employers pay for social insurance and some compensation by insurance/taxation</td>
<td>employment related; employers pay for insurance funds or use public services provided by taxation</td>
</tr>
<tr>
<td>Industrial relations as control mechanism</td>
<td>bilateral, corporatist</td>
<td>corporatist, bilateral, state-centred</td>
<td>corporatist, bilateral</td>
<td>bilateral, state-centred</td>
</tr>
<tr>
<td>Labour market</td>
<td>deregulation</td>
<td>insiders/outiders; large number of part-time workers</td>
<td>high public employment</td>
<td>large informal economy; large number of SMEs</td>
</tr>
<tr>
<td>Gender</td>
<td>female polarisation</td>
<td>part-time feminisation</td>
<td>occupations feminised</td>
<td>ambivalent familialism; late female mobilisation</td>
</tr>
</tbody>
</table>

\(^{72}\) Esping-Andersen 1990, Leibfried 1993, Alcock et al. 2001

\(^{73}\) Leibfried 1992
5.5.1 Reforms of the different systems

Governments in Europe have, irrespective their party political ideology, pursued policies that constrain and reduce the scope and generosity of the welfare state. The changes have included a shift to market-based and family-based welfare; decentralisation of responsibilities to institutional, regional, and local administrations; and increased pressure on social expenditures due to EMU, governments’ trials to generate additional income, public sector reforms, and increased selectivity in benefits (Kleinman 2002). George (1998) recognised eight types of reforms: increased tax incentives to encourage the use of private rather than public services, moving welfare responsibility to employers, stiffened eligibility criteria for the payment of social security benefits to unemployed people, reduced generosity in benefits to retired and unemployed people, increased charges for the use of state health services, minor increases in salaries of state employees, increased state revenues and new management techniques with annual budgets due to privatisation of public services, and markets in social and health services.

The promises and threat of the harmonisation of social and economic policies in the EU reinforced the urgency of clarifying different and competing welfare regime models. The northern European welfare regimes seemed to be considered too expensive in comparison to southern European welfare models (Cochrane, Clarke 1993). The trends have been shifting between liberal and corporatist welfare regime models. The employment-based insurance welfare regime model would reinforce differentiation, segregation, polarisation, exclusions, and marginalisation. Convergence towards the employment model can be criticised on ideological, moral, and political grounds, because the model would induce member states to distance themselves from a redistributive conception of welfare state citizenship (Hantrais 1995).

However, the changes vary across all countries in relation to emphasis, substance, and areas of reforms (financing, organisation, or administration). The differences are related to political forces or institutional factors as brakes on policies for radical changes. Continuity for welfare states has been more evident, if strong organisational interests supported the impetus not to change. There is little evidence of radical change, but rather the idea is to get through the retrenchment period
and continue developing the welfare state (Pierson 2001, Kleinman 2002, Palier 2002). National governments have not been able to agree on the core functions of the welfare states, but they have been able to adopt minimum European standards on social and workers’ rights. This has occurred either through council directives or agreements reached in the social dialogue (Leibfried, Pierson 1995; Falkner 1998), as in the case of Framework Directive 89/391/EEC. Therefore only very undemanding regulations have been passed (Streeck 1995, 1997). These regulations might be useful in Anglo-Saxon and southern European countries, but not in continental and Scandinavian welfare states (Scharpf 2002).

On the administrative side of welfare state reforms, deregulation meant a combination of deregulation and reregulation according to national circumstances. In the areas of social regulations and more specifically in health and safety, deregulations meant less burdensome methods were used in achieving relevant regulatory objectives. The framework directive and its sister directives were created for that purpose, but the approach changed to one of coordination and exchange of information to gain convergence among EU member states. A central feature of regulatory reform at European, national, and supranational levels was the delegation of significant policy-making powers to independent institutions, such as the European Central Bank. This delegation of power can be questioned as to whether political leaders were willing to limit their power and what is the democratic legitimacy and public accountability of such institutions and such politicians. Independent agencies were justified when highly qualified expertise was needed in combination with rule making that was inappropriate to a government department. That led to a freeing of the public administration from partisan politics and party political influence. Agencies also provided greater policy continuity than cabinets, because they were not connected to the electorates. An expert agency can also provide flexibility in policy implementation and formulation, especially in some particular situations. Independent agencies were able to protect citizens from bureaucratic arrogance and silence, and they were also able to focus public attention on controversial issues, such as absenteeism, high risks in the construction sector, and harassment at work (Majone 1996). The important EU institutions in the area of occupational health and safety are the European Agency for Health and Safety at Work, Bilbao; and the European Foundation for Living and Working Conditions, Dublin.
During the years of retrenchment, adjustment, transformation, and reform of welfare systems, politicians and researchers have learnt about the inability of markets to cope in the fields of health care, long-term care, and unemployment insurance. Some of the problems of the welfare state are related to market failure (markets do not provide protection for all) and the sustainability of welfare state. The sustainability of welfare states depends on tax capacity and labour market policy in relation to welfare regimes. One clear sustainable fiscal position is a high-spending universal social policy along with a high willingness of the population to be taxed, such as in the Nordic countries. A low-tax and low-spend welfare state is similarly sustainable, though selectivity must be increased to meet minimum objectives of providing the needs of the poor at low costs, such as in the United Kingdom. The reforms have taken a long time in the corporatist countries of Germany, France, and Italy. In relation to labour markets, welfare states need a flexible labour market to sustain high tax returns. The Netherlands claims to be highly committed to welfare and having flexible labour markets. The United Kingdom has moved to a flexible labour market, but its benefit policies should keep poverty low and encourage employment (Glennerster 1999, Ferrera et al. 2000). The discussion among researchers has been in relation to welfare regimes and the degree of changes. The terminology of describing changes has been from retrenchment to transformation and adjustment (Pierson 2001, Gilbert 2002, Maier et al. 2003). New terminology has appeared, and the relationships among state, economy, labour market, and welfare have shifted towards a market orientation. Welfare and work in relation to employability, initiative and responsibility, flexibility, and equal opportunity has changed. In addition, the role of the state in financing welfare systems in relation to stability pacts imposed by the EU has changed. Also, attitudes have changed towards the state’s responsibility to provide a minimum quality of life.

At the same time, welfare services faced retrenchment and the downsizing of structures, services, and personnel due to an expansion of services and scarce or limited funds available for services. Also several economical and political issues had to be taken into consideration in addition to retrenchment. Pierson (2001) argues that the politics of retrenchment was the politics of blame avoidance. Scarbrough (2000) and other scholars have supported this argument. ‘Old politics’—which
includes social democracy as well as socio-economic, partisan, and institutional factors—instead of new politics was emphasised and supported during the development of the welfare state. Huber and Stephens (2001a, b) and Castles (2001) stressed the importance of macroeconomic challenges, for example unemployment for cross-national variation in retrenchment. An important retarding point in welfare state expansion and retrenchment has been institutional fragmentation, for example multiple veto points (Huber et al. 1993, Castles 1999, Ferrera et al. 2000, Kleinman 2002).

Pierson (1994, 1996) argued that the fragmentation of the welfare state has been less straightforward in the case of retrenchment. The concentration of power also concentrated blame, but it facilitated the development of retrenchment strategies. Fragmentation provided places for veto points, which hindered reform, but it also allowed for sharing the blame (Pierson 2001). Also, political parties were significant players in retrenchment of the welfare state. Swank (2001) argued that whether globalisation leads to retrenchment depends on the institutional constellation in different countries. Trade unions and social corporations were considered important institutions for the politics of retrenchment (Swank 2001). Pierson (1994, 1996) pointed out the declining importance of trade unions for the defence of welfare states. Opposition of trade unions to retrenchment might be overcome by side payments and consensual political strategies (Palier 2000). Ross (2000) argued that new partisan politics of the welfare states or left parties in certain conditions can retrench more successfully than the right-wing parties. According to Kitschelt (2001), the prospects of social policy reforms can be improved in cases where a strong liberal party defends the welfare state, there are no competing parties, and configuration of competition is around economic rather than sociocultural issues. Green-Petersen (2001) claimed the importance of a party political consensus, which is achieved in the government if one party has a pivotal role in the government. The gradual transformation and adjustments of welfare systems and OHS and their limitations and reasons vary among member states (Maier et al. 2003). Gilbert (2002) described this transformation as moving in four directions, from protection to inclusion, from state to market, from universal to selective, and from citizenship to membership. These transformations were rather gradual and limited, but continuous.
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The changes in welfare state regimes have also been different; some countries have made path-dependent decisions and changes, and some welfare state regimes have been thought of as ‘frozen’ (Leibfried, Pierson 1995). Discussion on norms and regulations influences path-breaking reforms and adjustments. Also, politics—in the sense of competing parties and seeking consensus for changes—matters most during election times (Ross 2000, Green-Pedersen 2001). However, Lessenich (2003) described the dynamic inertia in the European social model. His argument is that the welfare state aimed to promote societal arrangements marked with diversity and social balance created by political, economic, and social institutions. These institutions were now presenting contradictory ideas, norms, and principles: market and state, autonomy and regulation, individual responsibility and solidarity. The continuous ambivalence of the European social model and welfare state institutions opened a permanent window of opportunity for institutional entrepreneurs looking for changes to welfare states. These entrepreneurs are claimed to be the European Commission, a member state, stakeholder, or industry. Institutional entrepreneurs created new paths by using the redundancy of institutional arrangements and by using previously unconsidered institutional resources. The incongruities and inconsistencies characteristic of European social models compromised institutions that represented untapped innovative potential (Crouch, Farrell 2002). This means that the role of political leadership, interest, and choice deserve greater attention in the welfare state restructuring debate. The endogenous sources of change, such as demographic and programme maturation, urged leaders to restructure costly and inefficient social programmes. As welfare reformulation often occurs under the leadership of left governments, depoliticising the forces of change has an obvious logic. Political choice matters and seemingly small events or choices can have far-reaching consequences (Ross 2000).

Despite the retrenchment, adjustment, or transformation, social expenditures have been growing constantly. It seems that Europe has not been the problem, and the EU seems to be unable to influence national social policies, including OHS. It also seems that European welfare reforms are based on national policies and that the EU plays a minor role. Pierson (2001) showed that in welfare state capitalism, the reform of the welfare state occurs through re-commodification in liberal welfare
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states, through recalibration with rationalisation in Nordic countries, and through updating recalibration in continental welfare systems.

However, diverse policy histories are sources of inconsistencies. Major reforms often occur in one or another policy field, while others are not touched (Pierson 1994, Kasza 2002). Welfare state regime distinctions have been of limited or no help in explaining the different patterns of welfare cutback (Taylor-Gooby 1996). Contrary to many other researchers, Palier (2003) argued that the convergence of European welfare states and European integration does not cause welfare state changes.

The first 25 years of the Community aimed to harmonise national regulations through regulatory reforms in the areas of goods, services, capital, and people. The objective was to adjust national rules to the requirements of the single European market. The instrument was a directive, which defined the regulatory objectives to be achieved, and member states selected the method to achieve the results. In practice, this would mean that all the states would have the same regulations or that minimum requirements are determined, which a member state may exceed (Hantrais 1995, Nieminen 1998). In some cases the harmonisation was successful and effective in making policy changes through different directives, such as in the case of competition policy (Hantrais 1995).

But the regulatory approach was taking too much time and was too elaborate for national governments. The regulatory method of harmonisation was complemented when the mutual recognition of national regulations was accepted and when standards and technical specifications were given for national standardisation organisations to agree on. This reduced the regulatory workload of the policymaking organisation of the Community. The occupational health and safety regulations were valid in each country, even if they were pursued by different methods (Majone 1990).

The mutual recognition principle (after the Single European Act) introduced competition among rules and regulators, which may have stimulated a flexible approach to regulations and policy innovations (Kay, Vickers 1990). When the regulatory strategy of mutual recognition was accepted, the changes influenced the structure and organisation of health and safety at work, political and economic strategies of the EU (enlargement and monetary union), and public expenditure constraints.
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The resources for regulatory inspectorates have decreased, and self-regulation has increased and enhanced managerial responsibility (Walters 2001b, Walters 2002a). Several gaps among the mutual recognition of regulations and standards have appeared and have needed further coordination and institution building within the EU (Majone 1990).

Differences among national practices and outside pressures have caused the foundation of European regulatory agencies, such as the European Agency for Safety and Health at Work in Bilbao, to follow and support the implementation of Framework Directive 89/391/EEC and sister directives. The move toward independent regulatory agencies represents an evolution of the regulatory approach to provide continuous attention to the regulated activity and to make assessments and rules with appropriate staff in the EU (Kaufer 1990). However, deregulation has not meant an end to all regulation. Deregulation has meant less restrictive or rigid regulations, which means less burdensome methods of governmental intervention with relevant regulatory objectives. The regulatory reform has meant in general a combination of deregulation and reregulation (Majone 1990).

5.5.2 Convergence

The Single European Act confirmed the shift towards respect and recognition of national social protection systems. The first social policy convergence measure was the Community Social Charter of the Fundamental Rights for Workers in 1989 (Sakslin 1995). Further, EU member states committed themselves to the recommended convergence trends published by the European Council in 1992 – dealing with sufficient resources and social assistance in social protection systems (92/441/EEC) – and also committed themselves to the convergence of social protection objectives and policies (92/442/EEC). Convergence as a mode of action in EU social policy is implemented by legislation, economic support programmes, joint programmes, and through agreements among social partners.

The common trend in political economies in Europe – such as support for less regulation, changing forms of employment and labour relations, an increasing number of SMEs, emphasis on self-regulations, and decreasing resources for labour inspections – converge EU mem-
ber states towards similar health and safety outcomes (Walters 2001b). In addition, the encompassing welfare states have to face the pressures of the global economy, increasing interdependence, and supranational policy-making. Increased political integrations promote policy learning and diffusion (van Kersbergen, Verbeek 1996). Alone or jointly they produce similar policy responses and needs for adjustments. The outcome is that differences and variations among welfare states decrease, which increases convergence (Kosonen 1994, Streeck 1995, 1996, Rhodes 1996, Scharpf 1999, 2000, Walters 2001b).

Several scholars confirm that there appears to be convergence in several policies and systems among countries (Montanari 2001, Bouget 2002, Cornelisse, Goudswaard 2002, Palier 2002, Pochet, de la Porte 2002). However, some researchers see a threat of downward levelling of social protection (Chapon, Euzéby 2002), or social dumping and a race to the bottom (Alber 2000). Wilensky et al. (1985) presented the idea that continued economic development makes societies more alike in their social security institutions, despite differences in cultural and political traditions. The influencing factors are converging political and economic systems, such as the integration of the EU and the monetary union among the EU member states. These have an impact on health and welfare programmes, which are increasingly comprehensive but are converging as well. However, the modes of financing a welfare state do not seem to be converging (Hagfors 2000, Wolf 2002). Wallace and Wallace (2000) argued that one should distinguish between evidence of congruence (e.g., the compatibility of the policy actors’ preferences as the basis for shared policy) among national policies as a requirement of common policy development, and evidence of convergence as a consequence of involvement in EU processes. There is a need to explain why responses in some countries seem to be more or less convergent than in others, and why some countries use the same EU policy regimes nationally different ways. In addition, countries close to EU member states, such as Norway and Switzerland, seem to be adopting approaches similar to EU member states in many policy areas (Wallace, Wallace 2000).
5.5.3 Europeanisation

The deepening of European integration brought changes to national social, health, industrial relations, and occupational health and safety policies. The actions taken to deepen integration as well as those taken in the areas of social, health, industrial relations, and occupational health and safety modify the same policies in EU member states. The integration of the EU in several policy areas transformed and converged social integration towards single social areas as defined by Threlfall (2003). She considers that single social areas in health care and the labour market, for example, are in the stage of full integration; she also believes that the EU has experience functioning as a single unit. Workplace health and safety areas are harmonised, but experience frontiers as barriers to further integration. However, she observes that employees’ experience of risks is not identical in all the member states that doubt the integration. The social dimension of the EU and the EU member states’ systems, policies, and strategies are incrementally integrated into a new constellation.

However, uneven implementation of Community law across the EU is a reality (Mendrinou 1996, Lampinen, Uusikylä 1999, Knill, Lehmkuhl 2002, Tallberg 2002, Linos 2003). Implementation structures and practices differ in different directives as well as per member state. Uniform rule application is by no means a common practice. The impact of European policy-making differs across policies and countries, and European policy means different things in different domestic constellations. The outcome is not surprising and is often reported in articles concerning Europeanisation (Moreno 2000, Radaelli 2000b, Knill, Lehmkuhl 2002, Haverland 2005, Trondal 2005). Europeanisation studies look at the domestic impact of the EU. The assumption is that domestic adjustment is to be expected, if there is misfit between the European and national levels in legislation and when there are sufficient mediating factors available that can induce changes (Krill, Lehmkuhl 2002, Versluis 2004).

Radaelli (2000b, 2004) defined Europeanisation as ‘consisting of processes of construction, diffusion, and institutionalisation of formal and informal rules, procedures, policy paradigms, styles, ‘ways of doing things,’ and shared beliefs and norms. All of these are first defined and
consolidated in the EU policy process and then incorporated in the logic of domestic (national and subnational) discourse, political structures, and public policies. However, other definitions have also been published. Börzel (1999) says that 'Europeanization is a process by which domestic policy areas become increasingly subject to European policy-making.' According to Ladrech (1994), 'Europeanization is an incremental process re-orienting the direction and shape of politics to the degree that EC political and economic dynamics become part of the organisation logic of national politics and policy-making.' These definitions emphasise the role of adaptation, learning, and policy change; they also point out that Europeanisation can produce divergence or convergence of policies.

For Streeck (1999), Europeanisation meant the search for public policy to balance between protection and risk, security and opportunity, collective solidarity and individual responsibility, public authority and private exchange. This balance enables public policy to distribute scarce resources for solidarity truly to those who cannot help themselves. Streeck calls this the European ‘third way.’ The Europeanisation and ‘Europeification’ (as used by Andersen et al. 1993) are identified with the emergence of EU competencies and the pooling of power. But Europeanisation as a continuum and the notion of domestic political systems being increasingly influenced by EU policy make the distinction between EU policy and domestic policy difficult. In addition, Europeanisation differs from integration theories in which the focus is on whether European integration strengthens intergovernmentalism, weakens it, or triggers multi-level governance dynamics. The focus of Europeanisation is on the role of domestic institutions in the process of adaptation to Europe (Börzel 1999, Radaelli 2004). Analytically the process leading to the formation of a certain policy and the reverberation of that policy in the member states are differentiated (Radaelli 2004). Graziano (2002) defined Europeanisation as two intertwined processes: the first one is a process through which national political, social and economic forces give birth to a new European supranational political and institutional setting; the second one is a process through which EU political, social and economic dynamics become an increasingly important part of domestic political discourse, identities, representation structures, public institutions and public policies.
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Europeanisation has an impact on political structures (e.g., institutions, public administration, and intergovernmental relations), legal structures, structures of representation, normative structures, and public policies. The Europeanisation of public policy can take different forms affecting actors, resources, and policy instruments (Radaelli 2004). Studies in policy level show the great impact that the EU has directly or indirectly on telecommunication, monetary, and tax policies (Radaelli 2000a). EU regulations also affect national competition policy, regulatory approaches (Majone 1996), and health policy (Mossialos, Belcher 1996; Mossialos, McKee 2001; McKee et al. 2003; Hämäläinen et al. 2004).

In the analysis of change in relation to national OHS policies and their Europeanisation, one can find four possible outcomes: inertia, absorption, transformation, and retrenchment. Inertia refers to the situation where change is not evident and there is a delay in the transposition of directives, implementation as transformation, and resistance to EU-induced change. Inertia might be impossible to sustain due to economic or political reasons. Examples of this include the EMU, and the United Kingdom’s opting out of social policy in the early 1990s. Absorption indicates change as adaptation. It might be only an accommodation of policy requirements without a real modification of the essential structures and changes in the political behaviour, as in the case of OHS in France. Transformation is the change of the fundamental logic of political behaviour and the adoption of a new process in policy, as in the case of OHS in Spain and Austria. Retrenchment implies a process defined by strong national intervention, wherein the policy becomes less European than it was originally. The important questions are the objects of Europeanisation (domestic structure or public policy) and the dimension of change (direction) (Radaelli 2000b).

The mechanisms of Europeanisation might concern institutional compatibility, the presence of the European model, domestic opportunity structure, and directives framing integration (Knill, Lehmkull 1999; Radaelli 2004). In addition, Radaelli (1997) explained the cognitive convergence caused by the EU.

The major impact of Europeanisation originates from intergovernmental relations. Intergovernmentalism refers to the notion that EU is a Europe of nation-states in which the member states have firm control over EU decision-making processes (Teague 2000). But the European
Commission has an interest in promoting integration, which can cause conflicts with member states (Eichener 1997). In the 1990s social policy again became a bargaining arena for the negotiations of compromises among the competing preferences of member states, and it gained a firmer legal basis in the treaties governing the EU. Also, the objectives and orientation of EU social policy had shifted (Radaelli 2000b, Teague 2000).

Another way of thinking about Europeanisation is by the institutions involved in policy-making. The political organisation of the EU contains a combination of institutional features that are not tightly integrated, and the competence to adopt or advance any EU social policy is not inside in any one of the institutional organs. The competence is dispersed across a number of substrata of the EU governance system, such as institutions, advisory committees, the directorate general of employment and social affairs, and the directorate general of health and consumer affairs. Traditionally, the roles of the Commission have included administrating, initiating, brokering, guarding, and representing (Teague 2000). Pollack (1997) argued that the Commission has used the various functions delegated to it to carve out a role as a supranational policy entrepreneur with the ability to persuade, mobilise, and manipulate opinions and interests to support its preferred position. This can be easily seen in recent initiatives that form 'European health policy' through the High Level Reflection Group, in several communications, and in new proposals for the open method of coordination (Hämäläinen et al 2004). On the other hand, Moravcsik (1999) stated that the Commission lacks the two main instruments that policy entrepreneurs use to influence political decision making: financial payments and credible threats. The Commission has to rely on the manipulation of information and ideas to affect authoritative political outcomes. As there is usually a lot of information available and member states are knowledgeable about the issues, the Commission has little room to operate in an entrepreneurial way (Moravcsik 1999), but it can use soft methods to pronounce its position through cognitive convergence and it can use different networks to justify and distribute the views (Knill, Lehmkull 1999, Radaelli 2000a).

The increasing interactions between national administrative structures and the institutional apparatus of the EU are hard to map, because the interactions occur mainly behind closed doors or informally. Institu-
5. THE POLICY ENVIRONMENT OF OHS

tions can either function to uphold the status quo or be the vehicle for policy innovations. This new type of governance has worked to advance the regulatory competence of the EU. The rise of comitology and the increased use of technical committees and expert policy network in the EU decision-making processes have led to the development of a European policy agenda in those respective fields. The committees are used in the preparation of regulations or laws, and often the policy agenda extends the EU’s regulatory competence or institutional presence in unexpected ways. Comitology helps build advanced forms of regulatory cooperation and joint rule making. This also contributes to the Europeanisation of national policy officials, who begin to understand different national approaches to solving problems and who become more aware of EU-wide policy solutions. This EU action coordination has advantages and opportunities, as one can note from benchmarking and best practice processes (Teague 2000). The direct effect of European integration on party systems can be noticed in the fact that policy issues are debated in the national arena, but are mostly decided at the EU level. Europeanisation contributes to the process of depoliticisation, indifference, and popular disengagement. The location of decision making has moved, and electorates do not really have representatives at the EU because administrators are mainly preparing policy papers and legislative issues (Mair 2000).

An additional form of Europeanisation is the exchange of information. The end of negotiations, linkages between negotiations, and outcomes are often difficult to define. A bargaining round might follow negotiations. Understanding the rules, procedures, and consequences of negotiation are central to the evolution of expectations and the perceived legitimacy of EU institutions. This creates interdependency among participants and ways of forming any policy for Europeanisation. Dynamic socialisation creates positive feedback loops with repeated interaction among national actor and interest groups within the EU (Teague 2000). European integration is seen as creating a political and social process.

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74 Comitology= Treaty permits the Council to impose requirements within enabling legislation on the way the Commission exercises its executive power. The three types of committees—advisory, management, and regulatory—work according to different procedures and have varying levels of legislative control over the Commission. The type of committee assigned normally depends on the policy area being regulated.
whereby national actors alter pre-existing preferences, expectations, and behaviour as a result of interactions with other political and economic forces from other member states. Socialisation also increases the legitimacy of EU social and health policy and creates focal points that mark off the boundaries between acceptable and unacceptable EU coordinated action (Teague 2000).

Major Europeanisation occurs through the socialisation of actors towards joint European tasks. This socialisation in the EU takes place in different committees. The committee types can be advisory, managerial, regulatory, or procedural to safeguard decisions in the Council instead of the Commission (Dogan 1997). The EU negotiations are highly institutionalised with formal and informal rules. Negotiations also have patterns of practices, such as negotiation frameworks, norms for procedures, minority protections, and a consensus culture. The EU is a continuous multilateral negotiation process and hides the range of contexts and occasions of negotiations. The diversity of actors adds its own dimension to influencing and lobbying (Elgström, Smith 2000).

In relation to different committees and their impact on policy-making in the EU, Egeberg et al. (2003) concluded that expert knowledge rather than country size plays a crucial role in the decision-making process. The members of Committees are also subject to dual instructions and loyalties. They are loyal both to their governments and to achieving results, which promotes consensual politics rather than bargaining (Andersen, Eliassen 2001). Also, participants across all types of committees evoke multiple allegiances and identities. They have loyalty to national institutions, but also to the committees themselves. The committees of the Council seem to be more intergovernmental, whereas the Commission committees are multifaceted because in many cases the participants do not have mandates about how to act, and the decision-making situations seem more relaxed. EU committees are sites of vertical and horizontal fusion of administrative systems and policy instruments. EU committees are indeed sites of Europeanisation of individual civil servants. The resocialising and transformative powers of the EU committees are heavily filtered and biased by the national institutions that are embedded in the EU committee participants (Egeberg et al 2003).
Chapter 5 describes various organisations influencing OHS, competence of the European Community in OHS, various policies affecting OHS, and the interrelations of all these. The major international players are WHO and the ILO with their several conventions and recommendations on OHS, but the actual impact has remained weak due to the non-binding nature of agreements. The ILO and WHO affect policy most heavily through tight collaboration with member states, taking initiatives to an international level and exchanging and providing comparative information.

The major supranational policy maker is the EU. In this study, the impact of the EU on EU member states is considered a complex interplay among actors, stakeholders, policy arenas, and policies. This interplay is responsible for the Europeanisation of several policies, including social, health, and occupational health and safety policies. Different institutions, such as ministries, national occupational health and safety institutes, and professional organisations, play an important role in any changes, mostly only in the implementation of internationally agreed issues. The interests and emphases of the member states are not always easy to establish within countries. Interest satisfaction plays a crucial role in national and international policy processes, and the same actors are often involved in bargaining at different locations for political action. Location might be regional, national, or European; or the location might be different policy domains. Besides the political orientation of governments, national institutions exert an influence on the scope, character, and style of policy-making, policy processes, and implementation of change. They make up the political incentive, the structure of policy-making, and the degree of influence and power. Policy actors can bring these to the policy processes. The national institutes share the structures of political debate, mediate preferences, and alter policy choices. The government’s administrative capacities (implementation and delivery) and decentralisation vary among countries. In addition, industrial relations affect individual policy areas depending on their independence from state interventions, self-regulations, and involvement of social partners in the management of welfare programmes.
Informal policy-making is a complex system with several locations, means, actors, and influencing powers in the EU policy-making and policy processes. In some cases informal policy-making is more important than its formal counterpart, because major choices, issues, and contents are decided in informal negotiations, bargaining processes, and lobbying activities. One of the informal policy-making methods is lobbying, which is the informal influence on shaping and making decisions. Several stakeholders, some of which have more influence than others, express their views in the policy-making process. EU lobbying concentrates on the initiation phase of any policy, and it includes activities aimed at gathering information and establishing oneself as an actor.

Formal policy-making includes several instruments, such as open method of coordination, regulation, social dialogue, structural funds, support programmes (such as public health programmes), integrated policy approach, research, mainstreaming, directives, and cooperation. Both hard and soft methods are used in the area of occupational health and safety. In addition to treaties, separate agreements have been used to build the European social dimension. Of the several instruments used by the EU, the strongest are regulations and directives. Regulations are binding and have direct legal force in EU member states and may supersede national legislation, if necessary. The directive is designed to reconcile the dual objectives of both securing the necessary uniformity of Community law and respecting the diversity of national traditions and structures. What the directive aims for, then, is not the unification of the law, which is the regulation's purpose, but its harmonisation. The idea is to remove contradictions and conflicts among national laws and regulations or gradually iron out inconsistencies so that, as far as possible, the same material conditions are obtained in all the EU member states. Framework Directive 89/391/EEC concerns minimum safety and health standards for the workplace and for the workers using machines, tools, products, and installations.

The principal aim of the EU was to create an internal market. The SEA sped up the development of the four freedoms, namely, the free movement of people, goods, services, and capital. The main aim of the EU was to increase the economic growth of the European countries, but the spillover effect has brought an internal market, competition, and the implementation of the four freedoms to OHS as well as health
and social services. Many conflicts, however, might arise between occupational health policy priorities and commercial interests, such as the common aims of universal coverage or solidarity of access to OHS.

The deepening of European economic integration has raised the importance of social policy, the so-called social dimension, as a balancing factor in European integration. The EU has increasing influence on national social policies, practices, and benchmarks. The administrative failures in the institutional connections among the EU member states and the EU centre and others reflect opportunities for new forms of pan-European policy collaboration. The socialisation among national actors and interest groups within the EU has created political and social processes where national actors can exchange and explore their preferences, expectations, and behaviours in the interaction of European political and economic forces. Socialisation works to increase the legitimacy of EU social policy through social dialogue, comitology, focal points, and networks.

In a broad sense health and safety at work in the EU framework has developed from a modest coordination of benefits among member states into action programmes to improve health and safety at work in EU member states. Thereafter the aim was to harmonise health and safety at work, to defend workers' rights, and to prevent social dumping using Framework Directive 89/391/EEC as a tool. The strategy adopted in 2002 brought health and safety at work to a new policy level by integrating issues with other policies and giving a mandate to the European Agency for Health and Safety at Work to follow and implement the strategy. The Council of the EU makes major decisions concerning EU social policy and OHS. Under the unanimity rule in the core area of social policy, one country is able to block EU decision making. The important issue is which decisions on social, health, labour, or other policies are made using unanimity, qualified majority, or co-decision procedures. Different processes give possibilities and opportunities to influence the content of policies, directives, or recommendations.

The EU plays an increasingly large role in social policy in European welfare states. It is very important to acknowledge the differences among the welfare states and their distinctive features, which reflect their historical, political, economical, and cultural backgrounds, when different actors exchange information in international connections and
try to build up common aims and joint activities. Most of the reasons for health sector reforms originate from reforms of the welfare state and from fiscal pressures. Given its importance to the electorate, health care reform is likely to provoke conflicts, which politicians try to avert because of blame avoidance and loss of support. Health reforms are also attractive due to power relations among various stakeholders. The industrial dimension of health reforms is important, owing to the large impact on employment, medical technology, and pharmaceuticals.

Different western European trade union systems have concentrated and collaborative relations. A homogeneous society and political system promotes a concentrated trade union system, whereas a heterogeneous society leads to dispersed and decentralised trade union movement. Trade unions can be centralised or decentralised, depending how much they compete and how many of their functions overlap. Labour market systems have been classified as bilateral (employers and trade unions), state-centred, and corporatist (capital, labour, and state).

Industrial relations are diverse in EU member states. The most important differences are in the level of unionisation, the degree of centralisation, the role of legislation, and the ideologies (Kosonen 1995). Industrial relations regulate and determine the relationship among enterprises, employees, and government. There are pressures to integrate industrial relations with market integration, transnational unions, and business structures. Labour relations cover the labour market relationship, including salaries or wages, working time, rules for employment, and the functioning of the labour market. The social partners negotiate agreements on labour relations and make partnerships in some countries in negotiations on welfare state reforms, policies, and initiatives with the government (Elvander 2002).
6 OHS IN EU MEMBER STATES IN 2000

The aim of this chapter is to describe OHS in EU member states following Framework Directive 89/391/EEC, which introduced measures to encourage improvements in the safety and health of workers at work (Figure 6). The main focus is in the implementation of Articles 6 and 7, which concern preventive and protective services, especially OHS. This chapter describes the justification, policies, financing, and quality of OHS. The independence and competence of occupational health professionals for OHS and stakeholders’ opinions on OHS are also described. The description is based on interviews\textsuperscript{75} conducted in 1999-2000 in EU member states.

The key areas of the framework directive for OHS in legislation and implementation were the following.

- employers have a general duty to ensure the safety and health of workers in every aspect of their work (Article 5)
- employers have general obligations to prevent and ensure safety by effective means (Article 6)
- employers evaluate workplace risks and adopt written risk assessments (Article 6)
- employers establish preventive services or use external ones (Article 7)

\textsuperscript{75} The answers are from several stakeholders in different countries working with occupational health. The interviewees were from ministries, professional organisations, trade unions, insurance companies, employers’ associations, and occupational health services (OHS) associations, for example. The views presented are those of the interviewee and do not necessarily represent the views of the organisation, institution, or company for which he or she works. However, the views might give some direction for the general view of OHS in EU member states, as the interviewees were the influential professionals in the area of OHS in each member state.
the framework directive applies to both public and private sectors
employers must take the measures necessary for the safety and health protection of workers, including prevention of occupational risks and provision of information and training as well as provision of the necessary organisation and means to achieve this (Article 6.1)
employers enlist competent people or services for protective and preventive services and ensure that people or services have necessary means and aptitudes (Article 7)

The following general principles of prevention are mentioned in Article 6, paragraph 2.
• avoid risks
• evaluate risks that cannot be avoided
• combat risks at the source
• adapt work to the individual (workplaces, choice of work equipment, and working and production methods influence health)
• adapt technical progress
• replace dangerous work with non-dangerous or less dangerous work
• develop a coherent overall prevention policy, which covers technology, organisation of work, working conditions, social relationships, and influence on factors related to the working environment
• give priority to collective protective measures over individual protective measures
• give appropriate instructions to workers

Article 7 states that the employer shall designate one or more workers to carry out activities related to the protection and prevention of occupational risks for the undertaking and/or establishment. If such protective and preventive measures cannot be organised for lack of competent personnel in the company, the employer shall enlist competent external services or personnel. In all cases, the designated workers must have the necessary capabilities and the necessary personal and professional means. The designated workers and the external services or personnel consulted must be sufficient in number to deal with the organisation
of protective and preventive measures, taking into account the size of the company, the hazards to which the workers are exposed, and the distribution of those hazards throughout the entire enterprise.

The data were collected mainly by interviews, and therefore the accuracy of the information was dependent on the interviewees’ knowledge of OHS in their countries. It was not possible to track all the information from various sources of information, such as legislation or documents.
6.1 Transposition of the Framework Directive 89/391/EEC for OHS

The transposition of Framework Directive 89/391/EEC triggered numerous actions for the normative and practical development in the relationship between the employer and OHS in the EU member states. The framework directive and its articles 6 and 7 gave legal responsibility to employers for workers’ health. The transposition deadline of the framework directive was 31 December 1992.

Austria, Finland, and Sweden joined the EU in 1995, by which time the framework directive was part of the negotiation for joining the EU. For some countries, such as Austria and Spain, the transposition meant new legislation and a quite new approach to occupational health and safety issues. France negotiated an opt-out agreement for preventive services, based on existing legislation and its provision on preventive services. Denmark’s legislation for OHS provided the example followed during the writing of the framework directive. In the mid-1990s, when the new Occupational Health and Safety Act of 1997 was adopted, a discussion started in Denmark on the coverage of OHS and quality management requirements, because all enterprises were supposed to be affiliated with OHS by 2005. In Belgium, the law on well-being at work was accepted, which was a broad approach to health and safety at work.

In Germany, the debate concentrated on the dual system of OHS regulation and enforcement. This caused competition among Länder (counties) as the governmental co-legislators and executor and the German OHS (Berufsgenossenschaften) as the self-regulatory and inspection body. Accident insurance law was changed, and the Social Security Act added prevention of industrial accidents, occupational diseases, and labour-related health risks to the tasks of Berufsgenossenschaften. Through Accident Insurance Orders, SMEs have also been more involved with OHS experts (Hämäläinen et al 2001, Schaapman 2002).

In Italy, health and safety issues have always been important to the labour movement. In addition, the National Health Service Act was instituted in 1978 (Act 833) and created a situation that made public...
health authorities the central actors in occupational health and safety and prevention. The framework directive was transposed into Italian law by legislative Decree 626/94 with seven other health-at-work directives and came into full force in 1997. The transposition required extensive changes to the Italian regulations. Official recognition of competent medical practitioners was included, and employers were required to have the competency to assess occupational risk and to do surveillance (formerly by USL, Labour Inspectorate, INAIL, and INPS77). The prevention services were organised internally or externally. Workers’ safety representatives became obligatory in all companies, regardless of size. OHS was provided with the power of the Labour Inspectorate in health and safety as a regulatory power. OHS was also responsible for preventive advisory activities, medical surveillance, occupational and environmental hygiene, and risk assessment. Decree 626/94 provided that the Labour Inspectorate would monitor the application of the occupational health and safety legislation. The Labour Inspectorate also had to inform the prevention and safety units of the OHS at the regional level (Rivist 2002).

Many provisions of the framework directive were already in line with the content and purpose of the Work Environment Act 1994 in the Netherlands, which was revised in 1998. Only risk assessment required adjustment in Dutch legislation. This meant more systematic approaches to OHS, where risk assessment was a base for occupational health and safety policy at workplaces. In addition, the new act obliged companies to contract certified multidisciplinary OHS services (Walters 2002a). The internal control system of Sweden complied with all the other aspects of the framework directive, but did not define adequate competence through OHS. The internal control ordinance was revised in 1996 to be adapted more to SMEs (Frick 2002). In Sweden a public investigation committee assigned by the government presented a proposal for new OHS legislation in 2005.

Of all the EU member states, the transposition was the most limited in the United Kingdom. Prevention services remained part of the tradition of voluntarism, and with few exceptions their use was left to the discretion of employers. Employers, the market, and the professional

bodies largely determined OHS coverage as well as the composition and qualifications of OHS personnel. The coverage of these services was limited (Walters 2002a).

In France, a government decree on 27 July 2004 introduced changes to the structure and content of services of OHS units. There was a shift in emphasis from annual medical examinations towards preventive action at workplaces, and the competencies of OHS professionals shifted towards a more multidisciplinary approach.

6.1.1 Institutions for OHS

The responsibility of OHS was linked to ministries of labour, health, social affairs, local governments, or trade and industry. Employers’ and workers’ organisations also took a variety of responsibilities in developing legislation, engaging in collective bargaining, and implementing OHS. The authorities with principal responsibility for the development, administration, and inspection of OHS varied among countries. In some countries there was no governmental authority with responsibility for the development, monitoring, or evaluation of OHS. In some countries, liberalisation and deregulation of the health market moved the responsibility to the ministry in charge of industry—as happened in Sweden in 2000. In many other countries, occupational health and safety was considered part of social policy and was the responsibility of the ministry concerned with well-being, welfare, or social affairs (Hämäläinen et al 2001).

OHS were the responsibility of the employer in all 15 EU member states. They were mandatory in some countries based on risks at the work (Denmark, the United Kingdom), and in some countries they are voluntarily based on the approach of self-regulation78 (the United Kingdom, Ireland, and Sweden). In these self-regulatory cases, health examinations for certain categories of workers were mandatory because of other legislation. In addition to ministries, several public or semi-public institutes

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78 Self-regulation was defined by a task force in the United Kingdom as the following: ‘Self-regulation is the means by which members of profession, trade or commercial activity are bound by a mutually agreed set of rules which govern their relationship with the citizen, client or customer’ (Better regulation task force. Interim report on self-regulation. October 1999. HMSO. UK. http://www.brtf.gov.uk/taskforce/reports/self_regulation.rtf 5/2004).
were responsible for administration, development, research, supervision, or information dissemination in the area of health and safety at work and OHS. These institutions included insurance boards and institutions, inspectorates, regional authorities, research and development institutes, industrial and labour market organisations, and various professional organisations for OHS, for example. More detailed information can be found from Hämäläinen et al. 2001.

6.1.2 Requirements for occupational health services

The structure of occupational health services’ legislation varies widely among EU member states. Some countries have laws made by parliament, and some countries have decrees made by a cabinet, ministers, or a president. Also, the forms of transposition vary. For example, a new law was introduced in Austria, Belgium, Denmark, Luxembourg, Spain, and Sweden; while other countries preferred to make amendments to existing laws. A list of laws concerning OHS is given in Appendix III.

Most EU member states have a list of tasks described in their regulations. The ILO and WHO conventions and recommendations were often the basis for these tasks. Table 8 describes set tasks and objectives for OHS in EU member states in 2000, based on the interviews. The tasks and objectives of OHS have been described in many ways, and the tasks vary without patterns of similarity. Despite the ILO’s recommendations, the tasks described by interviewees have not been defined clearly enough, which causes incoherence within OHS. The position of OHS varies in the welfare, health, social, and labour market policies and their administration in the EU member states. In some countries OHS relates more to health policies, systems, and administration; while in other countries OHS is related to social and labour market policies and administration. In addition the occupational health and safety legislation and its implementation vary among EU member states.
### Table 8. The tasks and objectives in regulations of OHS based on interviews

<table>
<thead>
<tr>
<th>Country</th>
<th>Description of tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>The tasks of OHS were workplace-related health promotion, planning, and job alterations and adjustments; working materials, work procedures, and personal protection equipment; occupational physiology and psychology; ergonomics and hygiene; first aid; job changes and reintegration; identification and assessment of workplace hazards; and information on workplace rules and regulations.</td>
</tr>
<tr>
<td>Belgium</td>
<td>The tasks of occupational health physicians were to advise on risks and to adapt working conditions in accordance with the state of health or the abilities of the worker. Physicians were to monitor hygienic conditions at work and the health of the workers.</td>
</tr>
<tr>
<td>Denmark</td>
<td>The main objectives were the prevention of accidents, ailments, and diseases at work and active promotion of improvements in work environment. The main functions were to advise enterprises and participate in the planning and implementation of measures that positively affected or influenced the work environment. Measures included registers, analysis, and evaluation of impact and requirements of work environment; advice on planning of new productions lines and hygiene; advice on purchasing protective equipment and on ergonomic planning; conducting systematic health risk assessments and monitoring chemical and biological agents; informing and advising on and preventing accidents, disease and injuries; and providing rehabilitation and training. However, OHS faced changes from the beginning of 2005.</td>
</tr>
<tr>
<td>Finland</td>
<td>The objectives of OHS were a healthy and safe work environment, a well-functioning work environment, prevention of occupational diseases, and promotion and maintenance of work ability.</td>
</tr>
<tr>
<td>France</td>
<td>OHS was to conduct workplace surveillance and advise employers on improvements. All employees had annual medical check-ups and follow-ups of occupational diseases or injuries. OHS produced an annual work environment action plan covering risks, jobs, and working conditions.</td>
</tr>
<tr>
<td>Germany</td>
<td>The tasks of OHS were health promotion, planning, and readjustment of jobs, working materials, work procedures, and personal protection equipment, occupational physiology and psychology, ergonomics and hygiene, first aid, identification and assessment of workplace hazards, and information on workplace rules and regulations.</td>
</tr>
</tbody>
</table>

Table 8. continues...
### 6. OHS IN EU MEMBER STATES IN 2000

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Greece</strong></td>
<td>Physicians were to conduct preventive medical examinations, provide advice to employers and employees, and provide first aid. Also, the National Health System was to provide OHS at the primary, secondary, and tertiary levels.</td>
</tr>
<tr>
<td><strong>Ireland</strong></td>
<td>Workplaces had to have a workplace safety statement in which preventive services can be established.</td>
</tr>
<tr>
<td><strong>Italy</strong></td>
<td>The duties of local health units were to cooperate with employers to identify risks and determine prevention of health and safety risks at work, suggest preventive plans and safety arrangements, and train workers about risks, occupational diseases, and emergency issues.</td>
</tr>
<tr>
<td><strong>Luxembourg</strong></td>
<td>OHS assured the protection of workers' health at the workplace through medical risk assessment and prevention of accidents and occupational diseases (not including state and municipal employees).</td>
</tr>
<tr>
<td><strong>Netherlands</strong></td>
<td>OHS tasks included inventories of health risks and hazards, consultation hours for workers, periodic health examinations, pre-employment check-ups, and rehabilitation on return to work of sick workers.</td>
</tr>
<tr>
<td><strong>Portugal</strong></td>
<td>Safety, hygiene, and occupational health services were to establish and manage work conditions towards safeguarding mental and physical health of workers, provide training and information to workers, and promote participation of employers and employees to improve the work environment.</td>
</tr>
<tr>
<td><strong>Spain</strong></td>
<td>Preventive services were to provide advice and support according to risks. The preventive services designed, applied, and coordinated plans and programmes of preventive actions, assessed risk factors, determined priorities for preventive measures, informed and trained workers, provided first aid and emergency measures, and conducted health surveillance.</td>
</tr>
<tr>
<td><strong>Sweden</strong></td>
<td>OHS was defined as an independent expert resource for the work environment and rehabilitation. OHS aimed to reduce health risks and identify problems among work environment, organisation, productivity, and health.</td>
</tr>
<tr>
<td><strong>United Kingdom</strong></td>
<td>Employer-appointed competent people were to undertake measures to comply with requirements and prohibitions imposed under statutory provisions. These statutory medical examinations were carried out by EMAS doctors or appointed doctors approved by EMAS.</td>
</tr>
</tbody>
</table>

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79 EMAS= Employment Medical Advisory Service as an integrated part of the Health and Safety Executive to give expert advice on medical matters relating to work
Belgian legislation included in a more detailed list the tasks of OHS as risk identification, annual action for prevention of risks, analysis of professional diseases, physio-psychosocial analysis of workplaces, and analysis of workplace organisation, environment, and equipment. OHS was also expected to give instructions for the use of new techniques and related issues at work, to train workers, to evaluate work ability, and to participate to emergency solutions. In Finland, the legislation named the tasks and content of OHS as cooperation with labour inspection, further education of personnel, protection of data, compensation of services, promotion of good occupational practices, risk assessment in the workplace, information dispersal, counselling, and training. In Germany, OHS tasks included developing company facilities, procuring technical instruments and materials and processes, integrating disabled personnel, and assessing risk. In Greece, the tasks of OHS were simply the tasks of the physician. Luxembourg’s objectives for OHS were to identify and assess occupational risks, supervise workers’ health and carry out health examinations, advise employers, and cooperate with workers’ delegations.

In Austria, OHS was defined in legislation as a preventive service. In Belgium OHS was provided by the non-profit associations to prevent and protect the well-being of workers. In this sense OHS in Belgium took a holistic approach. In Denmark, legislation urged OHS to cooperate with authorities and social security institutions. Legislation in France supports physicians’ independence and viewed OHS as exclusively preventive and with a medical orientation. This has been in a process of change because the importance of a multidisciplinary approach to occupational health and safety in France has been recognised. In France, legislation required surveillance of employees with risk exposures. In Greece, the legislation stated collaboration between safety engineers and occupational physicians, not between OHS and its professionals. In Ireland, any competent person was able to manage OHS and advise employers with the consultation of employees. The definition of safety in Ireland usually meant safety, health, and welfare. In Ireland, every workplace had a safety statement, which included hazards, risks, control measures, and names of responsible personnel. In Italy, legislation requested health and safety at work, prevention of risks and risk exposures, and health surveillance. In Portugal, health and safety services were separate from
6. OHS IN EU MEMBER STATES IN 2000

### Table 9. Classified tasks of OHS in 15 EU member states

<table>
<thead>
<tr>
<th>Task Description</th>
<th>Countries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive tasks of OHS including risk assessment, prevention and promotion of health and curative care</td>
<td>Finland (curative care is voluntary but common) and Italy³⁰</td>
</tr>
<tr>
<td>Comprehensive tasks of OHS including risk prevention, and promotion of health and well-being, but excluding curative care</td>
<td>Austria,³¹ Belgium, Denmark, Germany, the Netherlands, and Sweden (supplementary provision of curative services might be agreed with client enterprises)</td>
</tr>
<tr>
<td>Prevention- and protection-oriented tasks of OHS</td>
<td>France, Greece, Luxembourg, Portugal, Spain, and Ireland.</td>
</tr>
<tr>
<td>OHS assists employers to provide curative care, which is excluded by legislation</td>
<td>France, Germany, and Portugal (curative care can be on a contractual basis)</td>
</tr>
</tbody>
</table>

Hygiene services, depending on qualification, size of company, activities, and occupational risks. Health services were able to provide OHS in certain high-risk areas of industry. The tasks can be classified as in Table 9.

### 6.2 Competence of OHS professionals

Framework Directive 89/391/EEC states that competent external services or people should have the necessary means and aptitudes and be sufficient in numbers. It is left to EU member states to define appropriately qualified personnel. The aptitudes and capabilities were defined differently in the different EU member states, and this leads to differences in OHS quality in the member states. The provision of the framework directive can be interpreted such that the preventive services should be multidisciplinary, which increases the costs of these services for enterprises. Employers often prefer to purchase the services at low prices without considering the complex work environment and quality of preventive services.

³⁰ Universities and the National Sanitary System do curative care (teaching hospitals); day hospitals and outpatients are present in the hospital unit of occupational health (UOOML), environmental investigations are carried out by the Regional Agency for Environmental Prevention (ARPA).

³¹ The law does not designate curative care; but out of minimum time provided by law, curative care is theoretically possible as long as the employee pays for it and not the social insurance.
The regulatory requirements of OHS can be classified into two categories.

a) Requirements for qualification of OHS personnel in regulations:

Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, the Netherlands, Portugal, and Spain

b) Minimum resources of OHS defined in regulations (based on time):

Austria, France, Denmark (1 OHS personnel per 1.250 employees covered), and Germany (based on time and risk assessment)

Qualifications were mentioned in the regulations for the following professionals:

- Austria: specialised physician, non-specialised physician, safety engineer, occupational health assistant
- Belgium: physician specialised in occupational health and hygiene
- Denmark: specialised physician, occupational hygienist (occupational medicine training)
- Finland: specialised occupational physician, non-specialised physician, public health nurse and physiotherapists with additional occupational health training, other experts with training in occupational health (occupational hygienist, ergonomics, occupational psychologists, engineers)
- France: physician, occupational health nurse
- Germany: safety engineer, occupational health assistant, physician
- Greece: physician
- Italy: competent physician
- Netherlands: specialised physician, occupational hygienist, occupational safety expert, work organisation expert
- Portugal: occupational health nurse
- Sweden: specialist degree (diploma) for occupational health physicians issued by National Board of Health and Welfare (NBHW) after received specialist training based on government regulations on medical specialities
Austrian legislation mentioned the management and definition of tasks as well as the minimum amount of support staff. In Belgium, each OHS was to have medical and safety departments (internal or external). Danish legislation required the continuous training of OHS personnel. In Ireland and Spain, the requirements were rather broad because professionals who were competent were qualified for OHS positions. In Spain, OHS was to have necessary human resources and materials. In Sweden and the United Kingdom, legislation did not mention any professionals or their competences.

The competence and training of OHS personnel varied widely among different professionals, the background and training requirements for their professions, as well as their numbers in different EU member states. Free movement of health professionals makes unequal treatment, care, and services for workers likely, due to differences in professional competences and requirements. The just and equal evaluations of risks at work and their prevention also differ to a great extent among EU member states. Despite the other directives related to professional competence and the recognition of competences in other member states, the origin of the country of training and accreditation requirements vary, making the equal prevention and treatment of workers vary among OHS units.

Other aspects--such as professional independence, quality management requirements, and organisational models of OHS--influence the work of occupational professionals and the competence requirements. These aspects are discussed in other chapters.

### 6.2.1 Multidisciplinary OHS

ILO Convention 161 concerning OHS recommended multidisciplinary OHS. The multidisciplinary OHS has also been interpreted from framework directive. Because OHS operates in a variety of ways in EU member states, the motivations for an employer to contract OHS is to comply with legislation or--in insurance-based countries--to get financial benefits. However, the OHS should provide multidisciplinary expertise for the use of employers and employees to understand the real benefits of good occupational health practice.

The use of multidisciplinary OHS was compulsory in Austria, Belgium, Finland, France, Italy, Netherlands, Portugal, Spain, and Den-
mark (in specific industrial sectors only). In other countries, the use of multidisciplinary OHS was voluntary (Germany, Sweden, and the United Kingdom). The different professionals working in OHS tried to integrate their work through a multidisciplinary approach. The most systematic efforts were found in the Nordic countries, France, and the Netherlands (in some large companies and intercompany medical services only) and within the Local public health system in Italy (USL). In France, Italy, and the Netherlands the medical approach clearly predominated within such services. According to the interviews, a genuine multidisciplinary approach depended on previous training and good continuing training, existence of forums for socialisation, integration of the service into the company, and interaction between services and workers. In Denmark, Ireland, and the United Kingdom there was no obligation to include any medical doctor in OHS. In Sweden, the National Board of Occupational Safety and Health (currently the Swedish Work Environment Authority) implemented a multidisciplinary approach through internal control systems in enterprises, but OHS as such was not obliged to offer multidisciplinary services (Table 10).

In France, the legislation concerning the modernisation of the social system was passed in 2002, which required multidisciplinary services of OHS. This obligation can be implemented through the agreements of OHS with public sector organisations, such as CRAM, ARACT, and OPPBTP, or through OHS making contracts with experts recognised by these institutes.

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82 Internal control = the regulations on internal control require the person responsible for an enterprise to ensure that requirements set out in different regulations are complied with in a systematic manner.

83 La loi de modernisation sociale (2002) took the multidisciplinary approach as obligatory. The approach can be implemented through OHS, which has made contracts with public organisations (CRAM, ARACT, OPPBTP) or with experts who have been accredited by these public organisations. Organisations can recruit engineers, technicians, or other specialists accredited by the same organisations with same conditions.

84 CRAM = Regional Fund for Sickness (Caisse Régionale d’Assurance Maladie), ARACT = National Agency for Improvements in Working Conditions (Agence Nationale pour l’Amélioration des Conditions de Travail), OPPBTP = Professional Organisation of Prevention in Construction and Public Works (Organisme Professionnel de Prévention du Bâtiment et de Travaux Publics)
### Table 10. Multidisciplinary OHS in EU member states

<table>
<thead>
<tr>
<th>Country</th>
<th>Multidisciplinary OHS by regulation</th>
<th>Professionals mentioned in regulations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>yes</td>
<td>occupational physician, safety engineer, occupational assistants (normally occupational health nurses)</td>
</tr>
<tr>
<td>Belgium</td>
<td>yes</td>
<td>safety engineer, psychosocial advisor, physician</td>
</tr>
<tr>
<td>Denmark</td>
<td>yes</td>
<td>interdisciplinary or multidisciplinary composition (technical, therapeutic and health service personnel)</td>
</tr>
<tr>
<td>Finland</td>
<td>yes</td>
<td>core team: occupational physician, occupational nurse, physiotherapist (other experts can be used as additional advisors)</td>
</tr>
<tr>
<td>France</td>
<td>recommendation in 2002</td>
<td>-</td>
</tr>
<tr>
<td>Germany</td>
<td>yes</td>
<td>physician and industrial safety adviser</td>
</tr>
<tr>
<td>Greece</td>
<td>yes</td>
<td>security technician and physician (if more than 50 employees in enterprise)</td>
</tr>
<tr>
<td>Ireland</td>
<td>no</td>
<td>-</td>
</tr>
<tr>
<td>Italy</td>
<td>yes</td>
<td>public OHS (UOOML and ARPA); private OHS: competent physician, safety officer (RSPP), and occupational hygienist; occupational physician (specialist), often industrial hygienist (chemist or physicist); sometimes physiotherapist or psychologist</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>recommendation</td>
<td>recommendation to have multidisciplinary staff</td>
</tr>
<tr>
<td>Netherlands</td>
<td>yes</td>
<td>physician, safety engineers, occupational hygienist, workplace organisation specialist</td>
</tr>
<tr>
<td>Portugal</td>
<td>yes</td>
<td>safety engineer, hygienist, nurse, physician</td>
</tr>
<tr>
<td>Spain</td>
<td>yes</td>
<td>specialists from at least two preventive disciplines (occupational medicine, occupational safety, industrial hygiene, ergonomics, or applied psychosociology)</td>
</tr>
<tr>
<td>Sweden</td>
<td>recommended in OHS legislation</td>
<td>-</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>no</td>
<td>-</td>
</tr>
</tbody>
</table>

85 UOOML = Hospital unit of occupational health (Unità Operative Ospedaliere di Medicina del Lavoro); ARPA = Regional Agency for Environmental Prevention (Agenzia Regionale per la Prevenzione Ambiente); RSPP = Responsible for Prevention and Safety Services (Responsabile del Servizio di Prevenzione e Protezione).
6. OHS IN EU MEMBER STATES IN 2000

6.2.2 Recognition of occupational health professionals

All member states regulated the practice of health care professionals (Table 11). Usually, professional regulation was undertaken by quasi-public bodies, which granted entitlements to use medical professional titles and to practice branches of the medical profession. Professional regulation is a key component in regulating national health policies by ensuring that competent professionals with appropriate training are giving safe treatment to patients.
Table 11. Some quasi-public bodies regulating occupational health professionals in 2000

<table>
<thead>
<tr>
<th>Country</th>
<th>Profession</th>
<th>Certification (Yes/No) or Other Credentials, and Recognising Body</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>specialised physicians</td>
<td>licensure by Chamber of Physicians</td>
</tr>
<tr>
<td></td>
<td>safety engineers</td>
<td>accreditation by (former) Fed. Ministry of Labour and Social Affairs (now Fed. Min. of Economics and Labour); licensure by the provider of training</td>
</tr>
<tr>
<td></td>
<td>occupational health assistants</td>
<td>Yes, Austrian Academy of Occupational Medicine</td>
</tr>
<tr>
<td>Belgium</td>
<td>specialised physicians in occupational health and hygiene</td>
<td>accreditation by the Ministry of Health; recognition by the Ministry of Employment and Labour, Administration of Hygiene and Occupational Medicine</td>
</tr>
<tr>
<td>Denmark</td>
<td>occupational health nurses</td>
<td>Yes, various health authorities</td>
</tr>
<tr>
<td>Finland</td>
<td>specialised physicians</td>
<td>Yes, National Authority for Medcollegial Affairs</td>
</tr>
<tr>
<td>Germany</td>
<td>1) occupational physician</td>
<td>Yes, Physician Chamber of the Federal States</td>
</tr>
<tr>
<td></td>
<td>2) occupational physician with a reduced level of training</td>
<td></td>
</tr>
<tr>
<td></td>
<td>occupational health assistant</td>
<td>Yes, provider of training</td>
</tr>
<tr>
<td></td>
<td>1) specialised industrial safety engineers</td>
<td>1) Yes, provider of training</td>
</tr>
<tr>
<td></td>
<td>2) labour inspectors</td>
<td>2) Yes, provider of training</td>
</tr>
<tr>
<td></td>
<td>3) technical controllers by the Accident Insurance Association</td>
<td>3) Yes, Main Association of Accident Insurance</td>
</tr>
</tbody>
</table>

Table 11. continues...
Table 11. continues...

<table>
<thead>
<tr>
<th>Country</th>
<th>Professionals</th>
<th>Certification and Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>specialised physicians</td>
<td>Occupational Health and Safety Institute will have register of competent people and organisations to ensure quality of training in occupational health and safety and to develop training and professional development</td>
</tr>
<tr>
<td>Italy</td>
<td>specialised physicians, hygienists</td>
<td>Yes, Ministry of Universities, Yes, Institute for Certification of Industrial Hygienists (Instituto per la Certificazione degli Industriali)</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>specialised physicians, occupational health nurses, psychologists, safety engineer</td>
<td>Yes, Ministry of Health, Yes, Ministry of Culture and Superior Education (only general health nurses), Yes, Ministry of National Education, Yes, Ministry of National Education</td>
</tr>
<tr>
<td>Netherlands</td>
<td>occupational health nurses, occupational hygienists</td>
<td>Yes, Association of Occupational Health Nurses (NVVB), Yes, Foundation for Certifying Occupational Hygienists (an independent professional body)</td>
</tr>
<tr>
<td>Portugal</td>
<td>specialised physicians, occupational health nurses</td>
<td>Yes, Ministry of Health, Yes, Ministry of Health, Human Resources, Nursing Education Services</td>
</tr>
<tr>
<td>Sweden</td>
<td>specialised physicians, occupational health nurses, physiotherapists</td>
<td>Certification by the National Board of Health and Welfare, Yes, National Board of Health and Welfare, Yes, National Board of Health and Welfare</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>occupational health nurses, hygienists</td>
<td>United Kingdom Central Council for Nurses (England, Scotland, Northern Ireland, and Wales), Yes, British Examination Board in Occupational Hygiene (BEBOH) and the Institute of Occupational Hygienists (IOH)</td>
</tr>
</tbody>
</table>
6. OHS IN EU MEMBER STATES IN 2000

6.2.3 Opinions on professional competence and work satisfaction

According to the interviewees, there are not enough competent physicians in France, Greece, and Ireland. In Greece stakeholders wanted to see the government become more committed to training of OHS professionals. Some interviewees underlined that additional training was needed in Finland, Italy, the Netherlands, and Sweden. Interviewees from Germany, Portugal, and Spain requested a curriculum for occupational health professionals and proposed competence development for the professionals as well. The competence level of occupational health professionals was considered high in Austria, Belgium, Denmark, France, Portugal, and the United Kingdom, whereas competence was expected to be higher in Austria, Finland, and Ireland, according to the interviewees. The competence of occupational health professionals varied in Austria, Germany, Italy, Luxembourg, and Sweden, based on the interviews. Interviewees would like to have increased multidisciplinary cooperation in Denmark, Finland, France, Italy, the Netherlands, and Sweden. There were more women in the profession, and this trend could influence the position of the profession in the labour market.

In relation to competence, interviewees from employers’ organisations thought that OHS should not provide human resource development and work organisation services (Finland), but a multidisciplinary approach was underlined (France). Representatives of trade unions considered the competence of occupational health professionals to be high. However, they proposed improvements in the multidisciplinary approach (Austria, Finland, and Sweden). Many countries asked for changes in the curriculum due to changes in working life, work organisations, techniques at work, and industrial relations (Austria, the Netherlands, Italy, Germany, Portugal, and Sweden). Many countries also looked forward to retraining their occupational health professionals, whether on an obligatory or voluntary basis (the Netherlands, Finland, Luxembourg, and Portugal).

According to the interviews, occupational health professionals seemed to be committed and satisfied with their work in general (Denmark, Finland, Ireland, Italy, and Luxembourg), but more respect was needed in some countries from other health professionals and employers
(Germany and Italy). However, data on occupational health professionals’ satisfaction with their work were missing in most of the countries. Funding agencies, such as insurance institutes, wanted to increase the income levels of occupational health professionals (Germany and Greece) and improve the definitions of tasks and needs of workplaces, which would increase satisfaction with work among occupational health professionals (Germany and Spain). Also, satisfaction with work decreased due to the ageing of occupational health professionals and lack of innovations in OHS (Finland). According to the interviews conducted at research institutes, work satisfaction for occupational health professionals was improved due to professional development and augmented salaries (Italy), whereas the externalisation of OHS units and market creation with larger OHS units created lower staff morale and satisfaction with work (lower salaries, temporary contracts, and discontinuity of work with companies) (Italy and Spain). Job satisfaction for occupational health professionals decreased their absenteeism (United Kingdom). The professional organisations interviewed aimed to increase work satisfaction through increased salaries and fees (Austria) and commitment and identity (Austria and Germany). Lack of government support for OHS professionals caused some frustration (Ireland, Portugal, and the United Kingdom), which was mostly related to marketisation, competition, the quality of OHS, and overall confidence in OHS. Work satisfaction among professionals had increased due to new legislation, improved basic training, and further training opportunities (Italy). For increased satisfaction at work, occupational health professionals needed more respect among their colleagues (Germany and Austria), and the share of tasks needed to shift towards prevention instead of sick leave prescriptions (Sweden and the Netherlands). In addition, according to interviewees, satisfaction increased through tools, and cost and impact assessments of OHS (United Kingdom).

Generally, employers’ organisations and trade unions considered occupational health professionals to be satisfied with their work, but the professionals in Greece, Germany, and the Netherlands needed more respect in order to be satisfied. New tasks for OHS have improved satisfaction in Finland, whereas in the Netherlands new approaches to OHS management increased satisfaction.
6.3 Coverage of OHS

In principle, all workers should have access to OHS in EU member states. The study conducted by the European Foundation for the Improvement of Living and Working Conditions in the early 1990s concluded that the integration of preventive functions was implicit in the requirements of Framework Directive 89/391/EEC and essential if the health effects of modern trends in employment were to be adequately addressed by preventive services. However, the coverage of OHS varied widely among countries. The coverage of OHS should be counted on the percentage of employees or of the working population covered by OHS. However, the percentages in Table 12 were collected from several sources and can be considered estimates on a national level. This explains the need for accurate and up-to-date information on OHS because otherwise decisions are made based on estimates only. The coverage of people for OHS ranged from 5 per cent to 100 per cent in principle.
### Table 12. Estimated coverage of OHS in some EU member states

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>-</td>
<td>55%</td>
<td>70%</td>
<td>-</td>
</tr>
<tr>
<td>Belgium</td>
<td>60% (86)</td>
<td>-</td>
<td>universal in principle</td>
<td>91% of enterprises have contracts with external services</td>
</tr>
<tr>
<td>Denmark</td>
<td>34% (85)</td>
<td>30%</td>
<td>35%</td>
<td>62% of SMEs use OHS</td>
</tr>
<tr>
<td>Finland</td>
<td>90%</td>
<td>86%</td>
<td>95%</td>
<td>majority of workers are covered by preventive services</td>
</tr>
<tr>
<td>France</td>
<td>86% refers to employees covered by Labour Code</td>
<td>in principle universal; SMEs have low coverage of OHS</td>
<td>universal with limitations</td>
<td>about 85% of the workforce.</td>
</tr>
<tr>
<td>Germany</td>
<td>50% (1995 estimate by practitioners)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Greece</td>
<td>5.5% (92)</td>
<td>28% of manufacturing sector are covered by OHS; in other sectors lower</td>
<td>-</td>
<td>OHS coverage with more than 150 workers is satisfactory</td>
</tr>
<tr>
<td>Ireland</td>
<td>OHS limited to employees in large enterprises</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Italy</td>
<td>10% (94)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>-</td>
<td>OHS limited to employees in the private sector</td>
<td>universal in principle</td>
<td>about 50%</td>
</tr>
<tr>
<td>Netherlands</td>
<td>42% (1990) 65% (1995)</td>
<td>close to 100% for all employed workers</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>Portugal</td>
<td>13%</td>
<td>55% in SMEs with &lt;50 employees</td>
<td>minority of enterprises provide preventive expertise</td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>15%</td>
<td>About 65%</td>
<td>30%</td>
<td>in 1999, 24% of firms had no organised OHS</td>
</tr>
<tr>
<td>Sweden</td>
<td>60% (1994)</td>
<td>80%</td>
<td>60%</td>
<td>72%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>53% (100)</td>
<td>50%</td>
<td>30%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Table 12. continues...
Table 12. continues...

86 Per cent of employees or per cent of working population, based on interviews.
87 OHS coverage in SMEs was superficial.
88 Group services of OHS were established in local authority administration. With fewer than 20 employees, the employer may function as safety officer.
89 Reflects the legislation Working Environment Act and Order 889 of 28.12.1987, which required some industries to use preventive services.
90 OHS was used by 12% of companies with fewer than 10 workers in 1994; 38% of SMEs did not make use of preventive services, and 21% of SMEs used them less than once a year in 1999.
91 About 8% of workers were without medical care. OHS was not provided in 44% of SMEs with fewer than 10 workers.
92 The number of SMEs and the limitation of legislation reflected the low coverage.
93 In half of the SMEs with fewer than 20 workers, there was no safety engineer and/or occupational health expert. Workers in SMEs did not have access to OHS.
94 This figure covers only company-related OHS. Local health centres also provide OHS.
95 Half of the enterprises with 50–249 workers and the majority of SMEs with fewer than 50 workers did not make sufficient use of preventive services.
96 97% of the enterprises signed prescribed contracts with certified external companies to provide occupational safety and health care.
97 Even 90% of workers in large companies may be covered. Many state institutions and services did not provide OHS.
98 About 65% of the enterprises with more than 500 employees had an internal preventive service.
99 The 72% reflects the enterprises and public institution provided with preventive services. In SMEs with fewer than 10 workers, 45% had access to preventive services.
100 Coverage for public sector employees was 98% and private sector employees was 50%.
101 85% of the enterprises had coverage by a specialist for occupational safety and health (internal or external).
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6.3.1 Opinions on coverage, access, and equity of OHS

The answers of ministries and regional governments about coverage explained the variety of ways to determine coverage. In some countries the coverage of OHS was considered to be 100 per cent if legislation required employers to provide OHS (France and the Netherlands), whereas other countries had statistics on coverage based on surveys. The main difficulty was to reach workers in SMEs with regular monitoring of the health situation. The reasons for not reaching such workers were given as the costs of OHS to employers and the willingness of OHS units to provide tailor-made services to meet the needs of the respective enterprises (Finland). Other difficulties were the availability of professionals (Greece), the geographic layout of the country (Germany, Greece, Italy, and the United Kingdom), and the lack of incentives and innovative approaches to enterprises (Finland). In some countries, the public sector was not obliged to provide OHS to employees (Luxembourg and Portugal). This also decreased compliance with legislation, because the public sector did not send a positive signal about applying the rules. Also, Labour Inspectorates did not have the access or the possibility to intervene in the practices of the public sector due to national legislation (France). Some branches of industry had a higher coverage of OHS than other branches (United Kingdom).

According to the interviews in Austria, access to OHS improved as the General Accident Insurance Board started to provide OHS to SMEs. This caused inequality among employers in relation to their ability to pay for the services. Access to OHS was considered high in Belgium, Denmark, Finland, France (compulsory health examinations for all), Luxembourg, and the Netherlands. In many countries, access varied based on regional differences, branches of industry, size of companies, and enterprises' interest and willingness in providing OHS, as well as the risks at work. However, as long as the concept of OHS is not operationally defined, the coverage estimates are uncertain.

Equity, according to the interviews conducted among ministries and regional governments, was not reached between workers in SMEs and workers in larger companies, between low-risk professionals and high-risk professionals, between remote areas and core industrial areas, and
between the types and services available and those needed. The different branches of industry also created some variation in equity, for example OHS was available in the chemical industry (mostly men), while OHS needed improvement in the service sector (mostly women).

According to insurance companies, which funded OHS, coverage and access were lower than expected despite the laws and regulations (Austria, Germany, Greece, and Spain). Minimum standards for OHS among regions varied, which had an impact on access to OHS (Spain). The minimum standards also decreased equity in OHS, which should have improved in several countries (Austria, Germany, Greece, and Spain).

The interviewed representatives of research institutes stated that the coverage was difficult to reach due to changes in working life (Austria), lack of clear OHS objectives (Greece), and the market and competition situation among OHS units (Sweden). Coverage of OHS needed improvement among SMEs, agriculture, and crafts (Italy). Coverage depended on the size and location of a company, areas of work, and availability of occupational professionals (Italy and Sweden). Equity varied between large companies and SMEs, low- and high-risk professionals, implementation of quality management system, informal and short-term contracts, and regions (Austria, Belgium, Denmark, Germany, Ireland, Italy, Spain, and the United Kingdom).

The professional organisations and their representatives confirmed the same issues in coverage, access, and equity. However, coverage also depended on the quality of OHS and the ability to gain customers (Sweden). Access was limited in SMEs and in hazardous jobs; and usually the only professional available was an occupational health nurse, instead of multidisciplinary teams of professionals.

Generally, trade unions expected to get higher OHS coverage, specifically in SMEs (Finland, Germany, Greece, Italy, and Portugal). However, the content of OHS varied among and within OHS (Austria, Italy and Sweden), which also gave an idea of what kind of coverage was discussed. On the other hand, some companies had OHS simply to reduce taxes or to reduce political tensions (Italy) between employers’ and employees’ organisations.

Representatives of trade unions mentioned that there is a lack of access to OHS by workers in SMEs and there is often a need for
improvement in cooperation among occupational health and safety experts (Austria, Greece, and Portugal). Access depended on contracts between OHS and employers. In some contracts, limitations and limits for consultation time were defined (Sweden). However, trade unions in many countries viewed access to OHS positively (Denmark, Finland, Germany, Italy, and Luxembourg). In the interviews representatives of trade unions spoke of the inequity among regions (Finland, Greece, and Italy) and service provisions. In addition temporary workers (Finland and Greece) and SMEs (Greece) often lacked OHS.

Employers considered coverage acceptable (Belgium and France), though many companies did not recognise the connection among coverage, OHS, and health (Spain). Employers’ organisations also viewed access to OHS positively (France, Belgium, Finland, and the Netherlands) despite the variations among regions, company size, and service provisions (Finland, Spain, and Portugal). Representatives of employers’ organisations mentioned that equity was the aim, but it was hard to reach in every branch of industry (Belgium, the Netherlands, and Spain).

6.3.2 Independence of OHS

One of the important issues among employers, employees, and OHS is the independence of health professionals working in OHS. Health professionals should stay neutral and take an advisory role in all questions concerning workers’ health and safety. Employers pay for OHS, and so the health professionals must strike a balance among customer (employer) and clients (employees) in their activities, actions, and behaviour. This independence reflects the ethical values of society and the workplace. It is also an important question in relation to privacy, information confidentiality, and trust among OHS, employees, and employers.

Among several ethical questions, the independence of occupational health professionals is important for employees and employers. Independence was mentioned in legislation in several countries (Austria, Belgium, Denmark, Finland, France, Germany, Luxembourg, and the Netherlands). The issues mentioned most often about independence in this study were related to pre-employment check-ups, long sick leaves, integration of employees to work after injuries, and data protection. In
some countries, pre-employment check-ups were forbidden. In some countries legislation was being prepared about gene tests, data protection, and drug tests at work.

Because the employer is responsible for organising and funding OHS, contradictions are possible. The choice of OHS was related to legislative debates related to independence among employers, employees and OHS. In France, though employers fund OHS, independence is preserved by legislation. The boards of OHS units in France have representatives of trade unions (majority), employers, and physicians. Moreover, there are provisions about independence in OHS regulations and in each physician’s contract with an OHS unit.

According to some interviewees, the free market situation, such as in the Netherlands and Sweden, caused problems with independence among OHS professionals. There were conflicting interests between economic and ethical principles in efficiency and the working ability of employees, for example. On the other hand, the economic situation also raised ethical issues; if problems existed, both the OHS unit and the professional could lose the contract to employers and employees (Austria, Germany, and Italy). Independence was also evaluated based on public discussion in the country, and evaluations were made in relation to independence. Also, the number of legal cases about the impartiality of the physicians showed problems of independence. In Belgium, there were roughly two cases annually for examination in the Commission of the Ministry of Labour. In Italy, the independence issues were examined by the courts at the local level. In France, the board of OHS units followed the independence of OHS professionals. Also, interviewees from Finland and Denmark admitted there were problems of independence. In addition, customer satisfaction inquiries revealed some independence problems (the Netherlands).

6.3.3 Opinions on professional ethical standards

Ethical principles are formulated through legislation, but moral and technical independence are assessed through the outcome of independence. Ethical considerations can be introduced in national legislation, contracts between OHS and company, official documents (contracts of personnel with statement of independence), and free engagement by
professional associations. Ethical principles are laid down in some EU member states on International Commission of Occupational Health (ICOH) principles (Italy, Portugal, and Spain), or on general medical practitioners’ principles.

Answers can be biased, because ethical standards are essential in OHS and in the medical profession in general. The standards of the ICOH were recognised and were mentioned in answers from interviewees. However, there is no evidence based on this study that ICOH standards were applied. Conflicting rights were also mentioned, including the right to the protection of employment and the right to the protection of health, the right to information and the right to confidentiality, and individual rights and collective rights. Statements were also made about professional independence, confidentiality of medical records, and medical confidentiality.

In general, ethical standards were considered good in the 15 EU member states. Ethical concerns were mentioned in relation to SMEs, privacy, data security, confidentiality, workers’ participation in OHS activities at the workplace, and financial independence.

Ministries and regional governments emphasised good ethical standards but also recognised the possibility that occupational health professionals might intervene in cases of individual workers. Ethical standards depend on each professional individually (Portugal), which was related to education and professional conduct (Sweden). According to insurance companies, the independence was challenging between SMEs and OHS units. However, ethical standards were subject to economic factors (Germany and the Netherlands); an OHS unit might lose a contract if the independence of professionals was not kept. Research institutes confirmed a high level of ethical standards but also mentioned that laws needed to be created and improved (Italy and Luxembourg). Professional organisations further underlined the importance of ICOH ethical standards in interviews.

Representatives of trade unions claimed in interviews that ethical standards were respected in relation to privacy, data security, and confidentiality (Belgium, Finland, Germany, and Sweden). However, more attention needed to be paid to other aspects of ethical standards, such as building good relationships among OHS, employers, and employees (Portugal) and the dilemma between lay-offs and needed changes in
workplaces (Austria). Ethical standards depended very much on the individual doctor (Luxembourg).

Representatives of employers’ organisations considered ethical standards to be high (Belgium, France, and the Netherlands), but OHS faced pressures (Greece) and workers’ participation in OHS was necessary to avoid ethical problems (Italy).

6.4 Policies for OHS

ILO Convention No. 161 Article 2 defined occupational health policy as follows. 'In the light of national conditions and practice and in consultation with the most representative organisations of employers and workers, where they exist, each Member shall formulate, implement, and periodically review a coherent national policy on occupational health services.'

Only three countries in this study had ratified ILO Convention 161. Sweden did not have a written national policy or statement of OHS, but in Finland and Germany such a policy existed (in addition to what is stated in the legislation). Denmark, Italy, Portugal, and the United Kingdom have a policy or policy statement. There were significant differences about how the occupational health policies were formed, their content and preparation process, and the organisations involved. There were also differences in the integration of the policy with other policies at national level. Italy and the United Kingdom were the largest countries to have an OHS policy, despite their strong regional differences in socio-economic development. Denmark, Finland, and the Netherlands have been in the forefront on OHS issues. Belgium took the opportunity to move forward with OHS after Framework Directive 89/391/EEC.
Table 13. Policy papers concerning occupational health in 2000 in some countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy papers related to OHS</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>Policy statement: Towards a clean working environment by the year 2005 prepared by the Danish Working Environment Service.</td>
<td>There is a holistic approach to occupational health and safety.</td>
</tr>
<tr>
<td>Italy</td>
<td>CARTA 2000: Safety for work 1999; National health plan (1998-2000).</td>
<td>OHS is part of the national health plan and health care system, which concerns mainly regional authorities especially on prevention of work accidents and diseases. CARTA 2000 is a national statement from several national organisations as well as governmental bodies.</td>
</tr>
</tbody>
</table>

Table 13. continues...
Portugal

UK
Report and recommendation on Improving Access to Occupational Health Support, published 1999. The Revitalising Health and Safety strategy statement was launched jointly by the Government and Health and Safety Commission on 7 June 2000 for the next ten years. Based on that, a strategic plan was worked out with priorities, resources, and outputs. The occupational health strategy makes the Revitalising Health and Safety Strategy Statement happen and complements the public health initiatives in England, Scotland, and Wales. It also complements other government initiatives, such as A Strategy for Sustainable Development and Modernising Government in the United Kingdom.

Governmental programmes and plans, agreements among social partners, green and white papers on preventive services at enterprises, and other political instruments in social and economic areas are related to Security, Hygiene and Health at Work (SHST), such as National Plan of Employment, Integrated Support to Innovations, and Strategic Options in Health.

England, Scotland, and Wales developed their own public health strategies. The associated green papers emphasised that occupational health is an important part of public health, and they urged interested parties to contribute to the development of ten-year occupational health strategy.
6. OHS IN EU MEMBER STATES IN 2000

A variety of policy documents and responses exist in EU member states (Table 13). The situation is in flux, and new policies and policy renewals occur frequently. In Germany, both the National Ministry of Health and Social Affairs and the Ministries of the Federal States can give policy statements in OHS, but at the moment there are no federal statements. In Ireland, the Health and Safety Authority (HSA) had the Annual Work Plan to implement OHS legislation. In Italy, the National Health Plan (1998-2000) referred mainly to regional authorities and their responsibilities, especially on the prevention of work accidents and diseases, but not specifically to organization of OHS. In Luxembourg, the plan of action for the promotion of security, health, and well-being of workers with specific action to prevent accidents at work for 2003-2007 was launched in 2003 by the Ministry of Employment and Labour, trade unions, employers’ organisations, and insurance institutes. In France, social partners had national negotiations about the modernisation of the occupational health and safety system during 1999-2000, after 25 years of silence, and concluded the negotiations in September of 2000. The Advisory Committee for Safety, Health, and Working Conditions (Conseil supérieur de la prévention des risques professionnels), at the Ministry of Labour and Solidarity, includes social partners, the public authorities, and the insurance organisations. This committee took forward the proposal to modernise the system of prevention.

For the implementation of Working Conditions Policy in the Netherlands, the ARBO Agreements (Arbo convenanten) supplemented occupational safety and health regulations, financial incentives, public information campaigns, and tax breaks. The ARBO Agreements were agreed on by the State-Secretary for Social Affairs and Employment and employers and employees of sectors that have the most work-related risks. The ultimate goal of the agreement was to reduce the number of employees exposed to work-related risks. In relation to OHS, the parties of the agreement saw OHS as a platform for knowledge and information, and the government granted once-only subsidies for the initiative. The role of OHS was only supportive in the implementation of activities at the company level (Ministry of Social Affairs and Employment 2000, Marcet 2001).
In Sweden, occupational safety and health was implemented through internal control systems of companies. The internal control system was renewed in 2001 towards 'systematic work environment management' to better respond to the needs of SMEs. Companies consulted OHS only when needed. The system was voluntary, which raised issues of certifying the system and inspecting the regular use of the internal control system. There seemed to be a need to pay attention to the costs and incentives of internal control systems for SMEs to encourage them to manage the systematic work environment (Antonsson 2001, Delang 2001).

Limits in the occupational health model of the Italian National Health Service were competition with other health services (including an emerging consultation market in the area of occupational health and safety), the diminished role of inspection, and difficulties in facing ergonomic risks and stresses at work among other occupational health and safety challenges. The underfunding of local health units to conduct their occupational health work was a major issue in Italy to improve coverage and the health situation at work (Biocca 2001).

### 6.4.1 Policy formulation processes

In general, the process of policy preparation was led by the specific steering committee nominated by the main governmental institution responsible for health and safety at work. In the United Kingdom, the consultation process involved a large number and a wide variety of stakeholders through seminars, the Internet, and other types of exchanges of views. In addition, the consultation process was fully described in the final British strategy paper. In Denmark, the process involved background papers produced by the main authority and then debate in the Parliament. In Finland the process of policy formulation was initiated by the Permanent Committee on OHS based on the evaluation of the situation. In Italy, the process to form a policy required tripartite negotiations and agreement. In Belgium, the policy preparation was a government-led policy process with tripartite participation. The way OHS policy documents were finalised and legitimised differed according to the normal political or administrative practice in each country. The legitimacy of any policy can be conferred by the transparency of the process for policy formulation, monitoring, and evaluation (see Table 14).
Table 14. Policy formulation processes for OHS in some European countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy formulation</th>
<th>Policy content</th>
<th>Policy preparation process</th>
<th>Organisations involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Law August 4, 1996, and its explanation were aimed to give a basis to regulations about protection and well-being at work. The law was prepared with the Higher Council of Prevention and Protection at Work (Conseil supérieur pour la prevention et la protection au travail).</td>
<td>The law and its explanation aim to expand the concept of safety and health at work and the quality of work conditions. In addition, it aims to follow Framework Directive 89/391/CEE more closely. The law aims to put in place minimum standards for safety and health at workplaces and to update the concepts used in occupational safety and health.</td>
<td>Higher Council of Prevention and Protection at Work (Conseil supérieur pour la prevention et la protection au travail), which includes social partners CSC, FGTB, and CGSLB;102 employers’ organisations Belgian Federation of Enterprises (Fédération des entreprises de Belgique), Federation of Unions for Farmers (le Boerenbond belge, la Fédération des unions professionnelles agricoles et l’Alliance agricole belge); and permanent and temporary experts.</td>
<td>The text was prepared by the Ministry of Employment and Labour within the General Directorate of Studies, Administration of Safety of Work, and Administration of Hygiene and Occupational Health (Direction Generale des etudes, Administration de la securite du travail and administration de l’hygiene et de la medecine du travail) in December 1997.</td>
</tr>
<tr>
<td>Denmark</td>
<td>Parliamentary debate in 1994 on the status, perspectives, and development of health and safety at work, which prioritised occupational health and safety policy area. The policy was based on extensive project material prepared in 1994 by the Danish Working Environment Services and was the basis for discussion and an action programme.</td>
<td>The policy includes reasoning for the policy, vision and objectives until 2005 with priorities, global cooperation, advocacy role of the society, and the role of the working environment system to implement the policy.</td>
<td>The policy and action programme was prepared based on documents, prioritisation, and prevention objectives for intersectoral and sector-specific areas; prevention with new instruments; registration and documentation of prevention and occupational health and safety indicators; and a ten-year perspective with continuous improvement of the working environment.</td>
<td>The Danish Working Environment Service.</td>
</tr>
</tbody>
</table>

102 CSC = Belgium’s Confederation of Christian Trade Unions, FGTB = Fédération Générale du Travail de Belgique (General Federation for Work in Belgium), CGSLB = The Federation of Liberal Trade Unions of Belgium

Table 14. continues...
Table 14. continues...

| Country | National Plan for Occupational Health Service was prepared in 1989. The plan was evaluated in 1998, and the new Health at Work 2015 was launched in 2004. | The policy of 1989 included general and specific improvement lines of OHS within the health system and with employers. The main aims are to promote health at work and to gain full coverage of workers in principle during the following years. In 2004 the policy included ten action areas. | The Permanent Committee on OHS made resume about the present situation and future issues for improvement into policy on OHS to be implemented with government, social partners, and other institutions. The Health at Work 2015 strategy was prepared by the Permanent Committee on OHS. | The Ministry of Social Affairs and Health; Permanent Committee on OHS with representatives from employers’ organisations and trade unions. The same applies to Health at Work 2015 preparation. |

| Country | The Conference in Genoa 1999 agreed on the implementation of Carta 2000 objectives. These objectives were the following: promote and realise legislative conditions and agree on instruments to reach better results in safety and in reference to the European level, intensify vigilance and inspection, prevent or decrease ‘black market work,’ change the culture of health and safety, and start the change in the schools. | Set out the practical application of legislation through three-sided consultations to identify the best and most efficient ways of preventing work-related accidents and diseases with the highest safety standards for workers. | Conference in Genoa with the parties, which gave 100 days or 6 months time to complement the tasks agreed to in Carta 2000. Beforehand, trade unions and employers’ organisations set up joint industrial bodies for health and safety at work under interbranch agreements to coordinate training, awareness-building campaigns, and dispute mediation activities. | Government (Ministry of Labour), institutions (occupational health and safety agencies), local administration, social partners (trade unions, employers’ organisations). |

Table 14. continues...
### Portugal

By the Commission of White Paper for Preventive Services. The task was to reflect the problems in relation to safety, hygiene, and health activities at work and the involved systems. Based on analysis, the White Paper forms the strategic framework for developing work safety and health at companies and outlines a series of considerations and proposals for developing safety resources and models of companies. Occupational hygiene, health, and safety agreement among social partners in 1991 followed by the creation of IDICT in 1993. Several norms and legislation were prepared during the 1990s. In 1996 there was an Agreement on Joint Strategy (A Acordo de concertação Estratégica) between government and social partners. In 1997 the Green Paper was published on Preventive Services in Enterprises by IDICT based on questionnaires sent to stakeholders. Ministry of Labour and Solidarity, Ministry of Health, IDICT, social partners, research institutes.

### United Kingdom

Revitalising Health and Safety Strategy Statement in June of 2000. The initiative was taken by the Deputy Prime Minister in 1999, when he launched the consultative document to revitalise the 25-year-old Health and Safety at Work Act from 1974. Views from the Health and Safety Commission as well as the stakeholders were requested for the Deputy Prime minister’s consultative document. The Strategy Statement includes the first targets for the occupational health and safety system and an action plan to reach the targets. The next ten years will emphasise the importance of a better working environment, motivating employers to improve health and safety, and simplifying overcomplicated regulations. An Inter-Departmental Steering Group was set up in April of 1999 to oversee and coordinate work. Exploratory meetings were organised that included the Steering Group and Confederation of British Industry, the Trade Union Congress, Federation of Small Businesses, the British Chambers of Commerce, the Forum of Private Business, the Health and Safety Executive/Local Authority Enforcement Liaison Committee (HELA), and the Association of British Insurers. The consultation document sought views from different stakeholders during nearly three months. In addition three summary leaflets about the document were prepared to target employers, workers, and SMEs. Key themes were identified from the responses. The Steering Group consisted of members of the Department of the Environment, Transport and the Regions; Health and Safety Executive; Departments of Health, Social Security, Education, Employment, and Trade & Industry; Ministry of Agriculture, Fisheries and Food; Lord Chancellor’s Department; Cabinet Office; HM Treasury; the Scottish Executive; and Welsh Administration.

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103 IDICT = Development and Inspection of the Work Condition
6. OHS IN EU MEMBER STATES IN 2000

6.4.2 Aims, objectives and mandates of OHS policies

This section provides examples of the content and format of policy documents highlighting the diversity of the approaches used in EU member states towards OHS. Usually the policy papers start with the purpose of the policy, description of the process, and definition of challenges. As OHS is part of larger policy papers, only the aims (Table 15), specific objectives (Table 16), and mandates (Table 17) of OHS are described here.

In the majority of the OHS policy documents, qualitative policy statements were preferred to quantitative targets. The time targets varied from short-term to long-term. In addition, many target types, such as outcome, strategic steps, or actions in the implementation process, were mentioned in OHS policy documents. Also, there were different targets for the working population and the general population.

In the Belgian policy paper, the principal values for OHS were to extend the coverage of OHS services in different forms depending on the size of company and to extend coverage for temporary workers, while domestic workers and their employers were left out. The cooperation between social partners and governmental institutions was clearly described in the law and its explanations.

In the Danish policy paper, political choices were presented to determine the development of the working environment policy. The choices and spectrum of development depended on maximum or minimum social welfare state, industrial policy goals, competition between low technology and low pay versus high technology and qualifications, and passive or active employment policy. The document considered the policy to be ‘proof of social mission as occupational health and safety can’t be left to market forces. The working environment must be a popular cause that concerns everyone and in which everyone is involved.’ The document emphasised a holistic approach to the working environment as part of political objectives and society. The policy underlined the ethical standards and prevention objectives as stated in the ‘Health for all by the year 2000’ programme by WHO. The overall improvement of well-being of workers was underlined, as well as increased coverage and access to OHS by SME employees. The participation of employees in the policy and planning of the working environment was emphasised as well (Danish Working Environment Service 1994).
The national framework for OHS aimed to improve Finnish OHS by promoting all employees’ health and working ability through access to OHS. In addition the policy emphasised extending coverage of OHS to all employees. High participation and cooperation among stakeholders was encouraged (Sosiaali- ja terveysministeriö 1988). The policy was renewed in 2004 (Sosiaali- ja terveysministeriö 2004). The general aim of the policy ‘Health at Work 2015’ was to develop OHS in cooperation with employers, employees, and OHS.

In Portugal, the policy paper was prepared by IDICT\textsuperscript{104} in collaboration with governmental and social partners. The values included significant participation of stakeholders in the implementation of the strategy and therefore in the improvement of the workers’ well-being (Commission of White Paper for Preventive Services 1999).

In Italy, the National Health Plan aimed to act in the working environment to reduce exposure to health risks and accidents, through improvements in standards of safety. That meant improved and correct application of legislation. In addition, increased action was needed in regions to apply legislation correctly; in particular the aim was to increase personnel by 1 per cent in regional health authorities and to improve vigilance and prevention activities as stated in Carta 2000 (Ministry of Health 1998).

In the United Kingdom, the strategy paper on revitalising health and safety focused on sustainable development and securing a better quality of life for all (Departments of the Environment, Transport, and the Regions 2000). Among the indicators of the strategy for sustainable development for the United Kingdom, published in May 1999, were working days lost through illness, work fatalities, and injury rate. In the policy paper ‘Saving lives: Our Healthier Nation,’ the government set targets for England in priority areas, such as death rates from cancer, coronary heart disease, and stroke. The Health and Safety Commission’s Strategic Plan for 1999/2002 (1999) set out five strategic themes supported by key programmes. These were raising the profile of occupational health, improving health and safety performance in key risk areas,

\textsuperscript{104} IDICT = Development and Inspection of the Work Condition (Desenvolvimento e Inspeção das Condições de Trabalho); transformed by law in 2004 to ISHST = Institute for Protection, Hygiene and Health at Work (Instituto para a Segurança, Higiene e Saúde no Trabalho).
6. OHS IN EU MEMBER STATES IN 2000

developing health and safety aspects of the competitiveness and social equality agendas, increasing the engagement of others, and promoting full participation in improving health and safety.

In the United Kingdom, the annual set of priorities was based on programmes of the ‘Occupational Health Strategy Paper and Strategic Plan of HSC’ (Health and Safety Committee) for the years 2001-2004. HSC selected eight priority programmes covering hazards or sectors where major improvements were necessary if the targets were to be met. These priorities aimed to tackle hazards and industries with large numbers of employees, with a high incidence rate of injuries or ill health, and with levers to bring about change (Health and Safety Commission 2001).

In addition to specific occupational health and safety policies, including OHS or separate policy papers on OHS, the Health and Safety Executive (HSE) in Ireland published an annual working programme in which priorities were listed. The overall aims for 2000 were to improve safety and health in the highest risk sectors for the highest risk exposures, to meet all national and international commitments, and to put into effect the findings of the Commission of Inquiry into Safety, Health, and Welfare at Work. OHS worked as a preventive measure, embracing all workers, adapting to changes in working conditions, acting at both national and workplace level, and maintaining partnership. The main priority areas were construction, mines and quarries, agriculture, transport, and health services. New approaches were to be developed in relation to welfare and well-being and occupational health and safety services, for example. In 2001, the main areas for intervention were health and safety management, safety management systems (larger organisations) and safety statements (all organisations). The aims of the HSE in 2002 included meeting the needs of clients and customers, developing a supportive and sustainable preventive infrastructure, piloting new approaches to obtaining compliance with good practice, and health and safety management.

In France, the policy-making institution was the High Council of Occupational Hazards Prevention (Conseil supérieur de la prévention des risques professionnels) and its committees. The council and its committees have been operating since 1978 between the public authorities and the social partners to develop policy about the prevention of occupational risks. The council is consulted on all legislative drafting
projects as well as on the action plans relating to occupational health and safety or occupational environmental quality, including OHS. The council participated in dialogue, formulation of proposals, investigations, and research on legal modifications or priority actions that were likely to improve working conditions. The structure of the council took into account the diversity of the fields covered and included six committees, of which the Occupational Diseases Committee and the Occupational Medicine Committees were important for OHS. The council also included a permanent committee (chaired by a member of the Council of State, the highest French administrative tribunal) that gave the council’s opinion on these projects to the Minister of Labour (www.sante-securite.travail.gouv.fr). In France, several separate institutions work with occupational health and safety; all of these institutions have scientific knowledge that can improve the regulations concerning the prevention of health risks at work. The insurance office for accidents at work and occupational diseases (Caisse nationale d’assurance maladie des travailleurs salariés (CNAMTS)) gives advice, expertise, and support to companies. Technical assistance and expertise come from the specialised bodies INRS, ANACT, OPPBTP, and OPRI. The major issues were to modernise health at work; to prevent professional risks by strengthening the coordination of prevention at the regional level among social partners, the state, and research interests; and to improve prevention activities in SMEs by using a multidisciplinary approach (Mounier-Vehier 2001).

105 InVS= Institute of Sanitation (Institut de veille sanitaire), INSERM= National Institute of Health and Medical Research(Institut National de la Santé et de la Recherche Médicale), CNRS= National Centre for Scientific Research (Centre National de la Recherche Scientifique), INRS= National Institute of Research for Safety and Prevention of Accidents and Occupational Diseases at Work (Institut National de Recherche et de Sécurité pour la Prévention des Accidents du Travail et des Maladies Professionnelles), INERIS= National Institute of Industrial Environment and Risks (Institut National de l’Environnement Industriel et des Risques), CRAM= Regional Fund for Sickness Insurance (Caisse Régionale d’Assurance Maladie).

### 6. OHS IN EU MEMBER STATES IN 2000

#### Table 15. General aims of policies related to OHS

<table>
<thead>
<tr>
<th>Country</th>
<th>Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Belgium</strong></td>
<td>The general principles were to take all necessary measures to safeguard the well-being of employers and employees. More specifically, enterprises should take control of as many measures as they can that are related to occupational safety, health protection, psychosocial issues, ergonomics, hygiene, and environment.</td>
</tr>
</tbody>
</table>
| **Denmark** | Seven primary objectives for prevention were presented:  
No fatal accidents caused by working environment factors  
No occupational exposure to carcinogenic chemicals  
No occupational brain damage due to exposure to organic solvents or heavy metals  
No young people may suffer serious injury at work  
No risk of injury due to heavy lifting and no risk of occupational diseases due to monotonous, repetitive work  
No risk of psychological disorders due to the way work is organised  
No risk of hearing damage due to noisy work  
The programme also mandates cooperation among the social partners and the other players in health and safety at work. |
| **Finland** | The general legal objectives before 2001 were the promotion of health in OHS, full coverage of employees by OHS, and a multidisciplinary approach with high participation and equal cooperation and partnership.  
In 2004, the general aims were the improvement of quality of work, promotion and maintenance of health and work ability, and safeguarding OHS with quality and high coverage. |
| **Italy**   | Fundamental objectives of modern society were presented in promotion of occupational safety, prevention of occupational risks, and occupational health for all citizens and workers. |
| **Portugal**| The state was obliged to improve national infrastructure to develop for enterprises competent professionals (education and training), scientific and technical knowledge, information (statistics, general information), and quality guarantees (professionals, service accreditation). In addition, the state was to develop public control on permanency, continuity, and quality of the above systems and efficiency of these systems to reach workplaces. |
| **United Kingdom** | The national aim was to revitalise health and safety at work. This was to inject new impetus into the health and safety agenda, and to identify new approaches to reduce further rates of accidents and ill health caused by SMEs in particular. This would ensure that the approach to health and safety regulation remained relevant for the changing world of work and gained the maximum benefits from links between occupational health and safety and other government programmes.  
The strategy for occupational health was to reduce ill health in workers and the public caused, or made worse, by work; to help people who have been ill, whether caused by work or not, to return to work; to improve work opportunities for people currently unemployed due to ill health or disability; and to use the work environment to help people maintain or improve their health. |
### 6. OHS IN EU MEMBER STATES IN 2000

#### Table 16. Specific objectives set in policies for OHS

<table>
<thead>
<tr>
<th>Country</th>
<th>Specific objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denmark</td>
<td>OHS was to contribute to a clean working environment by the year 2005 by ensuring, in close cooperation with all member enterprises, working environment solutions that offer a high degree of prevention and high effectiveness.</td>
</tr>
<tr>
<td>Finland</td>
<td>Content, tasks, and methods of OHS needed to be updated. In addition the proper functioning of OHS required development in relation to systems of services, human and financial resources, expertise services, information technology, and research. In 2004, the specific objectives were to improve the quality of work, maintain health and work ability, and provide OHS with high coverage and quality through ten action areas: legislation, content of OHS, OHS system, financing of OHS, human resources, ethics, cooperation, information systems, research and monitoring, and inspection.</td>
</tr>
<tr>
<td>Italy</td>
<td>The aim was to increase preventive activities—through adequate information, training, and support—by applying legislative requirements in health and safety at work. Specifically, this meant coordination and use of synergy to rationalise and systematise Law 626/94 among government agencies.</td>
</tr>
<tr>
<td>Portugal</td>
<td>The main aim was to prevent professional risks by providing periodic risk evaluation. The mission was to develop the system and methods of prevention and protection in a global management structure in order to provide adequate health and safety at work by considering all risk factors and workers.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>The government encouraged better access to occupational health support, and promoted coverage of occupational health in local Health Improvement Programmes and Primary Care Group strategies in England, as recommended by the Health and Safety Commission’s Occupational Health Advisory Committee. According to ‘Occupational Health Strategy by 2010,’ interested parties were to work together to achieve the following targets, among others: 20% reduction in the incidence of work-related ill health; 20% reduction in ill health to members of the public caused by work activity; 30% reduction in the number of work days lost due to work-related ill health; everyone currently employed but off work due to ill health or disability was, where necessary and appropriate, made aware of opportunities for rehabilitation back into work as early as possible.</td>
</tr>
</tbody>
</table>
6. OHS IN EU MEMBER STATES IN 2000

Table 17. Accountability and mandates mentioned in the policy papers

<table>
<thead>
<tr>
<th>Country</th>
<th>Accountability and mandates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>The Higher Council for Prevention and Protection at Work (Le Conseil supérieur pour la prevention et la protection au travail) had high competence in relation to executing the law and policy, making initiatives, and receiving proposals.</td>
</tr>
<tr>
<td>Denmark</td>
<td>Responsibility for coordinating and formulating policies as well as planning efforts in the field of occupational health and safety was clearly placed within the Ministry of Labour and the Working Environment Service.</td>
</tr>
<tr>
<td>Finland</td>
<td>Responsible organisations were the following: Ministry of Social Affairs and Health, Permanent Committee on OHS, National Research and Development Centre for Welfare and Health, Social Insurance Institute, Finnish Occupational Health Institute.</td>
</tr>
<tr>
<td>Italy</td>
<td>Government, regions, and social partners promoted legislative and financial instruments, labour policy, and safety issues.</td>
</tr>
<tr>
<td>Portugal</td>
<td>The main actor and the agency that was accountable for implementing the White Paper was the Labour Administration—which administered health, education, professional education, professional certification, licensing administration, quality authorities, and inspection systems. Mechanisms were put in place for periodic review of the policy although its implementation was inadequate. Decree-Law No. 245/2001 of 8 September 2001 restructured the tripartite National Council for occupational health and safety, whose purpose, as defined was ‘to promote cooperation and sharing of responsibilities between the State and the social partners in designing, monitoring, and evaluating policies on the prevention of occupational risks and accidents at work.’</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Government and Health and Safety Commission worked together to revitalise health and safety in partnership with the Scottish Executive and the National Assembly for Wales. In addition, the Health and Safety Commission wished to see continued cooperating with employers, employees, trade unions and consumers.</td>
</tr>
</tbody>
</table>
Several EU member states had national committees that worked for occupational health and safety, including OHS, or a separate committee only for OHS issues. These committees were important mediators between social partners and the government to extend coverage of OHS to all employees. The committees were also important to several occupational health and safety institutes of the EU member states by legitimising their existence; by supporting their research, development, training, and information; and by using their resources. The leadership of OHS issues varied in EU member states among the committees, institutes, ministries, and social partners. Just as the material and human resources differed among the countries, the continuous and incremental processes of development of OHS also had different speeds, contents, directions, and aims.

6.4.3 Policy of trade unions and employers’ organisations for OHS

In trade unions, OHS discussions referred to individual topics of health among workers, such as musculoskeletal diseases, stress, bullying, or work absenteeism, rather than OHS as a general subject. For individual topics related to health at work, several trade unions at a national level had launched prevention programmes with guidelines and brochures. In addition, the European Trade Union Confederation (ETUC) supported national trade unions with international guidelines. OHS is also part of welfare services, which the trade union movement generally favoured in their policy papers, though the actual OHS might not be referred to directly in policy papers. In addition, trade union representatives and employers’ organisations were members of the boards of several insurance companies that provided compensation for occupational diseases, injuries, and accidents. They were also on the boards of national institutions that administered, governed, researched, or monitored labour market issues, including health and safety at work.

There were significant differences in how trade unions and employers’ organisations formed their policies. In some countries (Austria, Italy, German, Luxembourg, Sweden, and Ireland), a policy document of trade unions was a written and published. In Ireland, the trade union had a twelve-point programme on quality of life, including health, safety, and
welfare at work. In Luxembourg the name of the policy was 'Policy on humanisation of work life for social dialogue.' In some countries the statements by trade unions were published in national meetings (Greece and Portugal). However, Greek trade union representatives considered their activities were decisive for the development of OHS. In the Netherlands, the major trade union periodically conducted a survey on 'Ideal OHS,' which collected scores of OHS activities from occupational health professionals in the OHS units and trade union representatives.

Employers are obliged to protect health and safety at work in all EU member states. In many countries OHS had an advisory role for companies. Employers also had to prepare an integrated well-being plan in Belgium, a safety and hygiene plan in Greece, a statement on health and safety at work in Ireland, a working conditions policy in the Netherlands, and a working conditions policy in Spain. Employers were also obliged to inform and instruct workers about risks at work and to assign competent and responsible personnel to risky tasks.

In France, occupational medicine was under review by employers' organisations and trade unions during the interview phase. Employers' organisations in general did not have a specific OHS policy in France. The responses from Finland, Italy, and Spain referred to joint committees in occupational health and safety at the national level, where employers' opinions might be presented. In Italy, such a forum was the Tripartite Permanent Commission of Safety and Health at Work, and in Spain the Commission of Preventing Professional Diseases worked internally in the organisation. However, the interviewees in Spain underlined the importance of OHS in collective bargaining; responses in Finland also referred to collective bargaining and the inclusion of OHS in that process. In the Netherlands, OHS as such was seen as an obligatory governmental policy for companies. According to the Dutch employers' organisation, joint policies were prepared, but occupational physicians were key actors in the development of OHS. In Belgium, there was no joint employers' policy on OHS.
OHS is mainly funded by employers, with some exceptional support from the government for OHS units based on compensation applications. However, employers are obliged to provide their employees with insurance coverage for occupational injuries, diseases, accidents, and deaths. Both occupational insurance coverage and OHS provide the basic compensation scheme for occupational ill health.

6.5.1 Organisation of OHS

OHS can be organised by enterprise or group of enterprises, by other bodies authorised by the competent authority, by public authorities, or by social security institution. OHS is organised as either an external or internal service for the company. The choice of internal or external service was optional for companies in the framework directive. The choice existed for all companies in Austria, Finland, France, Germany, Greece, Ireland, Luxembourg, Sweden, and the United Kingdom. In principle, companies in Denmark also had a choice, but some companies were required to use particular occupational health and safety services. In Portugal, companies with more than 50 employees had to make their own choice. In Belgium, Greece, Spain, and Sweden, the involvement of an external occupational health and safety service was mandatory, if the company did not have the know-how internally. It was also mandatory in Portugal, in certain conditions, to use external OHS; and in the United Kingdom, there was an obligation to use external help for occupational health issues, but not necessarily occupational health and safety services.

Requirements regarding internal occupational health and safety services (Art 7.1 of the framework directive) vary among countries. External certification of the internal service was required by regulations in Denmark, Finland, Greece, and Spain. A minimum quantity of personnel present in internal occupational health and safety services was required by regulation in all the other countries, but not in Ireland, Luxembourg, and the United Kingdom. The capabilities and means of the internal professionals were specified (Art 7.5 of the framework directive) in all
6. OHS IN EU MEMBER STATES IN 2000

Other countries, but not in Ireland. The resources of the internal OHS services were related to company size and hazard profile by obligation in Austria, Belgium, Finland, Greece, Portugal, Spain, Sweden, and the United Kingdom.

The requirements for external occupational health and safety services were related to tasks, resources, and status. Tasks were specified in detail in national laws in Austria, Belgium, Denmark, Finland, Greece, Portugal, Spain, and Sweden. In other countries, specification of tasks was relatively vague and open. The minimum number of employees and the specification of experts for occupational health and safety services were not mentioned in legislation in France, Ireland, and the United Kingdom. Occupational health and safety services had to be certified officially in Austria, Belgium, Denmark, Finland, Greece, Portugal, and Spain. Certification was not required in other countries. The employer's obligation to inform occupational health and safety services about possible risks of worker health and safety was stated in the legislation of Austria, Belgium, Denmark, Germany, Greece, Italy, Portugal, Spain, Sweden, and the United Kingdom (Hämäläinen et al. 2001, Dotan, van Waarden 2002, see for laws Appendix III).

Table 18 shows that OHS was organised in a variety of ways and was mainly composed of privately organised services for employees by employers. When OHS was organised by the enterprises, several companies might have a joint OHS unit, a company doctor, or a branch-based OHS unit. Public authorities provide OHS from the primary health care centres with specialised units or for their own public sector employees. Social security institutions provided OHS based on contributions paid by the employers’ insurance.
### 6. OHS IN EU MEMBER STATES IN 2000

#### Table 18. Models of OHS in EU member states

<table>
<thead>
<tr>
<th>Type of OHS</th>
<th>EU member states</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OHS organised by enterprise or group of enterprises</strong></td>
<td></td>
</tr>
<tr>
<td>Integrated ‘built-in’ internal OHS service</td>
<td>All EU member states</td>
</tr>
<tr>
<td>Joint OHS with different companies</td>
<td>Austria, Belgium, Denmark, Finland, Italy, the Netherlands, Spain, Sweden, the United Kingdom</td>
</tr>
<tr>
<td>Company doctor (full-time or part-time)</td>
<td>Austria, Germany, Ireland, Italy, the United Kingdom</td>
</tr>
<tr>
<td>OHS for occupational groups/OHS for particular trade or industry</td>
<td>Belgium, Denmark, France, Italy, Luxembourg, the United Kingdom</td>
</tr>
<tr>
<td><strong>OHS organised by other bodies authorised by the competent authority</strong></td>
<td></td>
</tr>
<tr>
<td>Intercompany medical services managed by departmental or regional employees’ organisations</td>
<td>France</td>
</tr>
<tr>
<td>Private medical stations providing OHS</td>
<td>Austria, Belgium, Finland, Germany, Ireland, Portugal, Spain, the United Kingdom</td>
</tr>
<tr>
<td><strong>OHS organised by public authorities</strong></td>
<td></td>
</tr>
<tr>
<td>(Primary) Health care centres providing OHS</td>
<td>Finland, Greece, Italy, the United Kingdom</td>
</tr>
<tr>
<td>Local authorities provide OHS</td>
<td>Finland (in principle, health care centres in the municipalities are under municipal funding), Italy (UOOML), the United Kingdom</td>
</tr>
<tr>
<td>State OHS for public sector employees and defence medical service</td>
<td>France, Spain, Italy, the United Kingdom</td>
</tr>
<tr>
<td>Semi-public OHS</td>
<td>Luxembourg</td>
</tr>
<tr>
<td><strong>OHS organised by social security institution</strong></td>
<td></td>
</tr>
<tr>
<td>OHS provided by statutory industrial accident insurance funds</td>
<td>Austria, Germany</td>
</tr>
</tbody>
</table>

*UOOML= Hospital unit of occupational health (Unità Operative Ospedaliere di Medicina del Lavoro)*
6.5.2 Funding of occupational health services

Employers fund OHS through payments to insurance institutions or providers of OHS. In some countries, such as Finland, the social insurance institute provided compensation for OHS, and in Italy local health units provided OHS. The economic status of OHS was mentioned in the legislation of Belgium and France to be a non-profit association. In Portugal, Italy, Finland, and the United Kingdom, national health services provided OHS. In Italy, local health service units provided the majority of OHS. In Portugal, regional health authorities with health services at a local level provided OHS to workers and employers. In Finland, companies could have a contract with a primary health care unit, private OHS centres, or association-based non-profit OHS centres. The Social Insurance Institute in Finland also provided financing by compensating up to 50 per cent of costs of OHS to employers. In the United Kingdom, the National Health Service could provide OHS from its own OHS unit, if workload allowed employers to provide external services.

In addition to economic status and who can provide OHS, the time used per employer or employee on OHS was also determined in legislation. In Austria, the minimum time per employee per year depended on the size of the company, but the inspection of the company was on an annual basis. In general, the time allocation was 0.66 hours per employee in an Austrian company with more than 50 employees. Regular inspections by OHS were obligatory in enterprises with fewer than 51 employees. In enterprises with fewer than 11 employees, one inspection every two years was obligatory. Additional inspections were obligatory in Austria in particular occupations, depending on several factors, including work accidents, new working procedures, and new agents. The minimum time spent per employee or employer provided the basic frame for OHS and its income. In France, time per employee spent by a physician was defined in the law. In Germany, branch-specific rules by statutory industrial accident insurance were defined. Usually, the definition was based on minimum hours per insured person and based on risk potential. In Greece periodic examinations and evaluations of working conditions were presented in legislation. The compensation system legitimised the state’s interventions into OHS and emphasised the importance of follow-up in getting results through minimum time spent at a workplace instead of needs and risks evaluations.
6.6 Monitoring and evaluation of occupational health

The actions that are needed to promote equity in occupational health and to strengthen sustainability of OHS require efforts by many partners. A written policy document on occupational health or OHS can provide a basis for many partners to be involved in improved occupational health. The policy paper often includes clear objectives, strategies, and targets to provide a framework for the preferred direction. Accountability for such a policy paper can be achieved through monitoring and evaluating progress in policy implementation. The monitoring requires indicators to measure progress towards targets, a mechanism for collecting indicators, analysis, and timing of evaluation and monitoring.

Through monitoring and evaluation, making decisions about OHS in national and international levels can be influenced, improved, enhanced, and strengthened. OHS coverage, access, and equity, as well as disease and accident patterns, can be followed through the collection of statistics. Based on statistical information, focus areas—such as different trades or industrial branches, geographical areas, or OHS service processes—where action is needed can be defined.

In this section on monitoring and evaluation, monitoring schemes and evaluations conducted in EU member states in OHS are reported. Both monitoring and evaluation need indicators to be followed to improve OHS and the occupational health of workers. Studies on cost-effectiveness and cost-efficiency have been conducted in order to evaluate the impact of OHS on occupational. The economic benefits and achievements are not the sole indicators for OHS, because services also need to present a certain quality, efficiency, and satisfaction for employees and employers (Mossink, Licher 1998, Mossink 2000).

6.6.1 Monitoring of OHS

There were several monitoring schemes for health and safety at work at the European level. Some of the schemes are only at the proposal level, some had reports available, and some had databases on which the schemes were based. The comparative data were available, but the indicators and measures used were not similar in each EU member state. There
were differences in the collection of data, definition of indicators, and measures of indicators, which need more harmonisation and discussion before justifiable comparisons can be made (Kreis, Bödeker 2003). The existing monitoring schemes are summarised in Appendix IV.

In most of the EU member states, the content of OHS is defined in legislation. In relation to monitoring, the variety of practices includes guidelines in good occupational health practices, continuous quality improvement, and monitoring of effectiveness. In some countries, monitoring of OHS is done through regular surveys or is based on needs of evaluation due to foreseen changes in legislation, regulations, or guidelines. In other countries, monitoring is based on social insurance or insurance companies’ compensation figures, statistics from the institutes themselves, or from the country’s statistical bureau. Even this indirect monitoring gives basic information about the inputs and outputs of OHS.

According to the interviews few countries conducted periodic external verification of the activities of OHS or quality management. Also, regular monitoring of OHS was rare in EU member states. In Austria, the Labour Inspectorate controls OHS activities, and OHS units provide an annual report. In Belgium, OHS units prepared an annual report for the National Council of Safety and Health. In Denmark, the quality management certification body required annual verification of activities, and the National Work Environment Authority conducted the monitoring. The Finnish Institute of Occupational Health conducted an OHS survey every third year. In Italy, the OHS activities were verified in local health units. In Luxembourg, verification of OHS activities occurred in major OHS units in large companies. In the Netherlands, OHS units are certified and reports were sent to the management of OHS. A certification body also monitors OHS activities. Internal preventive services were audited every five years in Spain, where external services were accredited by the Labour Authorities. In France, OHS units prepare annual reports on their activities.
6.6.2 Evaluation of OHS

Only a few countries conduct regular evaluations of OHS (Table 19). In Denmark, Finland, Portugal, and Sweden evaluations or situation analyses were prepared in the 1990s. Denmark evaluated OHS in 1999. Finland conducted a survey of the structure, input, and output of OHS in 1992, 1995, and 1997. Portugal conducted a situation analysis of OHS for discussion in 1997. The United Kingdom published a report, the ‘Recommendation of the occupational health advisory committee on improving access to occupational health support,’ which provided a baseline of the OHS situation. In Luxembourg and France, OHS units provide annual reports to regional and national authorities, which rarely lead to specific evaluations of OHS. Denmark and the Netherlands have evaluated quality management systems of OHS. In the Netherlands, the obligatory quality management systems are inspected annually.
## Table 19. Evaluation of OHS in some EU member states

<table>
<thead>
<tr>
<th>What was evaluated?</th>
<th>Denmark</th>
<th>Finland</th>
<th>Portugal</th>
<th>Sweden</th>
</tr>
</thead>
<tbody>
<tr>
<td>The purpose of the evaluation was to check if OHS fulfilled the objectives as formulated by legislation in 1999.</td>
<td>Evaluation of OHS functional environment, input, and output was conducted in 1999.</td>
<td>The purpose was how to build strategic approaches to develop resources and organisational models of OHS in the enterprises (Livro Verde 1991), to reflect problems of OHS at work, and to develop the systems (Livro Branco 1999).</td>
<td>Analysing OHS services provided ways of working with enterprises, management, and workers. In addition, competition among OHS units, views of OHS by different-sized enterprises, and coverage of OHS in different parts of the country were evaluated.</td>
<td></td>
</tr>
</tbody>
</table>

| Data gathered and method of gathering. | Interviews with managers and employees' representatives of OHS; questionnaire to OHS units, and case studies in OHS and affiliated enterprises. | All OHS units were asked to fill out a questionnaire. | Questionnaire to public administration, enterprises, professional organisations, institutes of education, centres of technology, foundations, services, professional schools, universities, and individuals. | National agency for public management analysed the data. |

| Criteria of evaluation (what criteria or standards were used to judge the value). | Legislative objectives and their fulfilment by OHS and employers; injury prevention and promotion of safety and health of employees by OHS; OHS support to enterprises so that enterprises solve their own OHS problems. | How best-practise guidelines on occupational health service practices were implemented in OHS units. | The mission of OHS, function and activities of OHS, structure of preventive services, education of actors in OHS, and quality and evaluation of OHS. | - |

| Comparison | Norms and standards | Good occupational health practices | Norms and standards; Livro Verde | Other EU countries with OHS |

| Who did the evaluation and why? | The Danish Technological Institute for the Ministry of Labour due to change work environment law in 1997 to expand OHS to cover all labour markets. | The Finnish Institute of Occupational Health; the evaluation was part of the legislation-based follow-up of OHS at the national and local levels. | Commission of white paper for the preventive services set by the Ministry of Labour and Solidarity; the evaluation followed the discussion and views presented by the study published in a green paper. | The government decision to State Treasury (Statskontoret). |

| Action from the evaluation. | OHS to be extended to cover all workplaces. | Differences in service structure and processes were the basis for the review of the OHS law in 2000. | Not known. | New law proposed by the Labour Market Department (Arbetsmarknadsdepartementet), Council of State (Regeringkanslet). |
6.6.3 Indicators for the impact on occupational health

In all countries, the government and its agencies played an important role in collecting data, distributing information, and steering OHS development through information. Usually employers had a legal obligation to report occupational injuries, accidents, and deaths. There was room for improvement in the available data, as well as the collection method and coverage of the data. In some countries, such as in Italy and Spain, regional authorities had much to say about collecting data and about influencing the reliability of the data. The lists of occupational diseases existed in all countries, except the Netherlands and Sweden, with variations of diseases included. The records of occupational diseases varied, depending on the education of occupational physicians, existence of occupational physicians, and systematic approach to data collection. The interviews showed there was underreporting due to the employers’ responsibility to cover the costs (France, Greece, and the Netherlands).

According the interviews conducted in 1999-2000, there was good cooperation about data collection in some countries among ministries responsible for OHS and insurance companies. The survey may take place annually or on regular intervals. Although the data did not give very detailed information, the results showed trends and development directions. Questionnaire-based surveys were also used in several specific occupational hazards or working conditions. Hardly any data were collected directly related to OHS or its quality management system. The number of certified OHS was known by certified bodies, but the quality management systems or any other detailed information was scarce. The role of EU member states in collecting data on OHS and the use of data to improve OHS access, coverage, and equity seems to be unclear. However, data on OHS units and their activities, impact, and effectiveness were scarce and rarely published.

Based on the interviews the data on health determinants were collected by different actors and institutes for several national purposes. Occupational health determinants can be reviewed from different sources and databases. The commonly collected health determinants
are working conditions, inherent factors (materials, processes, and products), exposures or burden/ emissions, and factors determining the susceptibility of the human risks. Factors can also be categorised as lifestyle, occupational, environmental, and social determinants. These indicators were collected at the national level or at the level of the OHS unit through workplace analysis, health examinations, or with other surveys, such as chemical, physical, and radiation analysis. This information collection was compared to similar earlier data, research, and experiences to make proper and justifiable conclusions and objectives for actions, such as prevention, treatment, rehabilitation, and training. However, data collected by national institutes and the impact of data on OHS activities rarely showed clear connections or was not known.

111 Data concerning working conditions, such as participation in training, influence on work tasks, monotony at work, physical and mental work load, stress at work, computerised work, and working culture, were mainly collected by the statistical offices, national institutes for occupational health, and labour inspectorates. The collections were often organised to serve the purposes of the European Foundation for Working and Living Conditions collection and reporting of data. Additional surveys were conducted in EU member states when needed.

112 Inherent factors, such as materials, processes, products and use of toxins, ergonomics, safety risks of technology, were collected, but few of the interviewees reported regular surveys. The surveys were conducted by the statistical offices or specific occupational health and safety authorities in EU member states.

113 The data for exposures and burden or emissions (e.g., heat, cold, vibration, draft, noise, dusts, smoke, dirtiness, poor lightning, irritant substances, and restlessness of work environment) were collected by surveys supported by the national statistical offices, labour inspectorates, occupational health and safety institutes, or insurance companies. Also, this data collection has connections to the European Foundation for Working and Living Conditions collection and reporting of exposures data.

114 Data concerning factors determining susceptibility of human risks were hardly reported by the interviewees and were mainly referred to as a separate survey activity in the countries.

115 Lifestyle determinants, such as smoking, drinking, physical activity, nutrition, and obesity, were collected by the health authorities on a national or regional level; national reports were mainly produced by the national public health institutes or equivalent. Environmental determinants, such as use of toxins, use of renewable materials, intensity of products and services, degeneration of ecosystem, traffic, air quality, and healthy and safe food, were collected by a variety of authorities; the authorities included ministries, regional authorities, national institutes in environmental issues, food authorities, statistical offices, public health institutes, and occupational health and safety institutes. Data for occupational determinants (education, income, place of living, etc.) were collected mostly by the statistical offices of the countries. Social determinants (stability of employment, possibilities for training, ability to communicate, etc.) were collected mostly by statistical offices and specific national surveys.
Some of the interviewees knew that institutions collected data on certain topics and published it, but to what use and how to use data to the benefit of OHS was not made clear in the interviews.

According to the interviews, individual occupational health issues were usually followed up at the level of the OHS unit. Some countries had databases on individuals with occupational related cancers or had other exposure-related databases. In the enterprises the follow-up was related to sick leave and work absenteeism. Parts of the statistics were used by the Labour Inspectors to focus their activities on certain branches of industry or even companies. The rigorous and systematic follow-up of the statistics was not necessarily related to either policies or local planning of activities in OHS. It was especially difficult to report any results from SMEs because confidentiality was a challenge.

Data on occupational diseases, injuries, and accidents were mainly collected by the national insurance institutes, insurance companies, or ministries responsible for occupational health. However, concern was reported about the reliability of the data collection; specific concerns were underreporting and irregular collection schemes. Data on the life expectancy of occupational groups were collected mainly by statistical offices, and data on premature retirement were collected by the social insurance institutes and responsible ministries, such as labour and social affairs.

### 6.6.4 Costs and benefits of OHS for enterprises

The effects of OHS on health can be described by changes in work conditions, work environment, and work health. The work capacity of employees includes health, functional capacity, skills, knowledge, abilities, willingness to work, and work requirements. The productivity of the company can be measured by dividing output (tasks, services, and methods) by input (personnel and costs). Therefore, the studies of the cost-effectiveness and cost-efficiency of OHS have been conducted to justify financial inputs by companies to OHS. Specific methods for assessing the economic impact of OHS exist in a minority of countries. In some countries, direct costs to society or to companies were calculated, but indirect costs on employment, national welfare, or national competitiveness were not included. According to the interviews, the means of
obtaining reliable data with which to calculate costs-effectiveness and cost-efficiency (e.g., real costs to human life, injuries, and basic values) were often limited.

All the interviewees from the ministries and regional governments had a general opinion that OHS had a positive effect on health, work capacity, and productivity. They admitted that it was difficult to show this with any certainty because many other factors also had influence. Health improvements were mentioned by interviewees from Denmark, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, and Sweden. Interviewees in Austria, Belgium, Finland, the Netherlands, and Sweden mentioned improvements in work capacity. Productivity was expected to increase due to OHS in Denmark, Finland, Germany, Italy, the Netherlands, Norway, and Portugal.

Many countries reported no available figures on effect (Austria, Belgium, Denmark, Germany, Italy, Luxembourg, and Portugal). Figures on the positive effects of OHS were available in Finland. According to the interviewees the general awareness of the relationship among health, work capacity, and productivity seemed to have increased in Austria, France, and the United Kingdom during recent years. Great effects of OHS on productivity of enterprises were expected in Denmark and Greece by interviewees.

Personnel accounting and health economics should prove the effects on health, work capacity, and productivity. However, most OHS investments were made by companies, each of which gave company-specific proof of cost-efficiency (Finland). OHS in large companies showed some effect (Germany, Greece, and Portugal) on a statistical basis. OHS had improved health status, decreased occupational injuries, and controlled diseases and pollutants (Italy). According to the interviews, SMEs increased productivity by 80 per cent due to health improvements among employees (Portugal).

Professional organisations emphasised the positive effect of OHS on work capacity and productivity, but agreed on the difficulty to demonstrate such effects (Denmark and Germany). However, absenteeism and sickness might both decrease (Ireland), and this will have a major impact on health and work capacity, but not on productivity (Netherlands). Insurance agencies did not have reliable figures on the general impact of OHS. Research institutes underlined the lack of reliable and
valid research on effects on productivity, but considered the impact to be generally positive, specifically to the costs of rehabilitation and treatments (Denmark, Italy, and Sweden).

According to the interviews, hardly any studies existed on the cost-effectiveness and cost-efficiency of OHS in most of the countries. Costs were considered by interviewees to be at an acceptable level in Austria, Belgium, Denmark, Finland, Italy, the Netherlands, Portugal, and the United Kingdom. Employers considered costs and efficiency of OHS to be negative in France, Greece, the Netherlands, and Spain, whereas they were positive in Germany, Italy and Sweden. Cost efficiency was also reported to depend on the competency of professionals, the location of OHS, and the methods of measurement.

Representatives of trade unions did not consider OHS cost-effectiveness and cost-efficiency to be a topic that concerned them because costs are regulated at the national level by law (Austria, Belgium, and Portugal). However, there seem to be no clear differences between services provided and prices charged (the Netherlands). Trade unions called for studies on cost-effectiveness and cost-efficiency (Sweden, Portugal, the Netherlands, Greece, Germany, Finland, and Austria), but they also noted that health effects can appear years after a problem has been solved (Germany). Employers’ organisations called for clearer connections between costs and OHS with benefits (the Netherlands, Belgium, and France) because OHS is often considered too expensive, especially by many SMEs (Germany). Voluntary personnel accounting might be a good basis for planning for OHS activities in companies (Finland).

Insurance agencies would invest more on rehabilitation and prevention if cost-effectiveness and cost-efficiency were well proven (Finland). Knowledge of OHS and its cost-effectiveness and cost-efficiency are important factors in decisions that companies make (Germany). Research institutes underlined the low costs of OHS in comparison to consultation services or accidents (Denmark). However, in Spain private OHS seemed to be more cost-efficient than public OHS. Costs are also related to the continuity and permanence of OHS units (Sweden), due to competition among OHS units. Professional organisations asked for OHS units to use better contracts for their financial or human resources (Belgium, Denmark, Ireland, and United Kingdom). OHS has decreased the costs of sick leave, but the direct and long-term impact of OHS is...
not well known (the Netherlands). Some companies consider OHS an additional tax to be paid out of the company’s profit (Spain).

Ministries considered overall OHS costs low in comparison to losses (sickness, absence, accidents, and injuries) (Denmark). However, the costs are mainly borne by companies, which incur the major increase of costs (France, Germany, Italy, the Netherlands, and Sweden). Few studies and evaluations have been conducted, but broadly speaking OHS can be considered cost-effective (United Kingdom). Cost-efficiency also depends on the management of OHS and of the company (Germany), and short-term cost-efficiency of OHS was considered good (Finland).

6.6.5 Quality, institutional competence, and efficiency of OHS

The quality of OHS became an important issue in health system reforms and the market orientation of OHS. Quality requirements set by regulations or recommendations were seen as a frame where OHS was able to operate while keeping the standards and ethical issues at a high level. Authorisation of OHS to provide services was mentioned in the legislation of several countries. Austrian OHS centres had to notify their services to the Federal Ministry of Economics and Labour. OHS needed authorisation from the Federal Ministry of Labour, Health and Social Affairs, Austria. In France OHS was a non-profit association requiring official agreement from the Ministry of Labour every fifth year. In Portugal, the Institute of Development and Inspection of Labour Conditions gave permission for OHS units. In Spain, external services needed accreditation from health and labour authorities (see Table 20).

Care is needed to differentiate among health service accreditation, certification, and licensing. In many European countries, doctors are individually 'accredited' when they complete designated speciality training, and accreditation of institutions is increasingly compulsory. However, few of the quality management bodies were certifying or accrediting OHS for their quality management systems at the time of interviews. The certification applied to Denmark and the Netherlands only. Some larger OHS units might have gained quality management certification based on a foreign certification procedure. Of the quality management bodies in EU member states, only Danish (Danish Accreditation, DANAK) and
Dutch (Raad voor Accreditatie, RvA) organisations had included OHS in their quality management programmes.

The quality and quality management (QM) of OHS in EU member states varies. In some countries, OHS quality management is based on regulations or recommendations or is based on integration with occupational health and safety management systems. Quality management of OHS was required in regulations in Denmark (requirement until the end of 2004), the Netherlands (certification), and Finland (statement for the need for continuous quality improvement). OHS and quality management were without any specific requirements in Ireland, Sweden, and the United Kingdom.

Quality requirements in legislation exist in Denmark, where OHS is required to have QM by law. In Finland the legislation refers to continuous quality improvement in OHS. The integration of OHS as part of a company’s management system has been popular in the United Kingdom, Nordic countries, and the Netherlands, but in different ways. Sweden has implemented ‘internal control,’ which aims to prevent hazards at the workplace through the employer’s systematic assessment of risk control. In the Netherlands, the aims are to reduce absenteeism through improved working conditions. In the United Kingdom, the main aims are to calculate prevention-related costs and benefits and to prevent work-related health problems. The integrated health and safety management system with quality control might have a supplementary role as an instrument or an intervention to improve health and safety at work. In Germany, a holistic approach to occupational health and safety management has been developed.

Some countries (Denmark and the Netherlands) have undertaken action to implement a quality management system in OHS, including auditing and certification. Good Occupational Health Practice guidelines have been tested in Finland (Taskinen 2001). Ireland and the United Kingdom lack specific legislation for OHS. The quality management policy statements can be categorised in the following way:
6. OHS IN EU MEMBER STATES IN 2000

1) Policy statement on quality management included in the legislation: Austria, Belgium (from 2000 onwards, with a four-year transition period), Denmark, Finland, and the Netherlands.

2) National (governmental) recommendation for quality management: Germany and Finland (in addition to legislation).

3) National policy statement from professional organisations and others: Austria, Germany, and Sweden.

4) No policy statements on quality management at the national level: France, Greece, Ireland, Italy, Luxembourg, Portugal, Spain, and the United Kingdom.

In Denmark, the application of quality management was enforced by law and an OHS quality management system had to be applied by the end of 1998 to continue the activities as OHS. In Finland, the Council of Quality in Health Care recommended to adopt written quality policy by the end of 1996. In the Netherlands, OHS quality management has been enforced by the law since 1994. Private certification institutes certified OHS in quality management certification.
Table 20. Some quality management policies of OHS in EU member states

<table>
<thead>
<tr>
<th>Country</th>
<th>Governmental policy statement on OHS quality management and aims of the policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Quality of structure and management of OHS defined in the law. Good practice in OHS guidelines was under preparation by the Austrian Academy of Occupational Medicine. The Austrian Association of Occupational Health Physicians prepared guidelines for self-evaluation of quality in OHS.</td>
</tr>
<tr>
<td>Belgium</td>
<td>Royal degree was in preparation; this required implementing quality management from 2000 onwards with transition time four years.</td>
</tr>
<tr>
<td>Denmark</td>
<td>OHS units had to have accepted and certified quality management systems by legislation. Quality levels of OHS defined qualifications, measurements, records, annual working programmes, and regular inspections. Requirements existed concerning the consulting activities and the preventive actions.</td>
</tr>
<tr>
<td>Finland</td>
<td>Good occupational health guidelines identified quality in OHS as effectiveness, appropriateness, accessibility and adequacy, functional efficiency, good scientific/technical level, and good tested quality.</td>
</tr>
<tr>
<td>France</td>
<td>Annual report from OHS units was sent to Regional Labour Inspection; Philosophy of Quality Management in Medical Inspection was in preparation by the Group of Labour Inspectorates.</td>
</tr>
<tr>
<td>Germany</td>
<td>Occupational health and safety management system concepts were developed jointly with the Ministry of Labour and Social Affairs; the statutory industrial accident insurance institutes; and the social partners, including the National Association of Company Physicians developed minimal requirements for OHS.</td>
</tr>
<tr>
<td>Italy</td>
<td>No policy statement on quality management in OHS existed, but the Italian Society of Occupational Medicine and Industrial Hygiene set up a working group on quality management in OHS.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Certification and quality management in OHS was compulsory by law. The objectives were to ensure professional quality (occupational physicians and hygienists, safety engineers), facilities, procedures, and content of services to the companies.</td>
</tr>
<tr>
<td>Sweden</td>
<td>No quality management statement by the government existed, but the Booklet on the Quality Management in OHS included recommendations in ISO Standards and the Swedish Quality Award, which was published by Swedish Association of OHS Organisations and the National Institute for Working Life.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>No quality management policy statement existed. Targets set by the government for the public health agenda included the reduction of specified diseases and injuries in the workplace.</td>
</tr>
<tr>
<td>Greece, Ireland, Luxembourg, Italy, Portugal, Spain, Sweden, United Kingdom</td>
<td>No policy statement on quality management in OHS existed.</td>
</tr>
</tbody>
</table>
Efficiency is one of the measures to assess the outcomes of OHS and OHS systems. Efficiency is most often viewed on financial grounds: the best that can be achieved with the available resources. This method of measurement is distinctly different from a method that measures OHS compliance with established standards. One can use statistics or performance measures when evaluating performance. However, the criteria of valuation must be explicit. One set of criteria for a national health programme evaluation is the set proposed by health impact assessment: relevance to the needs, priorities, adequacy, progress, effectiveness, and impact (Olsson 1999).

In general, two different levels of efficiency and quality assessment can be identified in EU member states: (1) efficiency measures at the OHS unit/enterprise level, and (2) efficiency measures at the regional/national level (or the industrial branch level).

a) At the OHS unit/enterprise level, annual reports and/or action plans are collected by national authorities in Austria, Belgium, Finland (enterprises for reimbursement of costs for arranging OHS from the Social Insurance Institution), France, and Italy (legally compulsory 'Risk Document' and consequent 'Sanitation Plan,' which specifies all the sanitation surveillance carried out in that company or working sector).

b) At the national/local level, annual reports are prepared in Germany, Luxembourg, and Spain; at least one national evaluation of occupational health services has been done in Austria, Denmark, and Finland.

c) There is no assessment of efficiency in Greece, Ireland, Italy, Portugal, Spain, Sweden, and the United Kingdom.

d) There is an annual inspection of quality management systems by the certification body in the Netherlands and Denmark (2-3 inspections in 5 years)

The EU member states have a variety of tools to assess the efficiency and quality management of OHS at the national, local, and enterprise levels, according to the interviews. The results are presented in Table 21.
### Table 21. Main tools to assess the efficiency and quality management of OHS

<table>
<thead>
<tr>
<th>Country</th>
<th>Main tools to assess efficiency and quality management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Qualification of OHS personnel. Minimum time used in enterprises with more than 50 employees. Annual reports.</td>
</tr>
<tr>
<td>Belgium</td>
<td>Annual action plans of OHS units. Five-year prevention plan in enterprises. Every third month, OHS units report to trade unions and employers' organisations.</td>
</tr>
<tr>
<td>Denmark</td>
<td>National evaluation survey of OHS in 1998. Efficiency measures, at the level of OHS units, based on quality management systems' requirements.</td>
</tr>
<tr>
<td>Finland</td>
<td>Development of one's own work. Good Occupational Health Practice guidelines. Every third year, follow-up study of OHS system by the Ministry of Social Affairs and Health.</td>
</tr>
<tr>
<td>France</td>
<td>Annual report of OHS to Regional Labour Inspection and collected in the Ministry of Labour.</td>
</tr>
<tr>
<td>Germany</td>
<td>Reports on federal states to ministries, combined with results by National Ministry of Health, Labour, and Social Affairs. Monitoring mainly on the level of professional organisations.</td>
</tr>
<tr>
<td>Italy</td>
<td>On-site inspections, yearly collections of targeted questionnaires, and epidemiological evaluations of occupational illnesses and accidents. Influence of workers' representatives on OHS units. Quality of life inspections at the regional level.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Annual report of OHS to the Ministry of Health.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Certification body performs annual inspection of OHS quality management.</td>
</tr>
<tr>
<td>Spain</td>
<td>No systematic evaluation of preventive services. External services must submit a set of documents on human resources, materials, and projects to be accredited by labour authorities. Labour authorities can inspect them whenever they consider it necessary. Internal preventive services must be audited every five years or whenever labour authorities consider it necessary.</td>
</tr>
<tr>
<td>Greece, Ireland, Portugal, Sweden, United Kingdom</td>
<td>No regular assessment of quality.</td>
</tr>
</tbody>
</table>
6.6.6 Overall impact and satisfaction with OHS

The interviewees were asked about the impact of OHS on the health of the population. The purpose was to determine and assess the effects produced by OHS and the extent to which the opinions were related to the implementation of OHS policies. Although the answers and interpretations rely on the descriptions and interpretation of observations, they gave an overall idea of the stakeholders' views of the functioning of OHS and the possible limits of the influence of OHS on the health of the population on the national level.

The overall impact on health, social, and OHS outcomes can be classified as direct, intermediate, or long-term. Direct impact on such health outcomes as accident figures, occupational diseases, and work-related illnesses were mentioned in many responses (France, Italy, Luxembourg, Sweden, and the United Kingdom). As a long-term impact, the image of OHS being increased or increasing was mentioned (Austria and Germany), and so was local development (Ireland). Improvements to workplaces were not mentioned. As direct OHS impact, changes of health and safety behaviour at workplaces were mentioned (Finland and Sweden) and so was increased health awareness (Belgium and Luxembourg). Of the long-term impact interviewees from Austria mentioned the integration of OHS into enterprises, and interviewees from Germany and Sweden mentioned support from management with safety and health policies. The role of public health and occupational health were mentioned as important by interviewees from France, Italy, Luxembourg, and Sweden.

The overall impact of OHS on the health of the population was considered marginal in Belgium, Denmark, Greece, Ireland, Portugal, and Spain (Table 22). The impact on the quality of life, absenteeism, or early retirement was not mentioned as a direct health or social outcome. Nor were intermediate outcomes related to health and social well-being mentioned, such as increasing productivity, staff turnover, and reduction of harmful emissions. Such intermediate OHS impact as improved safety and health and job satisfaction were not mentioned.

Several factors limited the possibilities of improving the health of the general population in a measurable way through OHS (Table 23). These factors were institutional, socio-economic, technical, professional,
market related, and policy related. Institutional limits, such as limited cooperation among stakeholders, were mentioned by interviewees from Ireland and the United Kingdom. Most interviewees held the opinion that OHS is generally advisory in nature (Austria, Finland, and Greece), and being in a primarily advisory role rather than in that the role of an actor was also considered a limiting factor. The limits on professional competence were believed to have an effect in Greece, because most specialised professionals in OHS are trained abroad and there is a general lack of OHS professionals in the country. France also has a lack of occupational health physicians. Factors related to the market were mentioned in Sweden and the Netherlands (competition among OHS), Spain (social insurance as a provider of OHS was considered problematic), and Portugal (collective bargaining against the health of workers). The focus of OHS and competition among curative, preventive, and health promotion activities were believed to affect the possibilities of influencing and limiting the impact of OHS on the health of workers.
Table 22. Impact of OHS on the health of the population, according to interviews (responses of different stakeholders have been combined)

<table>
<thead>
<tr>
<th>Country</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Impact was very difficult to assess because of the lack of statistical figures. Awareness of health and safety at work had increased and the rate of accidents had decreased, but still a holistic view of OHS was missing.</td>
</tr>
<tr>
<td>Belgium</td>
<td>OHS had a marginal impact on public health in general, but it had a remarkable effect on occupational diseases. OHS should include more primary prevention in all areas of occupational health.</td>
</tr>
<tr>
<td>Denmark</td>
<td>OHS might have improved the health situation, but long-term evaluations should be done to illustrate the impact.</td>
</tr>
<tr>
<td>Finland</td>
<td>OHS was considered a basic health service for the working population. OHS needed to be more involved in work environment questions and also in the development of ability and skills in workplaces.</td>
</tr>
<tr>
<td>France</td>
<td>More time was needed to demonstrate the impact of OHS. Public health partially takes care of OHS tasks, and OHS had an impact on public health.</td>
</tr>
<tr>
<td>Germany</td>
<td>Hardly any scientific evaluation of the impact of OHS on the health of the population had been carried out. The tasks and performance of OHS met the expectations of employers and employees. Employees realised the benefits of OHS earlier than employers did. Employer acceptance was considered important to have higher impact and investments in OHS.</td>
</tr>
<tr>
<td>Greece</td>
<td>The small numbers of internal OHS and individual occupational health physicians had made an impact on the working population. In general, OHS was a new area. Health and safety at work still required much more to be done.</td>
</tr>
<tr>
<td>Ireland</td>
<td>If OHS or individual professionals were available at the local level, the impact was a positive one.</td>
</tr>
<tr>
<td>Italy</td>
<td>The ‘traditional’ occupational illnesses practically disappeared during the last 30 years. More time was needed to demonstrate the impact of OHS. Public health took partial care of OHS tasks, and OHS had an impact on public health.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>OHS had been functioning since 1994. Occupational diseases were more easily discovered and the public health situation had improved. Periodic health examinations for employees in certain risk groups and obligatory employment examinations had begun, which in the longer term would have a positive impact on the health of the population.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>There was no measurable decrease, due to OHS, in the amount of sick leave or the amount of incapacity to work.</td>
</tr>
<tr>
<td>Portugal</td>
<td>Workers were more aware of OHS and were asking for their right to OHS. Otherwise, the impact of OHS had been low.</td>
</tr>
<tr>
<td>Spain</td>
<td>The law on occupational health and safety was good, but there was a lack of implementation.</td>
</tr>
<tr>
<td>Sweden</td>
<td>Fatal accidents decreased and ergonomics at workplaces improved. OHS influenced management, confidentiality, and reliability, and OHS advice gained respect. OHS acted as a bridge to primary health care and rehabilitation, and OHS provided early detection and prevention of work-related health problems.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Certain occupational diseases decreased due to OHS activities in workplaces.</td>
</tr>
</tbody>
</table>
Table 23. Interviewees’ responses about the limits of the impact of OHS on workers’ health
(responses of different stakeholders have been combined)

<table>
<thead>
<tr>
<th>Country</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>OHS had exclusively advisory functions, which limited its impact.</td>
</tr>
<tr>
<td>Belgium</td>
<td>OHS should limit services to work conditions and leave health issues for public health services.</td>
</tr>
<tr>
<td>Denmark</td>
<td>The role of OHS was preventive, but the final decision to change or improve work conditions at the workplace belonged to the management of the company.</td>
</tr>
<tr>
<td>Finland</td>
<td>OHS acted as advisers and consultants to identify, inform, and follow problems.</td>
</tr>
<tr>
<td>France</td>
<td>OHS had no limit for health improvement.</td>
</tr>
<tr>
<td>Germany</td>
<td>Primary and secondary prevention should be increased, and occupational physicians should improve their skills to work with employees. Prevention should be focused more on those workers and workplaces in need of a holistic approach.</td>
</tr>
<tr>
<td>Greece</td>
<td>OHS was only partly responsible for improving the life and health of workers. OHS had an advisory role towards employers.</td>
</tr>
<tr>
<td>Ireland</td>
<td>OHS had much more potential than recognised, and there were high expectations for improving health in the society.</td>
</tr>
<tr>
<td>Italy</td>
<td>There was a cultural limitation in understanding the importance of OHS and prevention activities in workplaces. There was also a lack of standards and references for OHS professionals. OHS was a small area in the public health area.</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>There was no limit to the impact of OHS. Health promotion was supported by the Ministry of Health and was integrated to some extent into public health.</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Impact was limited to health in relation to work.</td>
</tr>
<tr>
<td>Portugal</td>
<td>Collective bargaining used against the health of workers in some cases hindered the positive impact on health.</td>
</tr>
<tr>
<td>Spain</td>
<td>Workers’ acceptance of OHS (confidentiality, efficiency, and social climate) limited its impact. OHS depended on contracts and service requests from employers to make an impact.</td>
</tr>
<tr>
<td>Sweden</td>
<td>OHS was market oriented and provided services based on needs. OHS was too medically oriented instead of being socially, behaviourally, and environmentally oriented.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>The role of OHS was health at work and work in health, which might limit its impact and actions. A new government agenda regarding public health agenda included schools and workplaces. A partnership between primary care and OHS was promoted to increase the impact on health.</td>
</tr>
</tbody>
</table>
6. OHS IN EU MEMBER STATES IN 2000

6.6.6.1 Orientation of OHS towards employers’ and employees’ needs

The satisfaction of employers and employees (customers and clients) with OHS is based on the fulfilment of the contract between OHS and employer and is also based on the views presented by employees to employers on the need for OHS through tripartite committees in the companies. Certainly the activities of OHS towards employees and employers have an impact on satisfaction. Employers’ orientation toward OHS, including a multidisciplinary approach to health and safety issues at work, skills to cooperate, participation in workplace planning, and ethical questions (independence, data safety) influence the satisfaction with OHS. Differences in employer satisfaction also depend on the need for, expectations of, and requirements for OHS by law.

According to the interviews OHS in EU member states, such as Sweden, the Netherlands, the United Kingdom, and Ireland, were market oriented. OHS might have catered well to employers’ needs in a market environment with strong competition as well as in another more regulated environment for OHS. However, there were always two sides of the services: those satisfying the employees’ needs and those the employer was willing to cover and include in the OHS contract. OHS might or might not be biased towards serving employers’ needs rather than employees’ needs. In countries where there is more OHS regulation, such as the determination of OHS activities, flexibility may be needed to fulfil the requirements of changes in work life and workers’ needs. Usually legislation covers risk groups in certain industrial sectors, and these groups might be better covered by OHS than non-risk groups. Employees are very much dependent on contracts between employers and OHS units, and therefore they depend on the activity of workers’ representatives to influence employers to furnish OHS that cover their needs.

In Denmark and France, employers and employees were members of the boards of OHS units, and workers’ needs could be taken into consideration quite well. According to interviews in Germany, OHS should focus more on prevention to fulfil workers’ needs. In Greece, OHS should focus more on employees than on the needs of employers. In Italy, information and initiatives from OHS towards workers needed more attention at the time of the survey. Although OHS was difficult
to arrange in some areas due to political tensions, feedback on OHS was given in regional and national meetings between employees and employers in Italy. The Netherlands organised a survey every third year about the satisfaction towards OHS. The questionnaire was answered by OHS unit managers and employees’ representatives. The study gave up-to-date information from both sides and increased the competition between OHS units and the quality of services provided.

Needs were often fulfilled in large companies (Portugal), whereas SMEs got more than they needed or services that did not take enough employees into consideration (Portugal, Greece, Germany), according to the interviewees. Employers’ needs should have been taken more in consideration in Finland according to interviewees.

6.6.6.2 Focus of OHS on prevention in the workplace

OHS aims to influence employers so that employees’ health and work ability are protected and improved. OHS has the general aim of promoting health, safe work environments, and individual resources. According to the interviews the main areas to improve are work conditions and employee performance. In general, OHS was focused on prevention, but mainly on safety, personal protection, and work environment issues at workplaces. Prevention largely meant the prevention of disease and injuries as well as the promotion of health. According to the interviews there was a variety of concepts in regard to preventive actions depending on country, time of training of professionals, and tradition and requirements of OHS by legislation and practices. Also, new areas, such as work organisation, absenteeism, and profit from prevention were used as arguments for or against preventive activities. Based on the interviews employers expected immediate benefits from prevention, whereas professionals saw it as a long-term activity to improve the quality of life and work.

Trade union interviewees would like to increase the primary prevention activities of OHS (Denmark and Germany). However, preventive activities are a developing concept at workplaces (Italy, Greece, and Luxembourg) or are based on regulations (Finland). Employers expect immediate results, whereas preventive activities require time and might show low profitability for the company (Netherlands). A more holistic
approach is needed in OHS (Portugal). Representatives of employers’ organisations preferred the main area of OHS to be prevention (Belgium and France), maintenance of work ability (Finland), prevention of absenteeism, long sick leaves (Netherlands), and prevention of certain professional diseases and accidents and exposures to certain chemicals (France and Spain).

Interviewees from insurance agencies emphasised in prevention the importance of maintaining work ability activities (Finland), increasing the focus on SMEs (Germany) and health surveillance (Spain), and more application of law (Greece). Interviewees from ministries and regional governments, insurance agencies and research institutes, and professional organisations emphasised OHS as an advisory role in prevention. However, OHS should have a more holistic and supportive role in occupational health in the enterprises (Belgium), and prevention should be strengthened in new risk areas (Finland). In France OHS had to spend certain amount of time per employee at work, but the emphasis was on medicine. Safety and protection issues were well followed, but prevention activities needed systematisation (Germany). Despite a safety orientation (Ireland), strengthening of collaboration between safety and OHS in prevention is needed (Greece). However, the main task of OHS is risk reduction and elimination of safety problems and hygiene problems (Italy). Starting with good safety at work, OHS may proceed to prevention and promotion (Luxembourg). Prevention depends on the contracts between OHS and the company (Netherlands).

In the discussion of prevention activities, research institutes underlined the focus on new companies (Denmark), cooperation between OHS and enterprise (Italy), prevention of issues related to workplaces (Portugal), and cost-benefit analyses to convince companies of the benefits of prevention (Spain). Swedish respondents emphasised the importance of OHS in improving capability and employability of the workforce. In addition, preventive services were based on requests and needs of the customer (employer). Professional organisations would have liked to place more attention on prevention in the work environment instead of on the individual worker (Sweden and Denmark). Professional organisations also wanted to see changes in professional skills towards more prevention, and they emphasised the role of national health services in prevention (United Kingdom).
6. OHS IN EU MEMBER STATES IN 2000

6.7 Summary of the results

In principle all workers should have equal access to OHS organised by employers, if legislation of the EU member states were fully implemented. However, the reality varies in terms of OHS coverage, which relates to branch of the industry, region of the country, employment status of the worker, and gender of the worker. In addition, the quality and independence of OHS depend on the professional competence and contracts between OHS and employers.

In principle all EU member states have transposed Framework Directive 89/391/EEC into their national legislation. Kohte (1999) classified three forms of transposition in the EU member states, which depended on the pre-framework directive regulatory situation for OHS. The first was transposition by way of secondary law or regulations on health and safety at work (Denmark, Belgium, and Portugal). The second form of transposition was by way of punctual legal revisions, partly by new or reformed regulations (Denmark, France, the United Kingdom, and the Netherlands). The third way was through fundamental legal changes, especially in countries that were stuck with a fragmented and incomplete regulatory system of health and safety at work (Germany, Italy, and Spain) (Kohte 1999).

According to the framework directive, the European Commission was obliged to follow the progress of transposition. The Directorate General for Employment and Social Affairs (www.europa.eu.int) announced in 2000 that the framework directive was in line with on average 98.6 per cent of the national laws in EU member states. The Commission also published a communication on the evaluation of the framework directive in 2004 (COM (2004) 62). The EU member states were categorised according to the impact of the framework directive on national legislation. The first category included countries that had inadequate or old legislation and had considerable legal consequences (Greece, Ireland, Portugal, Spain, Italy, and Luxembourg). The second group of countries completed or refined their legislation due to the framework directive (Austria, France, Germany, the United Kingdom, the Netherlands, and Belgium). In the third group of countries, the legislation was in place and no major adjustments were required (Denmark, Finland, and Sweden). The same report stated that the framework directive with its first five
daughter directives (89/654, 89/655, 89/656, 90/269, and 90/270) were driving forces to increase preventing, rationalising, and simplifying the national legislation on health and safety at work. The impact was also that the member states had to change from prescriptive and detailed legislation towards goal-oriented law.

The legislative obligation does not seem to be the most important determinant of OHS coverage. Economic factors and workplace size are perhaps the most significant determinants for OHS. OHS has stronger coverage in northern European countries than in the economically weaker southern ones. The Nordic countries and the Netherlands seem to have operationalised the quality of preventive services, integration of services, accountability, and adaptability to the changing work life. The state subsidies to OHS had an impact on coverage in Sweden and Finland in the early 1990s.

There also seems to be link between histories and culture, for example, social democracy and consensual industrial relation. These have supported occupational health and safety and preventive services, and they have institutionalised the participation of social partners in the management and operation of OHS. In continental northern Europe, the institutional infrastructure also provided support in the form of networks and milieux for preventive services. Instituting social regulations was not a necessarily a prerequisite for OHS nor a means for reaching SMEs, but it is a significant support (Walters 1996). In addition, insurance systems for occupational accidents and ill health at work in most continental European countries fostered close ties between preventive strategies and social insurance. Continental countries had statutory requirements for employees to participate in works councils as well as for representation in issues of health and safety at work on boards of OHS.

Few countries have an exclusive OHS policy or strategy, and many countries considered legislation to be a policy or a strategy statement. This view can be seen in the answers given on the ILO survey on Integrated Approach to Standard-Related Activities in the Area of Occupational Safety and Health in 2003 (ILO 2003a).

The tasks of OHS varied. Comprehensive tasks included risk assessment, preventive, promotive, and curative care; and OHS also performed preventive and protective tasks. Also, competences were regulated differently between detailed descriptions of competence classifications,
resources, and minimum resources. In many countries, non-specialised occupational professionals were also entitled to work in OHS in order to increase OHS coverage and services. Countries other than the United Kingdom, Ireland, and Sweden had detailed provisions for OHS, but figures of coverage failed to indicate the impact of legislation on OHS coverage. The more important determinant seems to be the company size and, for example, the number of SMEs in a country. In some countries, the use of joint OHS had increased, which might reflect the changes in competition on health care markets and greater attention to economic effectiveness and efficiency by the employers. Employee representatives, employer representatives, and the state jointly managed the insurance bodies. In the United Kingdom and Ireland, employers were free to select an insurance company, and insurance premiums reflected market forces. In Ireland and Britain, OHS was concentrated into the large companies with human resource development (Walters 1996).

In general, OHS should extend its expertise through multidisciplinary services. The changes facing OHS also mean functional changes: OHS extends its services to more complicated work environments with additional experts, services of OHS are more rationed to higher efficiency and effectiveness, and development and improvement activities are changed to additional training, funding, and joint OHS services. OHS functions move from decreasing activities in relation to occupational diseases and injuries (changes in rates) towards less dangerous prevention activities and health promotion, and also more towards mental health and work organisational issues. The use of multidisciplinary teams depends on legislative and other organisational factors, such as the obligation of using teams as such, full-time or part-time positions, leadership of OHS by nurses or other professionals, and organisational models of OHS (MacDonald et al 2000). The use of different professionals in teams was assessed by the Danish study ‘Multidisciplinary services in occupational health and safety in the European Union.’ The most frequent teams consisted of nurses, physicians, safety engineers, occupational hygienists, ergonomics experts, physiotherapists, occupational therapists, laboratory technicians, occupational psychologists, clerical and computer staff, and managers (Danish Working Environment Service 1997).
Many countries accept untrained doctors as occupational physicians to enable enterprises to fulfil their statutory obligations to provide OHS for workers. This was mainly due to a lack of legislation to impose professional competence on physicians and other professionals. Despite the variation in training in EU member states, these conditions conform to the EU Medical Specialist Order. The directive on mutual recognition of the diploma, certificates, and other evidence recognised the right for accredited specialists to practice across the EU. The Charter on Training of Medical Specialists was adopted in 1993 by the European Union of Medical Specialists (UEMS). The charter described the requirements for adequate training, which prepared specialists to practice their specialty at an appropriate level in any EU member state. The definition of the content of the training was necessary to further the harmonisation of training into medical specialities.

In principle, OHS is funded by employers. The financing and organisational models of OHS varied among and within countries, according to historical developments of health services, tripartite and bargaining systems, and industrial activities. Some services are also provided by public primary health care units (Finland, Greece, and Italy), which might or might not be authorised to charge employers for the services they provide. According to the interviews, the real costs were often not charged, and services could be seen as subsidised by the state. In general, interviewees claimed that subsidies were needed to increase and maintain coverage as well as to keep OHS in the remote and periphery areas of the EU member states.

OHS is provided by a contract between employer and OHS unit, or between insurance company, OHS unit, and employer. Contracts form the base for service provisions and form the frame for employees’ access to OHS. Contracting became popular during the reform of health services and due to the trend of enterprises to outsource services outside their core business area. Contracting is expected to increase competition and improve efficiency, quantity, quality, and costs of care. The types of contract vary, and the contracting relationships can be divided into the contracting parties, legal status of contracts, content of contract, and comprehensiveness of contracts. Contracting typically includes

negotiation and bargaining over prices, remuneration levels, quality, and budget (Savas et al. 1998).

In the Beveridge models of health care systems (Denmark, Finland, Sweden, and the United Kingdom), the demand side is represented by government at all levels, including health authorities. The public health authorities, for example, primary health care units, provide OHS to employers also. In the Bismarck model (Austria, Belgium, France, Germany, Luxembourg, and the Netherlands), the statutory insurers act as the purchasers of care. This might be supplemented by a contract between insurers and the government for subsidies, and between insurers and central insurance agencies. In this model the purchaser-provider relationship might be regulated by collective rather than individual contracts (e.g., contracts between physicians’ associations and insurance associations or employers’/ees’ organisations) (Savas et al. 1998).

The constant increase in the costs of OHS includes financial, technical and human resource costs. New medical technology and treatments for diseases require specialists and financial resources. Increasing costs have raised questions about outcomes of OHS: what resources are allocated, and what are the results? In addition, the demands for cost-efficiency and cost-effectiveness are debated to make judgements about the use of scarce resources. Societies are increasingly oriented towards the individual as well as the market. Scarce resources should be ethically allocated to those most in need and with the best possible outcomes; but at the same time, customers/patients demand or request OHS. Also, patients’ expectations and satisfaction with the services have an influence on decisions that are made regarding resource allocation. This leads to questions of equity in resource allocation based on professional, political, or employer/employee justifications.

Workers’ compensation systems exist in all EU member states, although they differ according to who is covered, for what impairments, over which costs, and to what extent (Mossink, Licher 1998). In practice, the level of reimbursement by insurance companies for occupational diseases, injuries, and accidents is decreasing, as work is transferred to countries where compensation systems are less developed and as precarious non-standard employment increases (Dorman 2000). ILO Convention 121 (created in 1964; entered into force in 1967) on workers’ compensation listed five principles for such workers’ compensa-
tion systems: the system is funded by employer contributions; there are ongoing payments for costs of long duration; there is a minimum standard for coverage (minimum half of the workforce); the native and migrant labour force receive equal treatment; and occupational injuries, accidents, diseases, and deaths are covered by compulsory statutory insurance systems in EU member states. These workers’ compensations schemes are important for the workers because they cover most of the economic costs of occupational hazards for the workers and their families. The Mutual Information System on Social Protection in the European Union (MISSOC) provides information and descriptions of the systems (European Commission 2000b).

Cost-effectiveness and cost-efficiency were not considered to be high on the agenda of the countries surveyed. Obtaining comparable data would probably be difficult. The results could have an impact, however, in that they could reawaken interest in the importance of OHS and its preventive role in society. In advanced monitoring systems, the purpose would be to produce information for OHS units, workers’ councils, employers, employees, and other relevant organisations in order to plan and improve OHS. Statistics would be not be enough to monitor OHS, but measurements and follow-up of individuals, work conditions, and work environments would produce information to focus and improve the activities of OHS. The monitoring should be organised cooperatively by employees, employers, and OHS units. A basic minimum of relevant and measurable outcome indicators for OHS, at both the national level and the OHS unit level, supports the whole range of actions. Outcome indicators at the level of the OHS unit help to measure which interventions are effective and which interventions can be important tools for the monitoring the implementation of contracts between employers and OHS.

Despite several efforts, the data on occupational health (specifically in relation to OHS) are unreliable, though they indicate the direction that occupational health is going. Information systems at all levels should clearly support informed management and continuous quality development. The effectiveness of major occupational health strategies should be assessed in terms of health outcomes, and decisions regarding alternative strategies for dealing with individual health problems should increasingly be made by comparing health outcomes and their
cost-effectiveness. Countries should have a nationwide mechanism for continuous monitoring and development of the quality of care for at least the major health conditions, including the measurement of health impact, cost-effectiveness, and patient satisfaction. Occupational health outcomes for major occupational health conditions should show a significant improvement, and surveys should show an increase in patient's satisfaction with the quality of OHS received and show a heightened respect for workers' rights. Obviously, OHS can influence health only to a certain point. Many social factors affect how health status develops in an organisation.

The success of OHS in an organisation depends on customer expectations and needs. On the other hand, quality is a product of processes in which the causal relationships are complex. This requires careful collection and analysis of data on work processes and continuous improvements of the processes. Occupational health professionals should be sensitive to the needs of customers and should identify, assess, and satisfy these needs at workplaces. There are often discrepancies between stakeholders' needs and actual customer needs. The needs of the customer and the agreed-upon tasks (ethics and information security) form the base for customer satisfaction and also form the base for benefits of activities and investments regarding the health of workers.
Chapter 7 provides a larger perspective on OHS based on literature and also provides new openings for the OHS operating context. OHS policies, strategies, and implementation vary among the EU member states (based on, e.g., welfare state regimes, health care systems, and unionisation rates). The development of EU policies can have sporadic, direct, or indirect effects on OHS and its valuation, organisation, and provision of services.

This comparative case study might also show how, why, and to what extent different governments pursue particular courses of action or inaction in relation to OHS. The question of 'how' invited one to look at the EU member states and their decision-making structures and processes. The question of 'why' referred to the reasons that governments and various stakeholders pursue certain actions for or against OHS. The effects on peoples’ lives of these governmental actions (e.g., access to occupational health services) are also important. Government’s inaction or non-decision becomes a policy when it is pursued over time in a fairly consistent way against pressures to the contrary. The growth of controversy is a good measure of non-decisions becoming policy (Heidenheimer et al. 1990).

Several factors, policies, and actors influence OHS. The social, health, labour market, and industrial relations policies have a major impact on OHS. The major determinants for OHS policies are economic, trade, and industrial policies. The discussion and policy choices made since the 1980s have included such issues as job protection and social security versus worker productivity; a flexible labour supply, economic growth, protection of the welfare state versus liberalisation and deregulation; and economic equality and democracy versus a strong economy. All
these issues have produced several reforms of welfare state services, benefits, organisational structures, and direction--including OHS. This chapter discusses the impact of some socio-economic factors on OHS, regulations and policies about OHS, aims of OHS, actors within OHS, and functions of OHS. As a result of the discussion on the impact of a number of factors--various policies on OHS, the changes in regulatory approaches to the Europeanisation of OHS, changes in actors who make initiatives in EU social policy area, and moving the OHS model towards more commercial OHS provisions of services--important progressive processes are developing (sometimes very quickly) within EU member states.

7.1 Socio-economic consequences on OHS

During the last few decades, the development of the welfare state has changed, and working conditions have also changed. In the 1990s, many European countries faced a deep recession, which created short-term and long-term unemployment. At the same time, globalisation of economics and free movement of capital shifted work to countries where the production costs (e.g., social protection costs) were the lowest in Europe or lower than in Europe. Many European countries faced structural changes in industrial production, towards more service-oriented industries. The labour markets started to favour flexible, temporary, and short-term contracts for employees due to continuously changing economical, political, and technological situations. In the labour market, the end of ‘full’ employment and the growth of informal, intermittent, precarious, and part-time paid employment upset the social insurance basis of welfare benefit systems.

The automatisation of production and the use of computers and robots instead of people to perform multiple tasks created new challenges and new forms of work organisation in most European countries. The work environment, new types of companies, and larger numbers of SMEs created increasingly demanding circumstances for workers and more risks at work. In the public sector, the trend of new public management led to the contracting-out of public services, the creation of semi-public agencies, a decrease in public sector employment, and
reorganisation. These circumstances required new perspectives and larger concepts about preventing ill health and promoting good health in workers to minimise the health effects of working overtime, increased stress, and precarious work contracts.

Women’s increased employment also challenged the traditionally patriarchal social, labour market, and occupational health and safety policies and their services. The growing number of women at work changed and increased preventive measures, rules, and arrangements of compensation schemes. Increased women’s employment also brought an awareness of the risks for which women were particularly liable. In addition, an ageing population increased the costs of social protection due to retirement and also created a need for care arrangements. There was a need for a global approach to the quality of work life as well as a need for attention to specific situations for the various age groups at work. In many workplaces, the profile of risk factors has changed due to changes at work. In the past, exposure to only one risk was common, but the set of risk factors has increased over time.

Political, economic, and social systems stipulate choices of OHS policy instruments. Choice-making capacities vary among European countries. Several European systems have a relatively greater ability to adapt social policies to economic constraints with less political conflict (e.g., the Netherlands, Luxembourg, Sweden, Germany, Austria, and Belgium). Some countries, for example the United Kingdom, are much less able to inhibit conflicts to reach political consensus on occupational safety and health issues. The reforms in many countries have required various innovations in occupational health policy, especially in relation to the efficiency and effectiveness of OHS in both the public and private sectors, but also in relation to negotiations with social partners.

The political, economic, and industrial history of a country influences the services provided by OHS systems. In southern European countries, for example, democracy and the free trade union movement were attained in the 1970s. Democratic development and the emergence of the welfare state were delayed, compared to some countries. Major political changes, such as economic recession, EU membership, and the end of dictatorships (Portugal 1974, Spain 1982, and Greece 1974), also influenced the development of the welfare state and consequently OHS as well. In the early 1990s, economic recession and the retrench-
ment of the welfare state in Sweden abolished governmental support for OHS, which caused a decrease in OHS coverage (Frick 2002). The political process of EU integration and the inclusion of new members also introduced new occupational health and safety legislation, such as Framework Directive 89/391/EEC. This legislation had to be transposed into national legislation in Austria, Finland, and Sweden before they were granted EU membership. On the other hand, Denmark has long been an EU member state and has relatively high coverage and a holistic approach to health and safety at work. In addition, Denmark supplied the majority of the content of the framework directive on health and safety at work.

The composition of industrial sectors and employment form another important factor for the development of OHS. In countries with a high number of SMEs, such as Italy, Spain, Greece, and Portugal (Eurostat 2003), OHS coverage is expected to be low. The organisation of OHS through public services to SMEs in Italy and Finland and through insurance companies in Austria might have given good input to provide SMEs with OHS coverage. It seems that OHS provision is equitable among large companies, but there is a disparity between coverage of employees in SMEs and employees of large companies. However, SMEs are usually the most dangerous workplaces (Eurostat 2001a, b).

There are several explanations for the development of OHS and quality management in some EU member states, including economic and industrial structure and large corporations with strong national influence. Finland (forestry, mines, and cellulose) and Sweden (metal, mines, and forestry) have large corporations in certain industrial sectors; while Italy, Spain, and Portugal have a large number of SMEs. Globalisation and multinational companies have an influence on local and regional OHS as models and partners for OHS, as seen in the United Kingdom and Ireland. The development of OHS can also be explained by industrial differences, evolution of industries, and economical development of regions and nations.

The regional distribution of population or the dispersed population can also give some explanation of OHS coverage and access to it. Due to health sector reforms, the decentralisation of health and social services also affected the development of OHS in different parts of Europe. In Portugal, health services are decentralised to regions, whereas the
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services of the Ministry of Labour (to which OHS and the framework directive’s follow-up belong) are centralised. In Italy, decentralising the health sector to regions has caused continuous constraints in financing local health services, including OHS. In Greece, health services were transformed into national health services, but the compensation practice is still partly in the national social security institute and partly in several private insurance companies.

Regional differences in socio-economic development have an influence on local development. In Italy, there are strong development disparities among southern, central, and northern parts of the country, which is reflected in the shortage of funds in local health units. In Spain, five autonomous communities decide on health services provided in their territories. In Germany, Länder (counties) have legislative power in the regions in relation to health services. Each of the three language-based communities in Belgium has its own administrative structures to follow and develop OHS.

The forms and models of OHS provisions seem to be more dependent on welfare systems than in the difference in producing efficient and effective OHS. In the insurance-based welfare systems of Austria and the Netherlands the coverage is high, as it is in the social democratic welfare systems of Finland and Sweden. In Spain, OHS is also provided by MUTUAS insurance companies, which are expected to extend OHS coverage as a long-term aim. Additionally, there are cultural differences in relation to risks and their prevention. Prevention seems to be more acceptable in risk-adverse countries than in risk-prone countries. Also, work and safety cultures and attitudes vary in relation to prevention and illness. Risk-averse countries include social democratic welfare states (Finland, Sweden, Denmark) and insurance-based welfare states (Germany, Austria, the Netherlands). Risk-prone countries tend to have a mix of public and private welfare state services (Italy and Greece), or their welfare state services are funded through taxation, through social security, or privately (Spain and Portugal).
7.2 Policies for OHS

Framework Directive 89/391/EEC followed ILO and WHO conventions and recommendations on OHS, but the directive made OHS more regulated among EU member states. ILO and WHO conventions are to be ratified by member states, whereas the framework directive obliged EU member states to transpose the directive into national law. According to Baumgartner and Jones (1994), international organisations reorient debate of future options. In the case of OHS, the ILO and WHO made earlier conventions and recommendations, which the EU adopted into this framework directive. However, the ILO and WHO work in close cooperation with national governments and publish joint recommendations and conventions.

Table 24 details the important agreements for OHS and some of the reporting schemes. Many international regulations are reported regularly to the international organisations. The roles of various agreements, conventions, and directives vary in relation to OHS. In principle, agreements and conventions are softer than directives. Countries are obliged to comply with directives up to the European Courts of Justice decisions. Many factors can affect states’ choices to comply, but institutions’ settings might command higher compliance levels (Haas 1998). In the case of the framework directive, the reporting should be done by the member states every five years. Reports are prepared by national governments with social partners.
Table 24. Reporting schemes of some agreements related to OHS

<table>
<thead>
<tr>
<th>Agreement</th>
<th>What is reported</th>
<th>Who does the report</th>
<th>Voluntary or mandatory reporting</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ILO Convention 155, 1981</td>
<td>Reporting on the implementation of Convention 155 and desirability of revision</td>
<td>Governing Body to General Conference; each member who has ratified the Convention</td>
<td>Reporting when considered necessary</td>
<td>When considered necessary</td>
</tr>
<tr>
<td>ILO Convention 161, 1985</td>
<td>Reporting on the implementation of Convention 161 and desirability of revision</td>
<td>Governing Body to General Conference; each member who has ratified the Convention</td>
<td>Reporting when considered necessary</td>
<td>When considered necessary</td>
</tr>
<tr>
<td>Global Strategy on Occupational Health for All, WHO 1995</td>
<td>Effective follow-up to the Global Strategy based on indicators developed in the future</td>
<td>WHO governing bodies and Planning Group of the Workers’ Health Programme; WHO Collaborating Centres in Occupational Health</td>
<td>Not mentioned</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Framework Directive 89/391/EEC</td>
<td>Transposition, implementation of the framework directive</td>
<td>Reporting by the member states with opinions of social partners, which are compiled by the European Commission; Report forwarded to the European Parliament, Council, Economic and Social Committee, and Health and Safety Committee</td>
<td>Mandatory</td>
<td>Every five years; transposition by the end of 1992</td>
</tr>
</tbody>
</table>
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The requirements for reporting to WHO and the ILO are not frequent, which leads to the conclusion that the EU member states consider the conventions advisory, rather than binding. This is confirmed by the small number of ILO conventions that have been ratified.\textsuperscript{117} In the case of WHO, the reporting reflects a monitoring process by WHO of its member states.

Political will for implementation is affected by information collection and information on the performance of other countries regarding OHS. Monitoring is usually the government’s responsibility, but other stakeholders are also active in using gathered information for alternative types of analysis. For example, WHO follows the application of the 'health for all' strategy through a statistical database available on the Internet, and the ILO collects information on injuries and accidents.

7.2.1 OHS in relation to different regimes

There is a wide variety of welfare systems, health care systems, and industrial relations systems among the EU member states, and all of these regimes influence OHS differently. The most uniform groupings are found in the Nordic countries and the Anglo-Saxon countries. Nordic welfare states have a Beveridge health system and a bilateral corporatist industrial system. This might be the reason that only small changes were needed in order to comply with Framework Directive 89/391/EEC. Anglo-Saxon welfare states (United Kingdom and Ireland) differ from each other in health and industrial relations systems. Bismarckian welfare

\textsuperscript{117} According to ILO procedures, the convention will be binding if the country ratifies the convention and registers it with the Director General of the ILO. Occupational Safety and Health Convention 155 (1981) of the ILO was related to formulation, implementation, and revision of national policy on occupational safety, occupational health, and the working environment. The convention has been ratified by Denmark (1995), Finland (1985), Ireland (1995), the Netherlands (1991), Norway (1982), Portugal (1985), Spain (1985), and Sweden (1982). Although ILO Convention 161 concerning occupational health services had been adopted in 1985 (date of coming into force was 17.02.1988), only three of the EU member countries have ratified the convention as of this writing: Finland (1987), Germany (1994) and Sweden (1986). Only 19 countries in the world have ratified Convention 161 (www.ilo.org). ILO Convention 161 has many points in common with the EU approach and its Framework Directive 89/391/EEC. The EU approach can be regarded as complementary. The Commission has insisted on the primacy of EU law over all other sources, such as ILO Conventions (Walters 2002a).
states with insurance-based health systems include the founding members of the EU and Austria. The range of industrial relations includes corporatist (Austria, the Netherlands, and Belgium), bilateral (Germany and the Netherlands), and state-centred (France). The approach towards OHS in all Bismarckian countries varies. Southern European welfare states have mixed health care systems with state-centred (Portugal and Greece) or bilateral (Spain and Italy) industrial relations. In this respect, the approaches to OHS are similar in the two southern country groupings.

The southern European countries have mixed health services and decentralisation of administration towards regions and local communities. In Italy, Spain, Greece, and Portugal the devolution of power has not been completed since reforms started. Institutionalisation of powers and institutions are devolving in southern European countries (Guillén 2002, Guillén et al. 2002, 2003, Matsagania 2002, 2003). The number of salaried employees in traditional sectors—such as agriculture, fishing, and construction—is lower in southern European states than the overall average for the 15 EU member states.

The approach in Anglo-Saxon welfare states can be characterised by universal health services, but with a strong self-regulatory approach to health and safety at work. OHS has a market-oriented approach with contracts for occupational health and safety professionals. Trade union density is low, and the unions tend to have little interest in and influence on OHS. However, the market orientation of OHS in Sweden has been strong as well, but trade union density is high and influential in occupational health and safety matters.

Industrial relations include the influence of trade unions, employers, and the government on OHS. These groups have several different interests and policy preferences towards decisions, and they each have their own goals in OHS, but their greatest influence is in the realm of bargaining. In Scandinavian countries OHS coverage is relatively universal, and OHS is relatively well institutionalised with strong national institutions, such as strong ministerial departments and national occupational health and safety institutions. In addition, trade union density is high. In Bismarckian countries, OHS as a benefit is related to the position in the labour market, and coverage is connected to large companies and high capital industries. Trade union density varies, but trade unions are especially powerful in Germany and France.
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The visibility of OHS expenditures, as part of public health or health or social services, is relatively obscure. OHS expenditures are usually included as part of a total health care expenditure and as an employee benefit. The occupational health expenditures should be more visible in the Health for All WHO database, or any other database with a focus on OHS per country. The invisibility of fiscal or occupational welfare (health expenditures, service provisions, and occupational benefits) has an influence on political steering. The ways and means for politicians to decide about areas of public expenditures are limited by the reduction of public spending on occupational welfare and by a lack of data on expenditures. In addition, the growth of private OHS elements in the welfare states is strengthened at the expense of public and universal elements of occupational health care, for example OHS. This type of segmentation and division of people can create inequity.

In addition to welfare, health care, and industrial relations systems, financing has an influence on OHS in each of the EU member states. However, most of the welfare or occupational diseases, injuries, and accident benefits are covered by taxation or insurance, but OHS is paid by employers. Varying amounts of state support is provided in Finland, France, the Netherlands, Austria, and Italy. Tax reductions for employers in relation to OHS provision have not been the subject of this study. Both professionals and SME owners expected state support for SMEs to extend OHS coverage for SME employees. However, state subsidies might provide competition advantages for some OHS units in the health care market.

The challenge is how to maintain a qualitatively good public supply of services, if large and well-off groups no longer have social security interests linked to other public welfare schemes. There has been little public debate in relation to OHS because the majority of the population has benefited from the silence of invisible welfare schemes with socially biased distribution of tax-subsidised private welfare. The growing private welfare schemes stimulated by tax reductions and occupation-related benefits do not imply a reduced importance of social and public welfare; this can be seen in the fact that expenditures in social welfare continue to increase (Ervik, Kuhnle 1996).
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7.2.2 Regulatory policy and compliance

Framework Directive 89/391/EEC is a binding instrument of the EU to reach specific policy objectives within a given timetable. It allows some flexibility in the specific means employed to reach the common goals. Several directives have been implemented, but there have been time constraints, substantial variations, gaps, and obstacles in implementation among EU member states.

The compliance refers to whether countries adhere to the provision of the accord and to the implementing measures that they have instituted (Haas 1998). Compliance is a matter of state choice in EU directives. Because there are variations in the extent of compliance with EU directives among member states, there are doubts about whether commitments are implemented after legislation has been passed. Implementation involves the conversion from international commitments on paper to national law, and compliance extends the application further. Compliance can be measured by state resources committed to the goal and by variations in behaviour in relation to treaty obligations (Haas 1998).

However, compliance depends on states’ rational cost calculation of changing their policy to meet EU commitments weighted against the benefits this change might bring (Downs et al. 1996). Compliance failures can be caused by treaty ambiguity, capacity limitations of the states, and uncontrollable social and economic changes (Chayes, Chayes 1993). Therefore the unclear definition of OHS and its tasks in the framework directive partly hinders compliance. The European Commission published its report on implementing the framework directive in 2004. The report stated that health and safety legislation in EU member states has been responded to mainly in a positive way. The social partners and member states considered ‘positive’ to be the philosophy of prevention, the large field of application, the obligation of employers to perform risk assessment, and the simplification of health and safety legislation by the framework directive (COM (2004) 62).

Two of the key reasons for the range in compliance are the variety of regulatory agencies and the differences in the activities that a state seeks to influence. One application of this notion is the non-compliance of the public sector regarding occupational health and safety, because
the Labour Inspectorate rarely has the possibility to implement health and safety legislation in the public sector. Also, the political capacity to claim the rule and the technical capacity to fulfil obligations hinder compliance with international commitments (Haas 1997). On the other hand, states would comply if they were compelled or if a hegemonic country exercises some degree of pressure to comply through rewards or sanctions. Compliance levels vary according to the presence and use of hegemony (Moravcsik 1993). Thus, the Commission often starts a case of non-compliance with a discussion with EU member states, in order to avoid an ECJ process or monetary sanctions on EU member states. Various researchers are debating the advantages and disadvantages of monitoring compliance and imposing sanctions versus building capacity and clarifying rules (Linos 2003). With the EU, compliance is more likely to be a matter of exercising institutional channels of influence and exercising national conviction (Moravcsik 1993, Haas 1997).

Other factors that contribute to compliance with regulations include negotiations, links, and frequency of interaction among the institutions involved. This might be the case with the Agency of Health and Safety at Work in Bilbao, which has established focal points to each EU member state to verify the application of occupational health and safety activities and to follow the application of directives. Verification and monitoring appear to be the most widely used institutional factors that affect state compliance. For EU health and safety policies, the information is collected mainly by the EU member states and collated together by EUROSTAT, the Agency for Health and Safety at Work in Bilbao, and the European Foundation for Living and Working Conditions in Dublin. Compliance seems to depend on institutional design, operation method, and learning. State competence and agency independence add persuasion, policy accumulation, and third-party influence to choices and decisions that are made (Haas 1998). However, in the case of OHS, the major verification for compliance seems to be the ECJ or national inspectorates, in the event that a company does not provide OHS to its employees. These seem to be the only ways to get countries to comply better with directives and improve health and safety at work (Eichener 1997). In addition, the European Commission seeks to improve compliance through economic funds, to adjust EU policy at the national level (such as European social funds). The Commission also negotiates transitional arrangements and interpretative guidelines in policy issues (Tallberg 2002).
7.2.3 National implementation of framework directive 89/391/EEC

There is large variation in compliance among EU member states in relation to directives. The implementation of the framework directive can be looked at from the viewpoints of different institutions, actors, and processes. Some aspects facilitate implementation, whereas others might hinder implementation and give insights into political realities. Political culture and the design of political institutions in the EU member states have the most significant impact on implementation. A high level of trust and political stability combined with efficient and flexible political and administrative institutions often succeed in implementing EU policies. State structures unrelated to national OHS interests, such as multiparty governments, federalism, and bureaucratic capacity, have at least as large an impact on timely directive implementation as government preferences (Linos 2003).

In general, many countries do not comply with directives. The countries differ in most characteristics that are important for compliance, such as administrative lethargy and clientelism versus professionalism and effective bureaucracy. The low implementation score in social policy confirms the fact that interest groups are important actors in national bargaining over compliance with European rules (Lampinen, Uusikylä 1998).

New legislation in relation to the framework directive was introduced in Austria, Belgium, Denmark, Luxembourg, Spain, and Sweden. Amendments to existing legislation were made in other countries. In relation to the framework directive and compliance to OHS provisions, major changes to national legislation were made in Austria, Belgium, Italy, Luxembourg, and Spain. Small changes were introduced in Denmark, Finland, and the Netherlands; and there was a 'minimum change approach' in Ireland, France, Germany, and the United Kingdom. In Ireland, a multiparty government might have been the reason for the minimum change approach (Helander 1991, Walters 2001a). In Greece, compliance was delayed due to capacity limitation in the areas of occupational health and safety (e.g., lack of occupational professionals, and reform phase for insurance systems and health services). The minimum change approach towards compliance in Germany and France can be
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understood by the costs of legislative change and follow-up. In Spain and Italy regions have autonomy, but changes after the framework directive were significant. The United Kingdom in general has not been willing to apply directives related to the social dimension. Austria, Finland, and Sweden joined the EU in 1995, and such legislation was part of their membership negotiations. The challenges of compliance with the framework directive still remain.

Finland, Denmark, Germany, and to some extent Italy have formed their OHS based on earlier ones and are incrementally changing OHS for future needs. Countries are not likely to possess coherent OHS systems, because each OHS system and its policy tend to change incrementally over many years. One may say that the development has been path dependent in Denmark, Finland, France, and Germany. Denmark has been the leading country in the framework development, and Finland has followed its OHS development according to its own preferences. The legacies of party policy choices, proxied by early activism in the OHS field and high current labour costs, constrained government preferences and shaped compliance patterns. Past choices shaped compliance, for example, path dependency influenced compliance. Bigger changes in Germany and Italy would have had a large economic impact due to the large size of the countries. The government took the opportunity provided by the framework directive to introduce radical changes in Austria, Spain, Belgium, and Luxembourg. This has also been true in France since 2002, when multidisciplinary OHS legislation was introduced into French OHS. Early introduction of new laws in health and safety at work has therefore also been implemented quickly, and a coherent national policy could achieve particular OHS policy outcomes (Linos 2003). The market has driven development in the United Kingdom, Sweden, Ireland, the Netherlands, and lately also Italy. Stagnation has remained in Portugal and Greece and to some extent Italy. The reasons for this include industrial relations, uncompleted health care reforms, lack of coherence, shared responsibilities between the Ministry of Labour and the Ministry of Health and Social Affairs, and generally low health spending based on OECD and WHO data.

In EU member states, OHS issues in particular and social issues in general are presented along left-right political divisions. However, they are issues of authority at the international, supranational, and subnational
levels. International organisations shape policy by permitting future constraints to enter current decision making (Linos 2003). At the sub-national level, regional organisations and regional governments also have a role to play in OHS (Germany, Italy, Spain, and the United Kingdom). A major reason for the variation in implementation is that it involves several semi-independent organisations and agencies, each of which can block or change the direction of implementation in EU member states (Andersen, Eliassen 1993). In OHS, these organisations include different ministries, specialised occupational health and safety institutions, trade unions, employers’ organisations, and professional organisations. The root of the implementation problems within the EU is the absence of institutionalised interdependency between the decisions made by the Commission and their implementation in EU member states.

Trade unions and employers’ organisations have the most important veto roles when it comes to compliance. Crude density figures for trade union membership according to the European Industrial Relations Observatory (2004) reported that the trade union density was between 80 and 89 per cent in Belgium, Denmark, Finland, and Sweden; in Italy the trade union density is around 70 per cent, and in Luxembourg above 50 per cent. In Austria the density remained above 40 per cent, but in Ireland and Portugal below 40 per cent. The density of trade unions was between 20 and 30 per cent in Germany, Greece, the Netherlands, and the United Kingdom; and in Spain below 20 per cent. Density figures for trade unions in EU member states might explain the significant changes in Belgium and Italy. On the other hand, density figures of trade unions were low in Germany, Greece, and the United Kingdom, which might explain the minimum change approach. However, in Sweden the density figure for trade unions was high, but there was no OHS legislation.

If labour costs are low, one could expect that occupational health and safety laws would be implemented slowly. The application of the framework directive and OHS development in EU member states was also related to some extent to employment status. Women account for 48 per cent of the workforce in Denmark, Finland, and Sweden, and changes in national legislation were small. Greece, Spain, and Italy had the lowest proportion of women in the labour force, and these countries had the most significant changes in terms of legislation. Salaried workers are in a different position than self-employed or family workers in oc-
cupational health and safety matters. About 85 per cent of the European workforce comprised salaried workers. In Luxembourg 92 per cent and in Greece 61 per cent of the workforce consisted of salaried workers in 2003. In agriculture and fishing 64 per cent of the workforce consisted of non-salaried workers, compared to 8 per cent in the industrial sector (manufacturing, mining and electricity, water and gas supply) (Eurostat 2003). This also means that workers in the industrial sector had better OHS access, coverage, and equity.

Part-time workers have a different position in relation to OHS than full-time workers do. They might have limited access to information and training, but they might also have in-service provision of OHS. The average proportion of part-time workers was 18 per cent in 2002 in EU member states. Part-time work was five times more common among women (33 per cent) than among men (6 per cent) (Eurostat 2003). The lowest numbers of part-time workers were in Greece, Spain, Italy, and Portugal. Most part-time workers were in Denmark, Germany, the Netherlands, Sweden, and the United Kingdom. Legislation on part-time work and liability to organise OHS for part-time workers explain some of the differences in relation to coverage of OHS or compliance with the framework directive. Nevertheless, there seems to be no logical connection to national legislation and compliance with the framework directive.

The details of various countries can be summarised based on the facilitating factors for implementation of regulations and policies of Walt (1998). Table 25 shows the categories of facilitating factors for the process of implementation and their relation to OHS in EU member states. The speed of implementation depends on technical features, extent of changes, number of actors, goals of the policy, and time frame.
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Table 25. Factors affecting the process of implementation of OHS

<table>
<thead>
<tr>
<th>Facilitating factor (Walt 1998)</th>
<th>Implementation of OHS in EU member states</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple technical features</td>
<td>The implementation of the framework directive had complex features. OHS reform was affected by training needs of occupational health professionals in several member states, lack of information to follow implementation, and costs for employers and governments to push the changes.</td>
</tr>
<tr>
<td>Marginal change from status quo</td>
<td>Major changes were strongly opposed specifically in France, Germany, and the United Kingdom. Incremental changes in Nordic countries were easy to pass. The status quo remained mainly in the United Kingdom, France and Germany.</td>
</tr>
<tr>
<td>Implementation by one actor</td>
<td>Implementation was complicated by policies and strategies in various countries that were a result of collaborations across sectors by health, social, and labour ministries. In Greece and Portugal, the intersectoral nature of the implementation of the framework directive might have complicated the reforms. Industrial relations have hindered implementation in Spain, Portugal, Greece, and France. In Italy, the decentralisation of health care left OHS with scarce resources.</td>
</tr>
<tr>
<td>Goals of policy clearly stated</td>
<td>Framework Directive 89/391/EEC was not clear in relation to OHS, which left room for interpretation. OHS is part of social, health, labour, and employment policies, which created conflicts in power relations, resources, and responsibilities.</td>
</tr>
<tr>
<td>Rapid implementation</td>
<td>The process of adopting the framework directive into national regulation systems was relatively long, but depending on the country's size and socio-economic-political situation, new systems and procedures took longer than expected.</td>
</tr>
</tbody>
</table>
7. DISCUSSION OF THE STUDY

7.3. Actors for OHS

International organisations form international recommendations for OHS and follow national development. International organisations can either constrain or facilitate the development of OHS; they mandate a certain course for development, but they might not necessarily provide alternatives or diversity to develop OHS. The ILO and WHO have agreed with their member states’ conventions and recommendations on OHS, but the actual follow-up of implementation remains with the countries. EU member states have agreed on the framework directive, according to which countries are obliged to transpose directive into national law. The European Commission follows up the implementation every five years, but in principle this depends on cases taken to the ECJ and the ECJ’s subsequent decisions.

At the EU level, such actors as the Directorate General for Social Affairs and Employment and the Directorate General for Health, Food Safety, and Consumer Affairs are in charge of developing policies, strategies, and initiatives in health and safety at work areas. In addition, the European Agency for Health and Safety in Bilbao and the European Foundation for Living and Working Conditions in Dublin play crucial roles in providing comparative information through their programmes with member states. But the legitimacy of the EU to interfere in the health services and OHS can be questioned. The treaty does not give a mandate to EC, but rather to member states to decide on their health and social service provisions. In general, the democratic deficit is largely discussed as being in the decisions that are made by the EU. However, the influence of industry, commercial actors, and other strong lobbying organisations with their own agenda might be stronger than the political forces in EU institutions, such as in the Council of the EU. Despite the wide interest presented in working groups, committees, and other gatherings, there seems to be a need to raise the question of legitimacy and governance structure of the EU. The reason this needs to be raised is that the processes, procedures, practices, and possibilities to influence depend on policies, and the opportunity to be heard depends on which organisation is being represented. Therefore, the main responsibility for equity, solidarity, and universality of OHS belongs within EU member states and according to their political will.
Policy networks are formed during the policy formation process and have an influence on OHS development, for example, in governments, professional organisations, and OHS units as well as other national, international, and institutional settings. Policy networks form connections within economic, social, and political contexts of the policy process among stakeholders. The employers' organisations and industry in general are among the most influential in European policy-making. Vested interests are of paramount importance to the politics of OHS. Freeman and Moran (2000) underlined the importance of the medical professions and actors in the industrial and technical areas of health care, which clash with the fiscal imperatives of cost containment. Professional actors, OHS providers, and employers exert influence over OHS development. The influence of occupational health institutions and policy legacies are emphasised in reforms rather than formal macro-political institutions and partisan politics (Giaimo 2001).

The role of industrial relations has diminished towards mere interest representation. The compensation systems for wage losses in collective bargaining have been replaced by social policies and by political compromises between social parties and workers' representatives. Any cut or change to the consistency, orientation, and introduction of non-negotiated mechanisms (regulations and laws) to change the equilibrium had to be achieved by consensus between employers' and employees' associations (Amoroso 1996).

Workers have consequently lost interest to trade unions, which have fewer members than before. The impact of the unions seems to be decreasing because workplaces are smaller and bargaining is local. The representation of social partners is weak in SMEs in many countries. New partnerships have been created among professional associations, OHS, and safety organisations. Also, employers' organisations and trade unions are merging into larger organisations. Many trade unions have institutionalised their involvement in statutory workplace representation, or they play a role in the co-management of social and employment policies and benefit systems. This has given trade unions additional legitimacy and resources. Welfare states provide several 'union securities' through union-friendly labour relations in the public sector, and they provide subsidies to collective insurance schemes run by trade unions. On the other hand, the trade unions have gained a bargaining role in
the private pension schemes that are emerging in addition to mandatory state pensions. However, trade unions should redefine their strategy in current welfare reforms (Ebbinghaus 2001, 2002).

7.4 OHS as service provider: Variations in services among countries

The SEA created the single European market, whose influence also affected health and social services. Therefore the EU member states had to make choices about economic allocations and distribution of services, for example, by cutting expenditures and services. Legislation and support (financial, educational, or infrastructure) are common interventions of governments to build an OHS system. One of the major supports for the OHS system has been the regulation of OHS units, occupational health professionals, and training requirements.

Some countries defined the organisational structures for OHS in their regulations (e.g., external and internal services or other types of services). This choice has been made when public OHS provisions or OHS for specific groups of workers or enterprises have not been defined in regulations. Spain and Austria used the framework directive as an opportunity to reform their OHS and occupational health and safety system, whereas changes have been modest in Finland, Germany, and Italy.

The costs of OHS units in some countries were defined in regulations according to the number of employees, or based on risk ratings at work, or based on contracts between OHS and employer. However, the framework directive left the coverage of costs as a national decision to be made. Most of the EU member states were keen for their enterprises to comply with the new legislation rather than to cover the costs of OHS, and so there was an efficient shift from public responsibility to private responsibility for OHS. This also created a market for OHS, due to compliance requirements for companies. However, some governments have created compensation schemes. For example, insurance companies organise and cover the costs of OHS for SMEs in Austria, and social insurance partly covers OHS in Finland. The voluntary insurance systems are gaining market share even in occupational health issues. Workers’ insurance can be included as a fringe benefit and thus attract certain types of professionals, mainly white-collar workers.
Another important choice, in relation to OHS distribution, concerned workers’ coverage by and access to OHS (e.g., the geographical and social distribution of OHS). Managers of OHS units are concerned by increasing expenditures, which causes contrasting views between employers and employees. The major determinants of OHS costs are demographic changes (more older workers with health problems), changes in disease patterns (new risks), advances in medical technology and public expectations, increased skill levels of OHS professionals leading to higher labour costs, and employers’ limited capacity to pay higher costs. In addition, politicians and managers control matters (Heidenheimer et al. 1990). Therefore the inequality of worker access to OHS can be related to income and to the costs of services paid by employers.

The fundamental choices for OHS were made at the beginning of the framework directive’s implementation. These choices include how to continue, terminate, or adapt occupational health and safety policies, strategies, and action programmes in order to fulfil the framework directive’s criteria. The joint opinions had to be built between administrative and social partners, such as trade unions and employers’ organisations. In general, governments were obliged to comply with the directive, employers’ organisations opposed the directive, and trade unions were in favour of the directive to avoid dumping of the workforce due to different social protection schemes and different OHS provisions among EU member states.

The free choice of OHS by employers has also brought attention to quality demands and has increased price competition among OHS units. However, the idea of choice when consulting an OHS doctor might not apply very widely. In many countries, OHS is organised by a company or by independent OHS units, which are relatively small and whose choices are limited or non-existent. However, an increased market has merged OHS units into larger units to cover an increasing number of companies. This builds economics of scale and also builds more sophisticated systems and services—mainly for large companies. In principle, large OHS units can increase the market share by eating small OHS units with price competition, variety of service provisions, and additional services. This might have created a choice of services and professionals in core areas of industries, but in remote areas or areas with small industries, public health providers are the source for OHS or for a substitute for specialised OHS. The public health services in Italy, Finland, and Greece are a relatively large part of OHS.
Preventive and protective occupational health services or multidisciplinary preventive services have reached a new paradigm in relation to new demands and legislation. The demand side is affected principally by the free market of services, including OHS, costs, and performance awareness (cost-efficiency studies), and the demand side has become shifted into more of a consulting role within OHS. Employers are responsible for policy on working conditions, but they might have focused too heavily on decreasing absenteeism instead of on work-related diseases or ill health. In addition, their focus has been more on preventive issues than on risk assessment, although that is fundamental for prevention. In some countries certification of OHS has enhanced the quality of OHS, but it has also made ‘OHS look as it should look like.’ In addition, the role of OHS at work has changed. It is seen as an agent for change because of its consultancy role, orientation to organisation, and its multidisciplinary and competitive aspects, all of which are related to efficiency and effectiveness of OHS. This change of direction has triggered discussions in many countries on the issues of OHS and the professional sets of competencies in the new fields of action.

### 7.4.1 Competent occupational health professionals for all?

The most regulated occupation in OHS is that of medical doctor. Other OHS professionals are subject to only limited or minimum regulations in many EU member states. The use of physicians has an important impact on OHS and the value that society puts on OHS. Occupational health policy choices are based on the ratio of physician to population and on the proportion of medical students to current practicing physicians. Admission to training in all EU member states has been regulated and has varied through the years. The tendencies seem to be towards specialisation, increasing the number of occupational health professionals, and enhanced cooperation and collaboration among different professionals—even in training (e.g., France, Finland, and the Netherlands). Differences in training of occupational health professionals have caused significant differences in competences, salaries, work definitions, bargaining power, and role at both the societal and individual level.
The public sector is a major employer for occupational health physicians in Sweden, Finland, and the Netherlands; whereas private occupational health physicians' practices dominate in Austria, Germany, the United Kingdom, and Ireland. This has an impact on the composition of services of different occupational health and safety professionals. This also reflects the different approaches for multidisciplinary services and the availability of multi-professional services, and it might explain differences in development of OHS in Europe. In Finland, Italy, and somewhat in Greece, OHS is considered part of public health. In Denmark OHS is integrated into regional hospitals. Training and education influence multidisciplinary collaboration, and collaboration depends on the degree of professionalism and on the advocacy role of the professional organisation. Safety engineers are relatively new professionals and main employers are large companies. Cooperation and joint training activities with safety and health professionals are rare.

Framework Directive 89/391/EEC asked for competent professionals in preventive and protective services. EU member states had the opportunity to define the competences. The regulated professionals, such as doctors and nurses, have basic competence requirements, but occupational health specialisations have not been defined or required from all working OHS units. However, competence can be conferred on professionals or OHS units through accreditation, licensure, or certifications (Shaw, Kalo 2002).

7.4.2 Occupational health for all?

OHS is a key stakeholder in the treatment of poor occupational health. However, overall health status is significantly shaped by socio-economic, lifestyle, and environmental conditions. The organisation of OHS in EU member states varied (with some similarities) even if they were facing similar challenges in occupational health and occupational health policy. There is also a great need to collaborate with other policies that have some influence on the determinants of occupational health. Better health brings the potential for higher productivity, longer working lives, and lower costs (e.g., less absence, fewer treatments, and fewer disabilities).
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Despite Framework Directive 89/391/EEC and the obvious need in EU member states to follow the implementation, impact, and efficiency of OHS, the statistics for OHS and occupational health in general were scarce. One must be careful when comparing different data sets from different countries, due to lack of information or methods of collecting data. Several work-related monitoring, data-gathering, and reporting schemes have been created within the EU, OECD, ILO, and WHO (Appendix IV).

In summary, occupational health in EU member states is influenced by type of industry, occupation, type of work contract or work time (shift work), age, and gender, all of which have an effect on the prevalence and incidence of diseases. Women represent 46 per cent of the workforce but have on average only 18 per cent of occupational diseases. The costs of preventive or curative OHS should be considered in relation to lost workdays, accidents, bad health, and loss of production and income. The combination of old and new occupational hazards requires an integrated preventive approach, which needs to redefine occupational health policies and services (Benach et al. 2002a, b). The implementation of occupational health laws is a necessary, but not sufficient, condition to increase prevention at the workplace (Rosner 2000). Workplace needs have changed to adapt to the new work environment. Occupational health hazards are partly technical and partly economical, but largely related to professional values and changing labour relations. Occupational health is increasingly related to the labour market and social policies (Benach et al. 2002a, b).
8 VALIDITY AND RELEVANCE OF THE STUDY

Qualitative research methods have long been used in the social sciences to study people in their natural settings. Typically several methods are combined, such as observation, interviews, and text analysis. Qualitative research methods have much to offer in the study of health, health services, or health service systems; and they are increasingly used in health services studies. Interviews and document analysis were chosen for this study. The choice of these research methods was based on a research strategy to study policy processes of OHS with an attempt to interpret OHS development in national and EU contexts. Therefore the interviews of the actors in 15 EU member states was considered the only possible research method; document analysis complemented the data collection and increased the validity of views expressed by interviewees. The selection of 15 EU member states brought richness to the perspectives and depth to the study.

Qualitative research can be assessed by the same broad criteria as quantitative research: validity and relevance (Mays, Pope 2000). In many cases, the interviews and document analysis formed a congruency among the topics of OHS and increased the credibility of the study by combining different data sets (data triangulation). In addition, interviews with members of different interest groups in each country increased validity as several data sources were used. Triangulation ensured comprehensiveness of the data analysis. Nevertheless the analysis required a high degree of interpretative skill and sensitivity to the ways in which the researcher and the process shaped the collected data (reflexivity). The number of respondents per country in this study was limited and biased to occupational health professionals from various institutions.
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The researcher selected only to interview these professionals in order to reduce errors (respondent validation). Nevertheless, the interviews and documents formed an entity for a comparative analysis of OHS in EU member states.

In the qualitative case study approach, a phenomenon is studied in its natural environment with various sources of data sets. Qualitative case study controls confounding variables with careful research design and greater attention to the proper selection of cases and fairness to all causes when doing the research analysis (Yin 1994, Peters 1998, Pope et al. 1999). This study aimed to describe OHS and to clarify the impact of Framework Directive 89/391/EEC on OHS. The interest was in the processes of OHS development in the EU context to comprehend the impact of various policies on OHS in the 1990s.

8.1 Validation and credibility

The validity of qualitative research is strengthened by triangulation, respondent validation, clear exposition of method of data collection and analysis, reflexivity, attention to negative cases, and fair dealing (Mays, Pope 2000). In this qualitative case study, two data collection methods—interviews and document analysis—were combined. This combination provided triangulation of data collection methods to look at changing policies in EU member states. The questions about local and national occupational health policy and practice in OHS were raised in the interviews. The successful implementation of OHS often depended on the involvement of several different stakeholders, so it was necessary to be sensitive to issues of collaboration and conflict. Each stakeholder had a legitimate, but different, interpretation of events in relation to OHS, which in turn provided several data sources forming part of the triangulation of data collection methods. The strength of this case study design was that the interviews provided insights into a complex real world, with the ‘case’ providing explanations for a wider development in national and EU policy processes and connecting the views presented in the interviews to possible data accounts of the researcher and document analysis. This can be seen as a respondent validation. All 15 EU member states of 1999 were selected for the study.
8. VALIDITY AND RELEVANCE OF THE STUDY

In addition to interviews, other materials and documents were used to form a triangulation among different reference materials (material triangulation) to increase reliability (Yin 1994, Eskola, Suoranta 1998). In material triangulation, OHS was described with the support of statistical information, documents, interviews, questionnaires, and observations. These different sources of material confirmed or contradicted the information from the interviews. The material was selected based on search engines and library databases with various research words. The researcher searched for material. The chosen databases and search engines were considered to be the most important for the area of study. The quality of the material was confirmed through scientific peer-reviewed articles, books, and governmental documents. Interest groups’ materials were also used, if considered valid and relevant. During the research process, Internet searches provided timely access to several documents and publications. It might be that material not available in electronic form has not received the attention it deserves. Such papers might be published nationally, might appear in seminars, might be published only as books without electronic access, or might not be in the university libraries in Finland. These issues are related to matters of what is published where; who has access to the most recent, accurate, and timely information; as well as transparency of governance systems, in the case of EU and ministerial materials.

The chosen method of data collection and analysis influenced the topics of the study. This study used a comparative OHS analysis among EU countries, which appeared similar and comparable in OHS terms. These countries also seemed comparable in terms of political, social, economic, health, and labour market processes, as well as institutions and their governance. The theories of political science and health policy studies and their explanations gave an impetus to shed light on the EU member states’ decisions on OHS and its functions in the European context. What makes OHS interesting is the unique combination of national and supranational rules and institutions for the development of OHS in EU. The study attempted to find individual cases and make observations through the comparison of different features, qualities, and solutions in different contexts for OHS. This comparative study generalised the development of OHS and found changes that occurred in the OHS systems as an entity, which were compared and analysed in
8. VALIDITY AND RELEVANCE OF THE STUDY

relation to the context of social, health, and industrial relations policies. However, time is an important element of the analysis; issues discussed in 1999-2000 might have changed their nature and significance. The development processes can be seen only over a period of years, even decades.

Reflexivity is an important feature for the validity of qualitative research. The reflexivity requires sensitivity to ways in which the researcher and the research process shape the collected data (Mays, Pope 2000). The interviews were conducted and the thesis written in English due to the international nature of the topic. Language can be critical when interpreting answers as well as expressing thoughts and responses through one’s own interpretation. The results are the interpretation of the author and can be questioned. However, in qualitative research, it is accepted that the researcher has an impact on results through her interpretations, which are nevertheless based on the collected data. The relief is that the opinions, results, concepts, and so on are continuously evolving and do not provide the final truth and correctness on issues, but rather reflect views at a certain point in time.

The researcher’s position is also to be considered in qualitative studies. A background in public health might have brought different points of view—both to interviews and to interpretations of results—than a background in sociology, medicine, or political science would. OHS is a medically oriented research area, and therefore public health aspects, policy studies, and EU concerns are not often profoundly touched in OHS studies. OHS has often been seen as a tripartite issue only and not thoroughly connected to welfare states’ development as a benefit for the employed.

In qualitative research, multiple cases increase external validity and help guard against observer bias (Yin 1994, Meyer 2000). Multiple case sampling also adds confidence to findings. A range of similar and contrasting cases can bring understanding to a single case and can provide answers to questions of how, where, and why the case performs as it does (Miles, Huberman 1994, Meyer 2000). The similarities and differences in applying Framework Directive 89/391/EEC in the EU member states were expected to replicate or extend theoretical categories of welfare state regimes or health systems and to provide examples from all categories.
The study attempted to improve the quality of explanation by searching contradicting cases and therefore discovering explanations for OHS in various EU member states. The clear strength of the completed study was making the connection between OHS and occupation-based benefits in the welfare state, instead of merely describing OHS in a vacuum or as a sole system of EU member states as the situation was in the beginning of the study. The process of interpreting the interviews and documents about OHS in EU member states was connected to earlier studies and 'deviant cases' that were analysed until acceptable an explanation was found. Therefore various types of cases can increase the understanding of OHS context.

A wide range of different perspectives also increases validity (Mays, Pope 2000). Generally, comparative research on compliance and implementation of any directive is focused on legislative or organisational systems and document analysis, without connection to reality. Many of the interviewees in this study were involved in forming Framework Directive 89/391/EEC or implementing it during several years, which made it possible to look at the different views and interpretations of stakeholders in relation to OHS. The interviewees gave more candid opinions about implementation than the formal documents showed. When looking at the status of OHS in EU member states, the interviewees expressed views about the significance, impact and follow-up of the framework directive. Interviews provided the possibility to gain knowledge about the background and beginnings of OHS, instead of only reading documents or getting the official understanding of OHS in a country. Interviews also gave interviewees the opportunity to elaborate on questions and to make statements, which documents would not provide. By using interviews, cultural and historical facts were also revealed and understood better in terms of the character of each country's OHS system. Interpretation is also an important factor when looking at documents only. However, interviews can form and clarify the interpretation and concepts of documents.

Credibility of this study was increased by using two different methods of collecting data, comparing results among various EU member states, and reflecting the results to various policy contexts of OHS to improve understanding and explanations. Smelser (2003) proposed comparative analysis to systematise the context of comparisons, both with
8. VALIDITY AND RELEVANCE OF THE STUDY

respect to selecting comparative measures and with respect to explaining comparative similarities and differences. Concepts should be based on equivalent or comparable measures in different national, societal, and cultural settings (Smelser 2003). The equivalence was reached in this study by using multiple concepts for the same issue and an independent process of comparative research. The tasks were to determine what we mean conceptually and theoretically by OHS, to determine what various manifestations this can take, and to conduct a systematic survey so that composite measures of the multifaceted phenomena can be devised.

The limitations of this study should have been the primary interest from the beginning. As the research process developed, the vast number of issues related to OHS was found. However, a reasonable summary of the topics has been included in this thesis. Limitation of the topics was needed to complete the task, and also to provide a concise and enjoyable reading experience for the interested. On the other hand, the material gives some possibility for generalising about OHS development within EU member states.

This study described the policy environment, major features of OHS systems, and other policies affecting OHS development. OHS as a system was more known to the researcher in the beginning than the policy environment in different countries. The approach to study OHS was more descriptive and interpretative, despite an attempt to find some causal explanations from the development of welfare states and health systems.

Comparative qualitative studies in EU contexts usually include 3-7 countries, excluding countries that are small in size and/or population. There were 15 EU member states in this study, which might have higher validity and credibility because more deviant cases than typical cases were included. A descriptive study might contribute to studies of occupational health and safety, because the description concerns the lesser known institution-building phase of OHS system.
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8.2 Comparability and generalisation

Innovative, successful, and challenging cases and their central features can be found when several cases are compared. Based on these features, some generalisations can be made (Yin 1994, Niemi-Iilahti 2000). The generalisations of OHS features depend on culture, time, place, and context of the society. When countries are similar, variations are small, but differences can still be found. Concentrating on a few differences in similar countries, one can find differences and draw conclusions in relation to the amount and significance of differences (Smelser 1976, Salminen 2000). Both Sartori (1994) and Ragin (1989) provided solutions for generalisation. Sartori used ‘upward aggregation’ or ‘downward specifications.’ Ragin used a narrowing and refining process of data in comparative studies. His method expects that explanatory variables can be simplified into binary forms to exist or not exist (Ragin 1989). The simplification seems to bring overwhelming difficulty to heterogenic and dynamic health and social system studies, as very few studies have been published (Kvist 1999).

This study was an attempt to compare EU member states and their OHS and to find different causal conditions connected to different outcomes, such as coverage, access, and equity. In addition, an attempt was made to locate OHS development in welfare state regimes and health system regimes. This type of comparison explains and interprets differences and similarities of features systematically and comprehensively, in order to find items for generalisation.

Comparative studies have increased due to international contacts, activities, development work, consultation, and training. One of the barriers to internationally valid knowledge and comparative studies is ethnocentrism, because every country claims to be specific. In addition, the cultural and cognitive limitations of the researcher limit the interpretation. International studies are usually locally assessed and rewarded, despite the evident interest in international recognition. Only through international recognition of comparative studies can international and comparative knowledge spread (Smelser 2003).

Theoretically and methodologically, international comparative studies face challenges. How and why should OHS systems be compared? Are OHS systems comparable, or am I comparing cats with dogs? What
can we learn from comparing OHS systems, and what does it bring to health or social sciences as a method or theory? A valid comparison takes into consideration cultural\footnote{Culture seems to refer to values, practices, emotions, artefacts, institutions, and ‘ways of doing things.’ See Chamberlayne et al. (1999) about welfare and culture in comparative studies.} or national differences, different definitions, and international classifications of OHS at the national level. The challenges are selecting comparative items, reliability of data-gathering methods, controlling for other factors influencing comparison, and recognizing context differences that affect or explain the phenomena in different places (Øvretveit 1998). Variations in context destroy both reliability and availability of common comparative measures. However, the deviant case can be a way of achieving descriptive depth, richness of analysis, and contextualization of explanations. By altering initial analytical frames in response to evidence, comparison refines and elaborates existing ideas and theoretical perspectives. In comparative research, one tries to specify the combinations of causal conditions leading to each type of case (Ragin 1994). Each EU member state and its OHS were considered as a combination of characteristics; and similarities and differences were examined in combinations of OHS, social, health, and welfare state characteristics across EU member states in order to find patterns. Some researchers believe that descriptive comparative studies lack a theoretical understanding of comparison. Comparative studies at best can strengthen our understanding of culture, system management, and structures of political or administrative decision making. Both a grand theory for comparative study (Salminen 2000), and the concepts, methods, and theories of comparative study are still under development; and empirical studies are few (Ragin 1989, Kvist 1999).

Comparability is not a natural feature of systems, but rather a consequence of selection, choices, and points of view. All systems are unique, but they can be reviewed and compared based on a researcher’s selection of defined concepts with uniform and analogical procedures that create the possibility to measure the system in a uniform way (Hyyryläinen 2000). Comparison also requires basic items that should be comparable. This involves a process in which sufficient similarities or differences are studied (Salminen 2000). However, the similarities might hinder sorting out effects of diffusion from effects of indigenous development.
8. VALIDITY AND RELEVANCE OF THE STUDY

(Peters 1998). As a frame for OHS, in which several items were studied and compared among countries, EU member states were considered comparable if they had similar social characteristics and similar historical, economical, political, administrative, and cultural backgrounds (Wilensky 1985, 2002, Ragin 1994, Peters 1998). OHS was considered comparable because all EU member states have OHS systems in principle and similar social protection systems with specific differences. These systems were considered comparable because the concepts used were universal and often used in similar health and social service system studies. In addition, all countries implement regulations, conventions, and recommendations of national and international organisations, such as WHO, ILO, and EU.

This study tries to paint a comprehensive picture of OHS in EU member states. It aims to strengthen generalisation as a comprehensive case of OHS in the context of development of welfare state benefits and the social dimension of the EU. However, generalisation is always an interpretation of multiple cases. Therefore the criterion for generalisation was to collect proper data from interviewees who were professionals, major OHS stakeholders in EU member states, knowledgeable about OHS in their own country, and interested in OHS research. In addition, the central features of OHS were compared among EU member states.

The sustainability and depth of interpretation were important for generalisation and were found by concentrating on a few differences in similar countries. The number and significance of differences have been found and discussed in this study. The time is a significant explanatory factor due to unsynchronised development of OHS, the welfare state, and the social dimension of the EU. The differences in features of OHS were dependent on the countries and their emphasis on the features of OHS. For example, some countries focused their OHS on the most dangerous areas of work, whereas others focused on occupational health for all. The transferability of generalisation is a challenge. The observations of one OHS system and its implementation in another case or environment is not likely, but some diffusion or lesson learning from other OHS systems certainly occur. The observations of this study might initiate change in some other OHS systems. (On generalisation, see Eskola, Suoranta 1998).
9 THE SIGNIFICANCE OF RESULTS

A comparative study has significant value if it helps explain supranational trends or helps highlight what is specific to individual EU member states. Basic comparative research can benefit policy makers by pointing out constraints and causes and showing that there is a policy matter leading to political choices and decisions. Comparative research can also specify policy options and programme emphasis for the decision makers. Research can also contribute to understanding problems and can offer real solutions and alternatives from which to choose.

Occupational health and safety has been a concern of the EU since the EU's beginning. However, in the 1990s pessimism surrounded OHS issues; after the introduction of Framework Directive 89/391/EEC, the EU neglected many other initiatives in occupational health and safety. Whether the implementation of the framework directive has been a success or not is difficult to measure, but similar regulations give EU member states the opportunity to develop further OHS. Nevertheless, new energy arrived in the 2000s from the Lisbon strategy and related areas of employment policy, social policy, and the health sector. The emphasis is on the quality of life and the demand to prolong staying at work in EU member states, which could initiate new momentum for OHS.

Some countries, such as France, Germany, Italy, and the United Kingdom, made minimal changes or delayed implementing the approaches in OHS development. In addition, OHS are private services in many countries. By outsourcing OHS and enlarging OHS units, transnational companies have led the development of OHS in some countries. During intergovernmental cooperation, political expression remains national. The European Commission introduces OHS topics, and each EU
member state views the European Commission through its own lens of preferences. This also means that OHS changes and reforms are national issues despite increasing international influence. In the EU, policy bargaining involves the combination of lowest-common-denominator bargaining and protection of sovereignty. Sovereignty in health and social issues has been highly protected, but latest developments show some breaking points in EU collaborations. Open-ended authority to develop OHS in EU member states seems unlikely but possible, through further authorisation to the European Agency for Health and Safety at Work in Bilbao, through another agency, or through some other form of cooperation.

Health, social, and labour market research also has a limited role in governance because the most influential politics are driven by ideology, value judgements, financial constraints, economic theory, political reasons, or intellectual fashion. Nevertheless all of these seem to affect health and social system reforms, and they also affect the application of research to the effectiveness, responsiveness, and fairness of the systems (Davis, Howden-Chapman 1996). Research evidence seems to be more influential on central policy, for example at the ministerial level than local level policy, where policy is marked by negotiation and uncertainty (Black 2001). Therefore the understanding of OHS is important to specify policy options in a changing context.

Policy-making is an incremental process, where policy makers strive for step-by-step improvements rather than fundamental changes. Concentration on a limited number of alternatives, which do not stray very far from existing policies, might bring results. Also, flexible policy-making processes can correct unanticipated consequences of policies and can handle the complexity of policy analysis and decision making (Rütten 1995). Therefore, for OHS to become a policy issue, a frame of reference to define policy problems of occupational health and safety and to formulate and implement such policy programmes requires joint efforts in the EU and collaboration across the policy borders. An example of this is mainstreaming occupational health and safety issues in other policies.

This comparative study on OHS system development was explained based on welfare state values and promises. Value-based explanation of OHS systems, structures, and functions reflected the values of equity
versus efficiency, and efficiency in relation to changes in OHS. However, values are connected to actors and their views of supporting them. Values also often reflect economical or political motives and move OHS in its own direction. Organisational or system-based explanations of OHS development reflect the responsibility of employers or trade unions to provide or not provide services as well as their power or capacity to defend such services. Provisions of OHS require resources, expertise, knowledge of workplaces, and solutions for occupational health issues, which are decided based on values or motives reflecting the power relations in the society. The market might be directing more OHS development than welfare state values or stated promises of stakeholders.

Some researchers believe that research provides policy options, fills gaps in knowledge, and prioritises certain issues. Several studies have focused on the use of resources by practitioners (practice policies), resource allocation and patterns of services (service policies), and organisational and financial structures (governance policies). Research on evidence-based occupational health has little influence on service policies because policy makers have other goals than clinical effectiveness. Such goals might be social, financial, or strategic. Sometimes the lack of consensus about research-based policy evidence and other types of evidence—such as personal experience, local information, or colleagues’ opinions—competes for policy change. However, the social environment might not be ready for policy change (Black 2001). This study provides examples of several OHS systems and services within different social, health, and industrial contexts, and the study also highlights the options available for policy processes to improve OHS.

Even so, the scientifically based promotion of OHS will be relevant only if it fits the rules of the policy game and contributes to political strategies of those in power or seeking power. Information and analysis are highly valued by policy makers, when the news is positive and can be assimilated into the stock of knowledge with which policy makers already make sense of the policy world. On the other hand, new knowledge can also cause turbulence and can carry political costs. Thus, when use could threaten organisational stability, non-use of new knowledge can be seen as a form of risk avoidance, (Rütten 1995). A time lag before
9. THE SIGNIFICANCE OF RESULTS

the use of information allows actors to deal with the organisational difficulties that ensue when an idea, innovation, or a new finding in OHS is first introduced.

Research rarely solves the problem of policy-making, but it can influence a process of argument and debate to help set an agenda. The situations are complex. Social, electoral, ethical, cultural, and economic concerns have influence on policy makers, but researchers can also have some influence through an extended process of communication. For research to have an impact, it is necessary to target the values of the policy makers, and to challenge and change beliefs. However, beliefs change slowly and as a result of repeated exposure (Walt 1994, Lomas 2000, Black 2001). Research might make people review their beliefs and legitimise unorthodox views. When policy makers’ values happen to coincide with the implications of research, there is a window of opportunity to make a change (Kingdon 1984, Walt 1994, Lomas 2000a,b, Black 2001).

This comparative study aims to understand differences and similarities, build relations among nations and people, and generate empirical scientific knowledge about similarities and differences in order to form explanatory knowledge of causes or understand influences using natural experimentation. The comparison of circumstances in different EU member states provides useful information about possible consequences of different political orders. The study demonstrates that what happens in one setting most certainly would not occur in another. Similarities and differences in propositions and types of OHS factors are not contradictory to each other, but complement the important issues in OHS.
10 CONCLUSIONS

This study concerns Framework Directive 89/391/EEC, which encourages improvements in occupational safety and health in EU member states in general and occupational health services (OHS) in particular.\textsuperscript{119} The framework directive originally aimed to bring occupational health and safety in the public and private sectors to the same level in EU member states. However, the implementation of the framework directive and OHS vary widely among EU member states. The study looks at the various social, health, and industrial relations policies in the EU and their impact on OHS. The EU social policy topics include health, industrial relations, occupational health and safety, and employment. However, the employment policy was not the focus of this study.

Knowledge and evidence are the major pillars for the formulation and implementation of effective occupational health policy (Spasoff 1999). Traditional occupational health, disease, injuries, and accidents are well known and data are available. There is a lack of comprehensive, reliable, and comparable health data (Piotet 1996, European Foundation for the Improvement of Living and Working Conditions 1996), which hinders the implementation of evidence-based policy. Several occupational health problems are undiagnosed and/or unreported (Karjalainen, Virtanen 1999, Karjalainen 1999). However, major OHS policy decisions are based on occupational health indicators rather than on actual OHS data.

To understand the lack of correspondence among occupational research, policy, and the needs of occupational health, it is important to analyse the principles that govern the decision-making process. Priorities are not free from values, and occupational health policy choices are neither neutral nor objective. They are closely linked to the values, interests, and power of actors involved in the policy process (Walt

\textsuperscript{119} Articles 6 and 7 of Framework Directive 89/391/EEC
In addition, the dominant lifestyle approach for occupational health and individual responsibility ignores social and organisational factors (Berlinguer, Falzi 1996). Also, OHS focuses on treating sick workers through health care interventions (instead of interventions to the entire working population), preventing illness by using a range of occupational health activities (Benach et al. 2002, 2002), and promoting health at work. Workers’ health and economic rationality drive the values-related issues in occupational health interventions. Conflicts of interest shape occupational health policies. A company does not prioritise the protection of workers’ health until workers’ hazards become costly to the company. Occupational health is sometimes a financial variable in occupational health policies. The main approach for discovering costs and benefits of OHS is the cost-benefit analysis as conducted by the European Foundation for the Improvement of Living and Working Conditions in 1998. Benach et al. (2002, 2002) argued that instead of costs, health should come first, because workers have the legal right to work in a healthy and safe environment. According to the Universal Declaration of Human Rights of 1948, people have a right to favourable working conditions.

Occupational hazards are mainly avoidable and preventable; and healthy, productive, and motivated personnel are a key to overall socio-economic development. Policy makers should prioritise public health over economics, improve their knowledge of contemporary occupational health needs, implement more efficient interventions, increase workers’ participation in such interventions, and enforce and assess interventions (Benach et al. 2002, 2002). Occupational health has an unstable position in the health policy arena, and its institutions are not a high priority.

10.1 Impact of EU policies in OHS context

The EU is considered a multilevel or intergovernmental entity in which EU member states use their power to influence the content of different policies that are important for joint activities. Global social policy practised by supranational organisations, such as the EU, seems to shape national health and social policies. Several policies in the EU context influence social policy aims, for example, values and condi-
tions for services and benefits. Social policies, of which OHS may be a part, are about fair and just societies, human rights, reciprocity, and the enhancement of human security. The role of governments is to guard redistribution, regulation, and rights in EU member states (Deacon et al. 2005), including OHS. The equity, redistributive, and universal social and health services provision for citizens has been the general aim of health and social policies. International organisations and their policies are characterised by globalisation, free trade, and economic growth. The creation of a common marketplace has produced negative consequences and concerns, at least for the low-income population (Deacon 1997, 1999, 2000). Therefore the role of the welfare state and the systems of health and industrial relations are important frames for the impact of EU policies on the development of OHS within Framework Directive and its implementation in EU member states.

The EU has shaped welfare states, health reforms, and industrial relations more intensively during last 15 years due to the creation of a single European market. In the policy process, the social dimension has been relatively high on the agenda for economic growth and employment since the mid-1990s. However, even if social dimensions or specific items of social or health policies have been highlighted in the EU, the priorities and actions in policies might not have supported these aims in the EU or in EU member states. Globalisation increasingly influences national governments through internal markets, competition, and trade. This means that people-centred policies are increasingly difficult to present in the integrated global economy. For example, deregulations have provided opportunities to multinational companies, whereas individual workers have to adjust to outsourcing OHS. Individuals without consuming power, such as low-salaried workers or the unemployed, are becoming less valuable in the eyes of those who emphasise economic principles, economic productivity, and growth (Koivusalo, Ollila 1996). The consequence is a two-tier society of the haves and have-nots that depends on employment status, health status, availability of health services, and income.

With a high level of income taxation and high levels of public health, education, and social security, some countries have been able to sustain welfare state premises and remain in global competition (Deacon 1997, 1999, 2000). The most competitive nations seem to have a comprehensive
10. CONCLUSIONS

welfare state, according to latest report by the World Economic Forum (2004). Public support for welfare and health care systems seems to depend on the welfare state regime, features of national systems, and individual social and demographic characteristics (Gevers et al. 2000). Several comparative survey analyses conducted by the International Social Survey Program (ISSP), World Value Studies, and Eurobarometer provided support for welfare state policies. The studies analysed the influence of welfare regimes on public support for welfare state policy. Regardless of whether people ‘get what they want’ or ‘want what they get,’ scholars expect a strong connection between welfare regimes and cross-national differences in support for welfare state policy. Comparative analyses have exploited the modules on social inequality (1987, 1992, and 1999) and on the role of government (1985, 1990, and 1996) conducted within the International Social Survey Program (ISSP). Others have used data from the International Social Justice Project (ISJP) (1991), the World Value Studies (1981, 1990, 1995, and 1999), and some of Eurobarometer surveys (e.g., Mossialos, King 1999). However, EU member states have retrenched, recalibrated, and reoriented welfare services due to globalisation, changes in attitudes about responsibilities of society and individuals, demographic changes, demands of labour market etc. The societies seem to be moving towards more individualised provisions, consumer voices, and economic constraints in the provisions of welfare services.

Although generally globalisation affects welfare states at the market level, there is an intention to coordinate and decrease differences or to make systems that communicate about social issues among EU member states. In most cases, nation-states remain sovereign states and welfare states continue to be the independent policy-making units. Still the EU’s impact is seen to be restricted due to the principle of subsidiarity (COM (93) 545). However, sovereignty and autonomy in national social policy-making have changed due to market integration. EU member states and people find themselves competing with powerful business interests for

the deregulation of social policy. Because the EU exercises its greatest decision-making power within the economic arena, enterprises and their management have gradually assumed increased political influence. At the same time, economic integration has eroded the influence of trade unions and other supporters of a strong social system. Thus, with business assuming a more influential role in deciding the direction of the European welfare state, the sovereign voice of member states and their citizens must often struggle to be heard (Falkner 1998, Scharpf 1997, 1999).

Because economic and social policies are decided in different forums and because the EU does not have joint decision-making bodies, the economic impact is larger on changes made in social policy areas (Kautto 2001). However, there are signs that economic policies are becoming more oriented towards social policy in order to avoid harmful social developments that might destroy economic growth and global competitiveness. Jessop (1999) argued that the national mixed economy of welfare (combination of market and plan) is giving way to a new post-national mixed economy in which networks and partnerships have become important. Each welfare-workfare mix has implications for welfare policy. The political economy will also be an influence (Jessop 1999). As the new process of OMC develops, hybridisation is possible in welfare and labour market policies. This could lead to new policy mixes, which are already apparent in Denmark, Ireland, the Netherlands, and Portugal (Hemerijck, Visser 2003).

The terms policy learning, diffusion, policy transfer, and spillover are commonly used to explain converging trends in several policy areas. The EU border nations seem to closely follow the policy development in neighbouring countries, and their welfare systems seem to be similar. This leads to the thought that diffusion of social policy initiatives, such as OHS, is a process of imitation from one country to another. Innovations and transmission or imitation of ideas and technologies spread from leaders to followers. Innovations spread to nearby countries and also along major lines of communication. Innovations first appear in the most advanced and largest centres, and they are diffused later to less advanced and smaller ones (Wilensky et al. 1985). Legislation concerning occupational health and safety usually starts in one country and then spreads to others. The difference between initiation and application of
legislation in the EU member states might be explained by economic level, ideology, ideologies in the parties (political or religious ideas), maturation rate of the welfare state system, and the age breakdown of the population. In addition, previous OHS spending, related programmes, and an interest in OHS all have some influence on the development of occupational health and safety systems. Denmark, Finland, the Netherlands, and Sweden have led OHS development. The United Kingdom has followed. Germany, Belgium, and Italy are closer to the leaders than to the follower. France is close to the leaders, but French OHS systems have been medically oriented.

The main question for several years in Europe has been what kinds of policies in occupational health and safety would be feasible and fair in Europe, taking into consideration the variety of welfare state designs and the differences in practices. In principle, there are several common views about the welfare state and its values, such as the commitment to social justice and the contributions to economic efficiency and progress. Universal human rights have also influenced the patterns of social welfare systems. On the other hand, European decision makers have stated that social policy is an essential factor in promoting economic adjustment, economic competitiveness, and social cohesion (European Council 2000a). Nevertheless the recent Mid-Term Review of Lisbon Strategy (Kok 2004) and New Start for the Lisbon Strategy (COM (2005) 24) hardly pay attention to the social dimension, but rather to growth and job creation. Interest organisations and their negotiations are intense between government and social partners in economic and social matters. Direct and indirect influence by the EU has become strong in OHS as well (Bouget 2003, Hämäläinen et al 2004). The main influences on OHS originate from the internal market and from competition policies.

EU policies and proposals are driven by market, trade, and competition. Because of this, the dominance of the ministries of trade and commerce in EU policy-making at the national level makes the accommodation of OHS concerns less evident. There also seems to be a bias towards the benefits of OHS markets and competition because competition requires, among other things, additional governance costs of contracts. A number of measures have been taken to ensure that producers of goods and providers of services from one member state are not discriminated against by another member state. According to
Mossialos and McKee (2002a), information asymmetry and the impact of competition law could disrupt the many agreements needed to provide equitable and accessible services. In the context of OHS systems, the aims of solidarity, universal access, equity, continuity of care, and effective and efficient treatment are priorities. Service delivery should be based on values other than those of competition.

Mossialos and McKee (2002a,b) asked for greater use of the open method of coordination in the health sector. This proposal was taken up in a new communication (COM 304 (2004)) from the Commission and will have a major impact on health policy. Similar processes have been used in social policy and employment policy (Ahonen 2002). The European Foundation for Improvement of Living and Working Conditions and the European Agency for Health and Safety at Work have been able to steer the development of some areas of occupational health and safety by gathering comparative data from EU member states and developing their databases. The institutions have used this information to make suggestions to the Commission about initiatives. These information sources also form a base for benchmarking, exchange of best practices, and peer reviews. The comparative databases and reports will be a base for indicators in the open method of coordination and in the continuing Europeanisation of health and safety systems and specific regulations. However, the benchmarking needs to be designed differently for different purposes and contexts in order to be effective for policy learning, policy transfer, and policy monitoring (Groenendijk 2004).

10.2 From harmonisation to Europeanisation

Harmonisation was the main aim of the framework directive and its daughter directives in the occupational health and safety area, to avoid social dumping among EU member states. However, the number of different directives did not produce the expected harmonisation effect for the smooth functioning of the single market. Therefore, mutual recognition and coordination were recognised as helping national governments bear the burden of transforming EU legislation into national legislation. Mutual adjustment meant that national governments adopted their own
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policies nationally, but at the same time responded to or anticipated policy choices of the other governments. In international negotiations, national policies were coordinated or standardised by agreements at the European level, but national governments remained in full control of such aspects as the decision process and treaty revisions.

Some of the competencies of the EU were centralised and exercised by supranational actors that are not part of a member state government, such as the ECJ and EC. Joint decisions were made to implement the policies that enhance the market and to provide market-correcting competencies for the European Community. Policy choices in the EU member states became dependent on the institutional choices and strategies of supranational actors (Scharpf 2001). These issues have specific implications for the institutional capacity and legitimacy of European governing functions. The increased coordination, exchanges of views, and best practices have resulted in the convergence of several spheres of social policies and systems. EU member states are responding through their policy choices to European interdependence, and the governing functions are becoming Europeanised. Scharpf (2001) defined Europeanisation as a governing function that is practised in institutionalised interactions, such as mutual adjustment, intergovernmental negotiation, joint decisions, and supranational centralisation. Studying the Europeanisation of OHS contributes to the understanding and analysis of the EU’s impact on OHS systems. Studying the Europeanisation of OHS can also give insight into the workings of international governance of OHS policies, as well as insight into the relationships among the policy actors after the framework directive was introduced.

Europeanisation is also reflected in the increasing socialisation of experts, officers, and civil servants from various organisations and in the information exchange among EU member states and several stakeholders. Increasing interest from several organisations can be seen in relation to social and health policies. Most of the organisations looking for representation in EU committees and working groups are insurance organisations, professional organisations, industrial organisations, trade unions, or organisations representing certain groups of people (elderly, patient, disease-based, disabled, etc.). The large, well-established, and wealthy organisations are able to function at the EU and represent opinions of large populations or industrial sector groups.
Small groups without sufficient importance at the EU or without economic means and power have difficulty getting their opinions heard and getting a seat to participate in working groups. This was seen in the High-level Process of Reflection in health during 2002 and 2003 (2440th Health Council Meeting 2002). This group included representatives from international organisations of insurance companies and some international professional organisations, despite its intergovernmental nature. In 2004, the two main advisory committees in the area of occupational health and safety were integrated and a new advisory committee was created. In the health area a new High Level Group in Health and Medical Services was also created in 2004 (COM (2004) 301). Most institutions that create specific health and social policies lack representation because they are not organised into a European representative association (or equivalent) and therefore have not pooled their forces to have a joint view at EU. This especially concerns national institutions and their involvement in making policy on a sound scientific basis.

The creation of EU health and social policy is thus direct, indirect, or unintentional creation of health policy. Direct policy-making refers to making laws, and also to funding or cooperation among EU member states. This can happen in domains other than the directorates general of health and consumer protection or social affairs and employment. Policy areas--such as trade, internal market, competition, social affairs, and employment--might have an indirect impact on occupational health and OHS. Unintentional policy is made when economic and social policy objectives are pursued that have an unforeseen impact on occupational health and safety policies. For example, common agriculture policy has an impact on nutrition and diet, and an ECJ decision on access to health services abroad has an impact on the free movement of patients (Watson 2001, Duncan 2002). On the other hand, the EU should develop a health policy to avoid frequent and unintentional impact (Mossialos, McKee 2001, 2002b, European Commission 2001). However, in the area of occupational health and safety, the systems seem to be diverse in organisational, financial, professional, and other aspects; and the building of consensus among different policy makers is a long process.

Pre-existing structures have an influence on domestic adaptation to policy content and process. EU member states seem to adjust their policies to EU decisions. When making policy, institutional structures, design, participants, and rules of conduct are important. Values that
10. CONCLUSIONS

are based on beliefs, ideologies, and interests also direct policy choices. Information-based research, stories, experience, and propaganda frame and form policy-making (Lomas 2000a, b). OHS is generally more developed in countries with strong institutional support and long-term conduct of social dialogue. Decisions in OHS are increasingly being made based on evidence and research. OHS systems have their path-dependent structures, which slow down rapid changes; however, most changes are incremental and probably have a profound impact on the direction of OHS in EU member states. Europeanisation seems most likely to occur when there is both domestic administrative and political support for compliance.

Occupational health and safety issues are similar to economic affairs, in that they both have a complex route to reach the policy-making agenda. Differences in the policy-making process of different policies can produce measures that reflect contradictory values and goals. Policy outputs vary depending on the policy-making route to resolution (Kasza 2002). Negotiation aspects, such as negotiation as a process, system, or order in European policy-making contribute to understanding the decision-making processes. Influencing can occur in different phases, such as agenda setting, the formulation of proposals, or in interinstitutional decision making, and influence depends on what sector or issues are being considered (Andersen, Eliassen 2001).

Elgström and Smith (2000) looked at the EU decision making as a negotiation process with special perspectives in the policy-making process. Those perspectives of EU actors are shared and contrasting interests, strategic interaction and signalling of expectations and values, linkages between issue areas and compromises made in the end of negotiations. The processes of institutionalisation, lock-in, and path dependence seem to characterise negotiations; and the mode of negotiations is cemented in the EU (Falkner 2000). The more Europeanised an issue is, the more it seems to be marked by institutionalised patterns of interaction (Elgström, Jönsson 2000). Occupational health and safety has its own institute in Bilbao. Nevertheless OHS is not within the activities covered because OHS seems to be more related to health, social, and industrial relations policies than occupational health and safety. It seems as if OHS has lost its momentum to be an important issue in occupational health and safety policies at the European level; and so the market and employers are left to decide how to provide such services within national regulations.
10.3 Actors as policy initiators for OHS

The roles of supranational, international, and national actors in the development of OHS are important. In occupational health policy, relevant institutional structures are manifold, and international negotiations are followed by national and international agreements. Table 26 identifies institutional areas of concern and their associated policy instruments with major actors. The major institutions of economic, social, cultural, and political characters play a key role in defining the potential for policy intervention. The possibilities and opportunities of impact and efficiency in influence vary among actors and issues, but in general the major actors and dimensions of occupational health policy are described.

Table 26. Institutional context and policy intervention for OHS and occupational health in EU

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Major institutional area</th>
<th>Principal focus</th>
<th>Policy instruments</th>
<th>Main actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political Political</td>
<td>Power</td>
<td>EU member states</td>
<td>Regulations set social and health policies, strategies, goals, and actions programmes, and financial incentives</td>
<td>EU member states Council of EU Ministers European Parliament</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Ideology</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Economic Economic</td>
<td>Internal market</td>
<td>Competitiveness</td>
<td>Reregulation and deregulation Decrease social costs by social inclusion Bargaining</td>
<td>DG Trade DG Competition DG Employment and Social Policy ECOSOC/EU EU member states</td>
</tr>
<tr>
<td></td>
<td>Trade</td>
<td>Economic growth</td>
<td></td>
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<td></td>
<td>Labour market</td>
<td>High employment</td>
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<td></td>
<td>Employment</td>
<td>Social dialogue</td>
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<td></td>
<td>Industrial relations</td>
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<tr>
<td>Social Social</td>
<td>Social policy</td>
<td>Social inclusion</td>
<td>Regulations Policies programmes, and information on workers' social rights</td>
<td>Council of EU DG Employment and Social policy EU member states</td>
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<tr>
<td></td>
<td>Health policy</td>
<td>Make work pay</td>
<td></td>
<td></td>
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<td></td>
<td>Employment policy</td>
<td>Full employment</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Labour market policy</td>
<td>Improved working and living conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and safety</td>
<td>Risk culture</td>
<td>Health and safety at work</td>
<td>Incentives for SMEs Public policy for good occupational health and safety inspections Specialised services</td>
<td>Enterprises and SMEs Workers Institutions in occupational health Health and safety professionals</td>
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<td>at work</td>
<td>Self-regulation vs regulation</td>
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<td>Trust</td>
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10. CONCLUSIONS

Framework Directive 89/391/EEC changed the approach concerning health and safety at work. The approach shifted from a medical and safety orientation towards the protection of workers from health hazards and the prevention of disease, injuries, and accidents at work. EU member states were obliged to make domestic arrangements by this type of supranational policy decision of a framework directive. This created a European model for OHS based on the framework directive. It also created adaptation pressures for new EU member states, which had to accept the terms of the directives in the process of the acquis communautaire during membership negotiations. The framework directive created coercion, and member states had to adapt the directive into their domestic legislation. On the other hand, flexible integration is possible in other policy areas, when countries may opt out of joining or may remain outside of the policy (Radaelli 2004), such as the United Kingdom in the case of social policy in 1980s and Sweden in the case of monetary union. Implementation of the framework directive has been flexible in EU member states and has created multispeed implementation processes.

The main aim of the EU is to create a common market. EU decisions are therefore made with the common market idea in the centre, instead of people, citizens, or other ideological views. The EU occupational health and safety policy initiatives might come from the directorate general of social affairs and health, but the occupational health and safety policy impact usually arrives unintentionally in the area of social policy and employment or health and consumer affairs. The major policy decisions are made among the European Commission, European Parliaments, and Council of Ministers. Politically, the European Commission requires support for its actions from the Parliaments and the Council of Ministers; on the other hand, the European Commission often responds to the questions from the Council or Parliaments (Duncan 2002). The president of the EU has also emerged as a policy initiator. Another health policy maker is the ECJ, which interprets the Treaty by the request of EU member states or citizens. The decisions of the ECJ have taken EU health policy in directions that none of the political institutions planned or expected (Richards, Smith 1994, Mosialos, Belcher 1996, Duncan 2002).
10. CONCLUSIONS

Even the trade union movement seems to be uninterested in defending OHS as part of the social benefits for workers. However, the trade union movement seems to be confronting serious issues of declining membership and power in national and European negotiation and bargaining to determine pay and major conditions at intersectoral, sectoral, and/or multinational company levels. Some explicit coordination includes formal coordination of the bargaining agenda across borders and/or collective agreements whose terms are expressly contingent on developments in other countries. Bargaining cooperation in the shape of exchange of information between employers' associations and trade unions is rather more widespread than bargaining coordination as such (Zagelmeyer, Schulten 1997). Traxler (2003) argued that the diversity of the national bargaining systems across Europe does not promote the building of a European supranational centralised and homogenised bargaining system. He proposed transnational coordination of the national bargaining strategies as a European approach (Traxler 2003).

10.4 From enterprise model of OHS to market model of OHS

The requirements for OHS in EU member states varied in relation to the model of organisation of OHS and the principle of multidiscipline in OHS. Therefore, policies other than the principles of social and health policies had an impact on the organisation of OHS and its development in recent years. As a consequence, global economic competition and social obligations tend to erode the social security provisions of Europe, for example, OHS and compensations for occupational diseases, injuries, and accidents. There is underreporting of accidents, and work is moved outside of the EU to decrease the insurance costs for companies. The pattern of work on which the social security has been based is eroded by flexible employment demand, and precarious and marginalised labour. This causes conflicting interests: capital versus labour, securely employed versus precarious, and present versus future generations (Deacon 1997). The conflicts put pressures on governments to decrease the social expenditure burden in companies and to loosen regulations. However, workers should not be considered a commodity (ILO 1944) or a product, and their occupational health should not be sacrificed for better economic growth and competitiveness in EU.
### Table 27. Three ideal types of health care models (applied to OHS from Twaddle 1996)

<table>
<thead>
<tr>
<th>Facet</th>
<th>Community model</th>
<th>Professional model</th>
<th>Market model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>Decision making by citizens or representatives accountable to the citizenry</td>
<td>Decision making by experts with special training and credentials based on abstract knowledge</td>
<td>Decision making by consumers under conditions where there are a large number of providers acting independently and with perfect knowledge of price and quality</td>
</tr>
<tr>
<td><strong>Dominant actor</strong></td>
<td>Political parties, politicians, civil servants, trade unions, employers’ organisations</td>
<td>Professionals</td>
<td>Business interests, industrial organisations</td>
</tr>
<tr>
<td><strong>Dominant goal</strong></td>
<td>Preservation and extension of democracy; influence on decision making</td>
<td>Enhancement of knowledge, improvement of technique and capacity, application to problems within domain of expertise</td>
<td>Profit</td>
</tr>
<tr>
<td><strong>Mode of regulation of control</strong></td>
<td>Elections, opposition parties</td>
<td>Socialisation, ethical standard, informal sanctions, formal sanctions by colleagues</td>
<td>Competition and trade</td>
</tr>
<tr>
<td><strong>Enhancing factors</strong></td>
<td>Tradition of democracy, equality of power, constitutional limits</td>
<td>Public trust, absence of exploitation</td>
<td>Newness of market, absence of hegemony, trust busting</td>
</tr>
<tr>
<td><strong>Undermining factors</strong></td>
<td>Concentration of power, wealth and control</td>
<td>Overextension of claims, professional threats to democracy, market inclusions into professional sphere</td>
<td>Concentration of economic power, strength of professional ideologies, strength of democracy</td>
</tr>
</tbody>
</table>

**TIME**
Twaddle (1996) described three ideal types of health care organisation and recognised a significant shift from the community model towards the market model (Table 27). Trade agreements designed, supported, and managed by the economic elite in international organisations are designed to maximise profits at the expense of social development. Trends towards internationalisation of economics have introduced privatisation and competition to public health care services, even though health care has a special category of services that requires a licensed monopoly to maintain standards. The important point is that the reform of health care systems can be a hegemonic project itself or it can become part of a larger hegemonic project.

The shift from the support of the whole population towards the support of strategically important sectors of the population has required containment and even repression of the whole population while simultaneously involving selective access and concessions for the more favoured population. The shift is tied to international corporate interests, for example, an interest in increasing the health market. The timing, speed, and direction of health care reforms can be described by this theoretical assumption about general repression and selective access (Twaddle 1996). In OHS the employed have access to and coverage by OHS, whereas the unemployed, workers with precarious employment, or public sector workers might not have OHS coverage. This creates three classes of OHS beneficiaries—people at work, people in precarious work, and people out of work—because OHS provision depends on employment status. Industry or employers are not willing to pay OHS for the last two groups of workers despite the requirements for a flexible labour force. On the other hand, occupational health belongs to the public health sphere, and functioning public health or primary health care could play a role in OHS for the unemployed or for workers with precarious employment.

**10.4.1 Market creation and competition for OHS**

The impact of the internal market on the organisation and financing of social and health care systems has been a concern to EU member states. A systematic evaluation of the impact of the internal market on these welfare system areas would be an asset. The deregulation of any welfare
state systems or services was due to requirements of creating a free market. The governments decreased the number of regulations based on market demand and decreased the funding of enforcement agencies based on the size and support of their activities. This deregulation was criticised by trade unions putting business interests and company profits ahead of worker health. The main argument from business is that the legislative framework is complicated and unclear. Companies think that there is too much legislation for companies to comply with, especially for SMEs. This can also be interpreted as a lack of capacity to manage occupational health and safety properly. The alternatives are state reregulation or state provision of economic incentives for businesses, especially SMEs, to comply with legislation in the free market. However, regulation is essential to ensure public safety and to promote quality standards despite the costs of enforcing regulations.

Competition is the main feature of markets and is debated in health and social policies. Reform through marketisation is a very different approach than the creation of integrated multidisciplinary OHS that covers the majority of workers. However, competition, contracting, outsourcing, and privatisation of OHS units to gain efficiency and effectiveness are associated with a naive concept of the market. The largest cost of OHS units is professionals, and so cost-effectiveness would lead to employing fewer professionals with lower competence. Most countries have tried to strengthen the role of prevention in occupational health because occupational health and safety systems created OHS for preventive and protective services for workers. However, the role of government in an individualistic society is currently less legitimate for health promotion due to deregulation based on the internal market. Alcohol, tobacco, medicine, and advertising are examples of such deregulation activities of the government, which seem to be contradictory and inconsistent in relation to health improvements. This is also related to the role of government in support of workplace health promotion. The ideological and material basis can be increasingly challenged because workplace health promotion mainly supports well-off citizens at work.

The purpose of health service reforms was to allocate resources more efficiently, innovatively, and in response to consumers’ preferences—while also maintaining equity. OHS is largely oriented to the market and paid by the employer (the Netherlands, Sweden, and the United Kingdom),
and governments seem not to pay attention to the discrepancies between competition and solidarity. There are triangular OHS arrangements among workers (patients), OHS units (providers; though OHS can be arranged by public health services or an insurance company, and there are non-profit as well as for-profit OHS units), and employers (payers to the government, insurance companies, or OHS companies). Thus an effective OHS policy discusses the triangular OHS arrangements through OHS financing, for example contributions by workers, employers, and the government (compensations to employers to organise OHS), and payments to OHS units by employers. The costs of organising OHS are born only to employers. Thus out-of-pocket payments by workers are not applicable in EU member states. Changes in these financing arrangements lead to changes of the OHS systems. Discussions of OHS systems focus, on the one hand, on competition among OHS providers and the methods used to compensate OHS by employers, and on the other hand, compensation for occupational diseases, injuries, accidents, and sick leaves. These issues are also related to effectiveness and efficiency of OHS to prevent such compensation needs. If a goal is equity in terms of universal coverage as a sign of solidarity, then EU member states need to pay attention to competition among various financing methods by employers and their impact on the organisation of OHS. This competition could take many forms. OHS providers compete with each other in relation to employers (paying or purchasing) and workers (if there is a possibility to select which OHS unit to consult with); and funding agencies (insurance companies or agencies, e.g., MUTUAS in Spain) compete for contributions made by employers.

Competition also occurs between the producers of occupational health sector goods and services, and the producers of OHS related goods and services, which workers or employers or OHS units might choose to buy. Such goods can be related to ergonomics, personal protection, and safety equipment for workers general health or rehabilitation.

121 The Community Charter of the Fundamental Social Rights of Workers states that in order to ensure equal treatment, it is important to combat every form of discrimination, including discrimination on grounds of sex, colour, race, opinions and beliefs, and whereas, in a spirit of solidarity, it is important to combat social exclusion. In addition the Charter underlines that ‘every worker of the European Community shall have a right to adequate social protection and shall, whatever and whatever the size of the undertaking in which he is employed, enjoy an adequate level of social security benefits.’
for example. Competition among funding agencies might significantly compromise equity and solidarity in sharing the financial burden of illness among workers. On the other hand, competition might improve efficiency, effectiveness, quality, and choices among financing agencies or OHS providers. There is a risk in introducing competition because it might also put solidarity and equity in OHS provisions at risk. The means to reduce the impact of insurers to select only good risks are caution, care of open mandatory enrolment, or an equalisation fund intended to counter the effects of risk selection. This is true in areas with risky work environments, such as construction sectors.

Because citizens can take their cases for judgement to the ECJ, its role has been increasing in the creation of occupational health policy and also in insurance markets. The ECJ has recently made a judgement on compulsory membership in a statutory work accident insurance body. The introduction of market mechanisms to insurance practices and institutions of occupational diseases, injuries, and risks in general promote competition among administrative institutions or the providers of benefits in kind. The compulsory sickness insurance funds in Germany now find themselves in competition with one another. A question arises concerning the quality of care provision and the evaluation of the activities of service providers. This requires the creation of new public law authorities for supervision of services and for regulation of insurance sectors.

**10.4.2 Changing OHS provisions**

The internal market policy barriers have been removed to promote trade, investment, freedom of establishment, and free movement of people with the mutual recognition of occupational health professionals, for example. The abolition of national regulations for occupational health professionals has no direct impact on how the OHS system is regulated at the national level. It only implies that occupational health professionals can practice their professions in other member states, which alters strategic opportunities and constraints for the domestic training of professionals, patient treatments, and service provisions in OHS. The policy impact is indirect via international regulatory competition; it could change the distribution of resources among domestic actors.
rather than affect the compatibility between EU and domestic policies. The indirect influence is hard to forecast and depends on who is empowered or disempowered (and how) by deregulation in EU member states. The direction might be between pro-reform and retrenchment of OHS systems.

A European OHS model is based on the framework directive and its implementation. The European OHS is for all workers in public and private sectors and has multidisciplinary staff with adequate training based on national requirements. The impact of internal markets on OHS has created a marketplace for employers to make competitive bids and to select the OHS unit that matches their own objectives. The basic OHS models are external or internal services of the companies, with specific features. Enterprises have increasingly outsourced activities outside their core business area, such as OHS. However, enterprises have noticed that outsourcing of services left them with less power to decide, influence, and control price development in needed services. Therefore, additional costs have emerged in managing the contracts among service suppliers, such OHS providers. Incremental and steadily and continuously changing circumstances for OHS might bring a vicious circle of compromises in long-term perspectives and might cause a collapse or minimisation of OHS.

One of the principal challenges in relation to OHS is providing OHS to all employees. An important equity and fundamental rights problem among EU member states lies in the difference between OHS provisions for private and public service employees. Also, public services should have an inspection system, penalties, and political sanctions with systematic and permanent monitoring of occupational health and safety situations. This is particularly important due to modernisation, privatisation, outsourcing, decentralisation, and efficiency demands on public sector employees (Vogel 1999).

Another important challenge is the workers in SMEs. The optimal model of OHS for SMEs contains on-site provision of services as well as services for groups of enterprises to extend the required services per SME. The optimal model would comprise statements on statutory provision, tasks of OHS, organisations and the staff, and required equipment. In the statutory provision, employers cover the costs and all employees are included in the OHS (Mehrtens et al. 1998). The increased coverage
10. CONCLUSIONS

for OHS in SMEs requires simplifications of regulations and legislation in order to handle specific features of SMEs. In addition, OHS professionals could be used more as advisors and consultants. Also, there should be incentive systems targeted at SMEs, which can focus on tax deductions on OHS investments and insurance premiums (Caillard 1998). Larger companies appreciate good OHS in SMEs, which encourage arrangements of SMEs to provide OHS for workers and favours SMEs to get orders from large companies (Clifton 1998). This is important because of changes in the environment for labour exploitation and new employment contracts (Walters 1996a,b,c).

Looking at the supply of OHS, a picture of considerable variation emerges in the level and the relative importance of OHS, both in preventive and protective services. In the Nordic countries, OHS coverage is relatively universal and OHS is relatively well institutionalised with strong national institutions, such as strong ministerial departments and national occupational health and safety institutions. Also, trade union density is high. In Bismarckian countries, OHS is a benefit that is related to the position in the labour market, and coverage is connected to large companies and high capital industries. Trade union density varies, but trade unions are especially powerful in Germany and France. The southern European countries have mixed welfare states because the responsibilities of welfare services are shared among family, church, and state. The reforms in health services and the decentralisation of administration towards regions and local communities have produced specific features. The devolution of power in Italy, Spain, Greece, and Portugal has not been completed since health reforms started. Institutionalisation of powers to lower administrative levels are devolving and institutions are developing (Guillem 2002, Guillem et al. 2002, 2003). The coverage of OHS is relatively low in southern Europe due to a large number of SMEs; and a lower number of salaried employees, mainly in traditional sectors (e.g., agriculture and fishing) and also in construction (lower than the average in the 15 EU member states) (Eurostat 2002, 2003b). Also, trade union density is low in the southern European countries, except Italy (European Foundation for the Improvement of Living and Working Conditions 2004). The approach in Anglo-Saxon welfare states can be characterised by universal health services but also a strong self-regulatory approach to health and safety at work. OHS has
a market-oriented approach with contracts of occupational health and safety professionals. Trade union density is low (European Foundation for the Improvement of Living and Working Conditions 2004), and their interests and influences on OHS are also low.

The social inequalities regarding access to health services are increasing due to competition, trade, and deregulatory pressures (Ollila et al. 2003). Wealthier, well-informed, and working populations will benefit from the extended rights to OHS and health care in general, and they will also have access to services in other EU member states. It is the role of occupational health policy makers to create conditions for OHS that will not weaken national occupational health goals; these conditions could include equity, universality, and access to OHS. Employees expect that OHS decisions are based on OHS priorities rather than on interests of equal treatment of service providers or the priorities of commercial actors. Even if equal treatment for entrepreneurs is important in competition, one also underlines continuity, sustainability, and foreseeable OHS from the perspectives of patients, professionals, and employers. In addition, the long-term development of OHS requires sustainability and human resource management, including sufficient and competent professionals. The danger is that equal treatment for entrepreneurs in competition takes priority over citizens’ rights for equal access to service and employers’ rights as service providers. Non-profit OHS units play a different role in service production than for-profit OHS units do. Large health service companies might dump prices to gain OHS market share, and soon large OHS chains will provide OHS within the framework of internal market and competition laws. The involvement of health service chains in the delivery of OHS has implications for OHS professionals and for the accountability of OHS systems. The question is whether countries have the regulatory framework in place to prevent malpractice cases or whether OHS is by default forgotten in the process.

In general, OHS is headed in the direction of greater units, a variety of services, and multidisciplinarianism by enforcement or by employer request. The member states have similar OHS challenges, but institutional diversity among EU member states remains. There are also greater demands of deregulation and decreased social protection costs for employers. Nevertheless the main sites for OHS reforms are at the national level, and these sites are shaped by supranational regulations.
and EU policy initiatives. One issue is subordinating domestic policy to EU directives, but other issues include learning about policy and the cooperation process among EU member states.

The government has its role to play in relation to often privately provided OHS. The government needs to keep its key inspection role (monitoring and statistics) to ensure that basic standards of health and safety at work are met. Usually, the economic sector is capable of raising standards of living and improving the quality of life, but it is incapable of delivering equity and social justice. The role of government is essential in policy, regulation, and legislation of OHS and its supporting services. Responsibility still remains within enterprises to ensure safe and healthy workplaces (Fingerhut 2003).

10.5 From occupational health to quality of work and life

The Health for All policy published by WHO in the 1980s made countries manage their health systems by setting targets and objectives. The trend of the next decade was to govern and manage by outcome results of service systems. For example, new public management emerged for public services, including OHS and health services in general. Recently, health policies have been guided by the concept of life politics introduced by Giddens (1991). This concept refers to the increased abilities to make choices about our lives, reflect upon our situations, and understand the long-term consequences of our actions. There is an issue of power in making decisions and choices on an individual basis, but this also has the potential for undermining public responsibility or public good in general. The concept of life politics reflects a new area of governance and polity beyond sectoral policy areas, and it makes health one of the policy issues that define quality of life. Health is rediscovered in the social policy area; and the impact of structural factors, such as economics and environment, on health is recognised. Health and social services are in an interface that brings restructuring and a new governance of modern societies; consumer orientation, third sector, and private sector all become involved in welfare services. There is also a political dimension of target setting in which health becomes a central component of the social
10. CONCLUSIONS

order and its governance (Kickbusch 2002). In addition, occupational health is facing an epidemiological shift towards new multiple risks and marketisation of OHS.

The changing labour market and work conditions have also changed the occupational health scene. There seems to be a transition from traditional occupational health diseases towards new risks and health issues, such as musculoskeletal diseases, mental illnesses, and psychosocial problems. Demographic changes and an ageing workforce have also enhanced the interest in maintaining and promoting health in the workplace. The health of citizens, or occupational health, is often seen as a social resource. Individuals, communities, enterprises, and societies can be empowered to build their capacity to improve health. This can be implemented by addressing health determinants as valued resources in workplaces, as well as in social organisations, for example (Kickbusch 2002). Another approach is to develop tools and methods to address the health effects of policies in areas other than health, such as social policy, employment policy, competition policy, and labour market policy. WHO and the EU have created tools to measure the policy impact on health through health impact assessments and through integrating health into other policies (Koivusalo, Santalahti 1999), for example, mainstreaming occupational health issues into other policies.

Health literacy and social capital are recognised as important items of societal development, and there is a call for investment in them at the community level in cities and municipalities. Some advanced and advancing companies also recognise that health among workers is good business for the company. One of the significant trends is viewing health as a product in the private market of health goods and services. People are becoming consumers of health in order to feel better, to reduce the effects of ageing, and to avoid being consumers in the ‘sickness business.’ The expanded health industry includes fitness, cosmetics, and health foods, as well as new types of health insurance to cover these specific expenditures (Kickbusch 2004). There also seem to be new demands on OHS to expand their services.

Occupational health becomes an ‘active added value’ as a sales promotion or as a supplement and product enhancement for employers and employees. Occupational health and safety systems and services are used to gain an advantage in personnel recruitment and to build an
image of a socially responsible company. Increasing the health literacy of consumers, by providing access to information on health and new health products or services, lay the foundation for ever greater business and markets. This is very much the aim of the EU as well, which at the moment emphasises the free movement of patients and their ability as consumers to make reliable decisions to select their health services. The EU launched the inauguration of a health portal in 2005, which followed the launching of European health card in 2003. The move is to ‘fix the health problems,’ for example, to create health. Who decides what information is provided, its relevance, and its accuracy in relation to values, ethics, and norms?

The major question in the marketisation of OHS is equity. The wellness industry and private occupational health services grow, but the public health sector has a critical shortage of public funding at all levels and so health gaps are widening. Cuts in public sectors reduce prevention, health education, and health promotion for the poor and unemployed (Kickbusch 2004). The retrenchment of public health services, including OHS, weakens governmental possibilities to regulate harmful goods and services due to lack of resources. A challenge to the future of occupational health prevention and promotion lies in ending the inequalities in health care by creating strategies to control the private sector. In OHS, the questions of occupational health and service provisions are related to additional services that are based on health concerns of workers and professions. In public health and the health marketplace, one has to question what social, political, and financial prices will be paid for better health as individuals and nations.
European integration has been studied from at least three different perspectives. First, European comparative studies have tried to find out how European societies differ from each other, such as the different models of the welfare state. On the other hand, some comparative studies have also shown how the social structures of European societies have been converging towards each other. Second, some integration studies of European countries have researched the relations among nations or the relations between European supranational organisations and national actors. Third, a few holistic studies have analysed Europe as an integrated social system with its own structures and dynamics (Nieminen 2005). In addition, commercial opinion polls and barometers in different countries bring comparative information. This information might lead to institution building in other areas, such as around the European Foundation for Improving Working and Living Conditions or the European Agency for Health and Safety at Work. They conduct regular surveys in various fields of working life and make comparative statements about EU member states or between EU member states and candidate countries or EFTA countries. Also, the OECD, WHO, and the ILO have used their collected information to publish reports, in which countries are compared by various variables and issues. The OECD also compares three global economic powers: Japan, the EU, and the United States.

International organisations are funded by their member states, and they have been seen as servants for national governments for a long time. Nevertheless, the current key issue is whether or not these supranational and international organisations have lives of their own, beyond the reach of the national governments. International organisations can be seen as
tools for the most powerful states or as autonomous bodies that address and develop policies relevant to global issues. National sovereignty and supranational governance are occasionally at odds on several issues, when initiatives of international organisations are transforming international society. However, the political dialogue about the social policy of the future is beyond the political thinking or political capacity of the states. International organisations are making political decisions that affect and influence global social policy-making (Deacon 1997). The direct influence of the ILO or WHO on OHS is still relatively weak; but policies of other organisations, such as EU industrial or trade policies, have a strong influence on OHS in EU member states.

The expansion of the EU has been rapid. In 1995, Austria, Finland, and Sweden joined the EU. The enlargement process was intensive and came to include ten new member states in May of 2004. The disparities between older EU member states and new member states in health, social, and industrial relations issues are remarkable. There has been an enormous amount of discussion about differences in social, health, and labour market issues in relation to productivity, competition, and the four freedoms. Nevertheless, EU expansion brought ambiguities and an increasingly complex situation about different policies and their implementation to new member states. The expansion brought many opportunities for mutual learning, improvements for health attainment and health system reforms, opportunities for accelerated progress, and risks in relation to trade and health (McKee et al. 2004).

The main aim of the EU is to create a common market. There was an ambition to create a social market economy based on the treaty establishing a Constitution for Europe in 2004, but the Constitution was turned down. The proposed Constitution would have significantly reoriented public health in the EU (Koivusalo 2003a, Koivusalo 2003b, Belcher et al. 2003, Hämäläinen et al. 2004). Instead, the new treaty – essentially a repackaging of most of the draft Constitution – is set to be finalised by the end of 2007 with one year for ratification, and is to come into force by mid-2009.

The EC also proposed a directive on services of the internal markets (COM (2004) 2). The directive aimed to remove barriers that allow companies to set up their services in other territories. The directive covers all services provided to consumers and businesses except 'non-economic'
services of general interest (welfare provisions, state schools, and health care services). Nevertheless the question is how to define boundaries for health services because health professionals, products (equipment and medication), and capital investments are already moving in the health sector. Therefore the pressure to create an internal market for health services remains.

In general, decisions in the EU are based on the common market idea instead of being based on people, citizens, or other ideological views. The Lisbon strategy, which aims to make the European Union 'the most dynamic and competitive knowledge-based economy in the world' by 2010, had a mid-term evaluation in 2004. The Commission announced a new start for the Lisbon strategy in February 2005, which included emphasis on the creation of workplaces and economic growth. The social dimension was considered as a subordinate to economic growth and the creation of more jobs, rather than the third corner of the triangle.
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In Helsinki between the years 2002–2008.

Riitta-Maija Hämäläinen
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**Council of Europe**


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Charters

European Council
14. LIST OF PUBLICATIONS OF INTERNATIONAL ORGANISATIONS


Council meetings


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**Recommendations**

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15 ABBREVIATIONS

ACSHH Advisory Committee on Safety, Hygiene and Health Protection at Work
CEC European Confederation of Executives and Managerial Staff
CEEP European Centre of Enterprises with Public Participation and of Enterprises of General Economic Interests
CESI European Confederation of Independent Trade Unions
CFSP Common Foreign and Security Policy
COREPER Permanent Representative Committee
EC European Community
ECHP European Community Household Panel
ECJ European Court of Justice
ECOSOC European Economic and Social Committee
ECSC European Coal and Steel Community
EEC European Economic Community
ECHP European Community Household Panel
EFTA European Free Trade Association
EMU European Monetary Union
EODS European Occupational Diseases Statistics
ESAWARE European statistical report on accident at work
ESC The Economic and Social Committe
ESFE European Sectoral Federation of Employers
ESWC European Survey on Working Conditions
ETUC European Trade Union Confederation
ETUI European Trade Union Institute
15. ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>EURATOM</td>
<td>European Atomic Energy Community</td>
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<tr>
<td>EUROCADRES/CEC</td>
<td>The Council of European Professional and Managerial Staff</td>
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<tr>
<td>GPHESME</td>
<td>Good Practice in Health, Environment and Safety Management in Enterprises</td>
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<td>HELA</td>
<td>Health and Safety Executive/Local Authority Enforcement Liaison Committee</td>
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<td>HESM</td>
<td>Health, environment, and safety management</td>
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<td>HFA</td>
<td>Health for All</td>
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<td>HSA</td>
<td>Health and Safety Authority, Ireland</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<td>ICOH</td>
<td>International Commission of Occupational Health</td>
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<td>IGC</td>
<td>Intergovernmental Conference</td>
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<td>INAIL</td>
<td>Workers Compensation Authority</td>
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<td>JHA</td>
<td>Justice and Home Affairs</td>
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<td>LFS</td>
<td>The European Union Labour Force Survey</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OEEC</td>
<td>Organisation for European Economic Co-operation</td>
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<tr>
<td>OHS</td>
<td>Occupational Health Services</td>
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<td>OMC</td>
<td>Open method of coordination</td>
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<td>QM</td>
<td>Quality Management</td>
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<tr>
<td>SALTSA</td>
<td>The Joint Programme for Working Life Research in Europe, Sweden</td>
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<td>SEA</td>
<td>Single European Act</td>
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<td>SHST</td>
<td>Security, Hygiene and Health at Work</td>
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<td>SME</td>
<td>Small and Medium Enterprise</td>
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<tr>
<td>SPC</td>
<td>Social Protection Committee</td>
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<td>TQM</td>
<td>Total quality management</td>
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<td>TUTB</td>
<td>European Trade Union Technical Bureau for Health and Safety</td>
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<td>UEMS</td>
<td>European Union of Medical Specialists</td>
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<tr>
<td>UEAPME</td>
<td>European Association of Craft and Small and Medium-sized Enterprises</td>
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<td>UN</td>
<td>United Nations</td>
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**15. ABBREVIATIONS**

<table>
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<th>Abbreviation</th>
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<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
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<td>UNICE</td>
<td>Union of Industrial and Employers’ Confederation of Europe</td>
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<tr>
<td>UNIDO</td>
<td>United Nations Industrial Development Organisation</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>WTO</td>
<td>World Trade Organisation</td>
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16 APPENDICES I–VI

APPENDIX I  Interview protocol
APPENDIX II  Major institutions related to OHS
APPENDIX III  List of laws concerning OHS
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APPENDIX V  Schematic timeline of EU policies in relation to occupational health and safety policy
APPENDIX VI  Typologies of welfare states and EU member states
16/I

Interview protocol
Dear ‘name of person’,

The Finnish Institute of Occupational Health is conducting a survey titled ‘Survey of quality and effectiveness of occupational health services in EU countries and Norway and Switzerland’. The survey is funded by the National Institute for Working Life, Solna, Sweden in collaboration with SALTSA (A joint Programme for Working Life Research in Europe) until April 2000. The additional funding for the continuation will be applied from the same source as well as from European Commission programmes.

The objectives of the survey are the following:

a) what kind of indicators are used to evaluate input, output, outcome and the impact of occupational health services

b) how are occupational health services, especially quality management systems incorporated in the enterprises’ management systems in different kind of enterprises

c) what is the role and which are the strategies of occupational health services in maintaining and developing employees work ability

d) Did the EU Framework Directive 89/391 make an impact on national legislation or regulations with respect to scope, role and tasks of occupational health services and on scope, priority setting, strategies and quality aspects of occupational health services practice on the enterprise level?

e) Form a network for research and development on quality of occupational health services.

We would like to ask your participation into the survey as an international contact group member to let different international organizations
to share views and opinions with National contact groups. We have invited partners from each country to support our survey by providing information and organize interviews with relevant authorities and OHS. The National collaborating group (5-6 persons) with representatives from trade unions, enterprise level occupational health services and government representatives to provide the information according to the objectives of the survey.

You are kindly invited to participate into meeting to be held in Amsterdam September 10-11, 1999. Also one representative from each country will be invited to the meeting to discuss further the cooperation and to form the network in occupational health services and quality management.

The interviews on the national level will be conducted in the autumn 1999 as well as surveys in three to five occupational health service posts according to the protocol provided by the researcher team (Professor Kaj Husman, Ms Riitta-Maija Hääläinen, Dr Kimmo Räsänen, and Professor Peter Westerholm).

Please do not hesitate to contact us if you require further information.

We are looking forward hearing from you to establish fruitful cooperation.

**Riitta-Maija Hääläinen**
**Researcher**
Finnish Institute of Occupational Health
R&D Centre for Occupational Health Services
Topeliuksenkatu 41 a A
FIN-00250 Helsinki
Tel. 358-9-4747 850 Fax 358-9-4583 092
e-mail: riitta-maija.hamalainen@occuphealth.fi
Dear Sir/Madam,

The Finnish Institute of Occupational Health is conducting a survey titled ‘Survey of quality and effectiveness of occupational health services in EU countries and Norway and Switzerland’. The survey is funded by the National Institute for Working Life, Solna, Sweden in collaboration with SALTSA (A joint Programme for Working Life Research in Europe) until April 2000. The additional funding for the continuation will be applied from the same source as well as from European Commission programmes.

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d) Did the EU Framework Directive 89/391 make an impact on national legislation or regulations with respect to scope, role and tasks of occupational health services and on scope, priority setting, strategies and quality aspects of occupational health services practice on the enterprise level?

e) Form a network for research and development on quality of occupational health services.
We are looking for partners from each country to support our survey by providing information and organize interviews with relevant authorities and OHS. We kindly ask you to form a national collaborating group (5-6 persons) with representatives from trade unions, enterprise level occupational health services and government representatives to provide the information according to the objectives of the survey.

One representative from each country will be invited to the meeting (travel by APEX and accommodation provided) to be held in Amsterdam 10-11.9.1999 to discuss further the cooperation and to form the network in occupational health services and quality management.

The interviews on the national level will be conducted in the autumn 1999 as well as surveys in three to five occupational health service posts according to the protocol provided by the researcher team (Professor Kaj Husman, Ms Riitta-Maija Hämäläinen, Dr Kimmo Räsänen, and Professor Peter Westerholm).

If you feel that you are unable to participate into the survey, please forward this letter to another person who could possibly become our partner. Let us know your decision to the following address:

Finnish Institute of Occupational Health
R&D Centre for Occupational Health Services
Riitta-Maija Hämäläinen
Topeliuksenkatu 41 a A
FIN-00250 Helsinki
Tel. 358-9-4747 850 Fax 358-9-4583 092
e-mail: riitta-maija.hamalainen@occuphealth.fi

Please do not hesitate to contact us if you require further information.

We are looking forward hearing from you to establish fruitful cooperation.

Riitta-Maija Hämäläinen
Researcher
Guidelines for Interviews 15.9.1999

National level guidelines for interviews

The Finnish Institute of Occupational Health (FIOH) is conducting a survey titled ‘Survey of quality and effectiveness of occupational health services in EU countries and Norway and Switzerland’. The survey is funded by the National Institute for Working Life, Solna, Sweden in collaboration with SALTSA (A Joint Programme for Working Life Research in Europe) until April 2000. The report will be published in the end of April, 2000.

The objectives of the survey are the following:

a) what kind of indicators are used to evaluate input, output, outcome and the impact of occupational health services

b) how are occupational health services, especially quality management systems incorporated in the enterprises’ management systems in different kind of enterprises

c) what is the role and which are the strategies of occupational health services in maintaining and developing employees work ability

d) Did the EU Framework Directive 89/391 make an impact on national legislation or regulations with respect to scope, role and tasks of occupational health services and on scope, priority setting, strategies and quality aspects of occupational health services practice on the enterprise level?

In each country the researcher group (Professor Kaj Husman, Ms Riitta-Maija Hämäläinen, Dr Kimmo Räsänen, Professor Peter Westerholm) has the National Collaborating Persons to support and contribute to the survey by providing information and organising interviews with relevant authorities and OHS units.
The interviews will be conducted by Ms Riitta-Maija Hämäläinen, FIOH, on the national level (ministries, trade union, research institutes, professional organisations, universities etc) in each participating countries in the autumn 1999. The choice of interviewed persons is under the judgement of the National Contact Persons.

For the interviews the questions will be sent beforehand to the persons to be interviewed by the National Collaborating Persons. The researchers would like to tape record the interviews to increase reliability and confirm notes with the information provided in the interview. If person refuses tape recording, the interview will be recorded by writing. The interview takes about one hour per person and will be conducted in English.

All names of participants will be mentioned in the final report. If you don’t want to be mentioned, please let us know.

Sincerely yours

Riitta-Maija Hämäläinen
Researcher
E-mail: riitta-maija.hamalainen@occuphealth.fi
A: Structure of health care and occupational health care systems
Please explain how is the health care organised in your country
Could you write or give organigramme of your health care system?
How is health care system organised in regional and local levels?
How is the financing of health care organised?
What are the legislative prerequisites for national health care system?

Please explain how the OHS are organised in your country
Could you write or give organigramme of your OHS?
How is OHS organised in regional and local levels?
How is the financing of OHS organised?

B. Legislation
What are legislative prerequisites for occupational health services in your country? What are legislative prerequisites for the OHS quality management system?
Is the ILO Convention no 161 ratified and applied in your country? Are ILO Recommendations no 170 followed up in your country? In the ILO Convention no 161 on OHS the importance of a professional independence of the OHS is emphasised. How do you assess the professional independence of OHS in your country?

C. Policy
Is there a clear governmental policy statement towards OHS? Is there governmental policy statement on OHS quality management? What
are the objectives and aims of the policy? Are there any enforcement structures or deadlines for application of OHS/QM? Is the certification of OHS/QM voluntary or enforced by law or regulations? Are there OHS QM certification bodies that are internationally recognised in your country?

D. Stakeholders
Which are the relevant research institutes to participate in development of OHS and do they participate sufficiently? How do they participate? Who are the other stakeholders and how do they participate? Are there regular Committees, meetings, and workgroups dealing with OHS matters or QM matters of OHS on national/regional levels in your country? Do your research institute participate?

F. Planning and implementation of OHS and OHS/QM
What are major tools to monitor and evaluate effectiveness of OHS used by governmental agencies? Employers and employees? Is there a well-established mechanism for OHS to demonstrate their effectiveness or quality management? Are objectives and timeframes for OHS quality management development defined clearly in your country? Are the most relevant national stakeholders informed and committed to promote OHS quality management? Are concrete action plans or activities formulated and communicated publicly? Who takes appropriate action to design and implement quality management systems for occupational health services on national level/regional level/local level? Is there an agency responsible for the coordination of OHS QM activities in the national system?

G. Monitoring, inspection, and evaluation
What is a definition of quality management in your country? What are measures of effectiveness in your country? Who is responsible to implement the inspection of occupational health services? Is there OHS system evaluation with input, process, output and outcome indicators? Is there inspection of quality management, if QM is driven by legislation?
H. How is the implementation of OHS and OHS/QM monitored?
To what extent is the Article 7 of the EU Framework Directive (89/391/EEC) on improvement of safety and health of workers implemented?
To what extent the quality issues are taken into consideration?
Are the national OHS/QM plans regularly evaluated and updated?
Has the legislation for OHS and QM been evaluated?
Is monitoring and evaluation an integral part of target setting and activity planning in OHS QM?
Is there a periodic external verification of the activities undertaken, the progress being made and the difficulties encountered with respect to OHS QM? To whom is this information communicated?
Is there a periodical evaluation/progress report of the national OHS QM?
What kind of statistics is collected in relation to OHS QM?

I. Financing of OHS
How is the financing of occupational health services provided? Funding by the state? Funding by employers? Funding by public social security agencies? Funding by insurance companies?
How the insurance practices determine organisation and use of occupational health services? Does employer get reimbursement of illnesses and what is the level of reimbursement?
Is there national enforcement and penalty structure to contribute to promotion of OHS and OHS/QM?

J. Integration of OHS
Are policy and objectives of OHS QM integrated into other policy areas (labour policies, health care policies etc)?

K. Promotion of OHS and OHS/QM
What concrete steps are taken to promote OHS QM by the stakeholders (guidelines, good OHS practices etc)?
Are national education and information sessions organised to promote OHS QM?
Are there any means to catalyse, facilitate and support the implementation of OHS QM in enterprises and/or OHS units? Are major companies implementing OHS QM systems in their OHS units? What kind of OHS QM systems and instruments are recommended at the national level at the moment? What is the proportion of enterprises/OHS Units using promoted key systems, instruments and tools?

Are universities and other research centres involved in development and dissemination of OHS QM? Are databases and information systems available to support decision-making in QM tools by the various key actors? Are other key actors taking initiatives to promote OHS QM than the government? What percentage of enterprises/OHS units are complying with legal OHS QM requirements? Has a network been established consisting of a communication system and summarising the capacities of participating agents in QM? How many inspections/certifications of OHS QM have been carried out per year? What is the total number of certified OHS QM (in numbers and %)?

What kind of plans are there for continuous quality management?

L. Training of OHS personnel

Which organisations are responsible for the education and training in your country of occupational health professionals? What kind of occupational groups are working in OHS? Are there training centres for various professional groups? To which professional groups? What kind of training is organised by these centres? Who accredits training? How is the training of OHS updated?

Are there legislation-based requirements for OHS personnel training and qualifications? Are there registers for persons qualified to OHS?

How long is the training for different occupational groups in OHS? What is the content of training?
How is occupational health professionals involved in education development processes? How are trade unions involved in training development?

In international conventions and in ILO and WHO documents on OHS the multidisciplinary competence and functioning of OHS is emphasised as important. Is the OHS in your country satisfying this criterions of multidiscipline?

M. Indicators for the impact on the occupational health (effectiveness and efficiency)

- Health determinants: are usually the following: working conditions, inherent factors (materials, processes, products), exposures or burden/emissions, factors determining the susceptibility of the human risks, life style determinants, environmental determinants

Are the above-mentioned statistics collected regularly? Who collects and compiles them for what purpose?

- Health outcomes, such as occupational diseases and injuries, work-related occupational diseases and injuries, chronic diseases affecting working ability, life expectancy of different professional groups and premature retirement

Is the above mentioned health outcomes followed on the individual, enterprise, sector or societal levels?

How systematic is the follow up? Give examples, please!

How much are these results used to improve processes and activities in OHS?

How the information is processed and how the results are used? To whom are the results distributed?

N. Workplace health promotion

What is your concept about workplace health promotion? What is included in workplace health promotion? Is workplace health promotion in any role in occupational health service in your country? What is the role and strategies of occupational health services in workplace health promotion?
O. Overall impact of OHS
Why the decision to develop a quality management system was made and who did the decision?
Are the tasks and performance of OHS those that are expected and wanted by employers and employees? What is the impact of OHS to the health of population? Where is the limit of impact of OHS in relation to health of workers?

Your opinion
Are occupational health professionals happy with what they are doing?
What is your personal assessment of the OHS organisation in your country with regard to the following value criteria?
• Coverage? Access? Equity?
• Orientation to customers/clients needs?
• Focus on preventive action at workplaces?
• Effects on health, work capacity and productivity of enterprises?
• Professional ethical standards?
• Cost-effectiveness? -Cost-efficiency?
• Professional competence?
16/II

Major institutions related to OHS
The major European level institutions are the European Council, Council of the EU, European Parliament, European Commission and European Court of Justice. The powers of these institutions vary based on the nature of the task and extent of power given by the Treaty.

The European Council consists of the heads of State or Government of the member states and the President of the European Commission. The European Council meets at least twice a year, generally in June and December, when it is presided over by the Head of State or Government of the Member State holding the Presidency of the Council. The decisions taken at the European Council meetings are a major impetus in defining the general political guidelines of the European Union. After each summit meeting the President of the European Council reports to the European Parliament (Nelsen, Stubb 1998, Raunio, Wiberg 1998, Andersen, Eliassen 2001). The decision made by the European Council may be categorised for broad guidelines and policy initiative, review of the economic situation, coordination of external relations and negotiation on constitutional reforms (Andersen, Eliassen 2001).

The Council of the European Union is the Community’s legislative body and it exercises these legislative and budgetary powers in co-decision with the European Parliament. The role of the Council includes also negotiation on compromises and discussion on an intergovernmental forum. The Council of the European Union is based in Brussels and is formed of the different ministers in different areas and composition may change depending on the matters and ministers’ competencies under decision making. There are no permanent members of the Council. The frequency of specific Council meetings varies according to the urgency of the subjects dealt with, but usually twice during the half year presidency. Meetings of the specific Council are convened by its President on his/her own initiative, at the request of its members or at the request
of the Commission. In the decision making the majority voting in the Council is the rule. Unanimity is required for decision on taxes, the free movement of workers, or the rights and obligations of employees. The decision making concerning common foreign and security policy and cooperation in justice and home affairs takes place outside the European Communities and mainly between individual countries (Raunio, Wiberg 1999). The Ministers of Health or Social Affairs from member states attend each Council meeting of Employment, Social Policy, Health and Consumer Affairs in what also matters of health and safety at work are on the agenda.

The General Secretariat of the Council of EU provides continuity to the work of different institutions, Councils and member states. The General Secretariat's main responsibility is to prepare the meetings of the European Council, and of the Council of the European Union and its preparatory bodies, namely the Permanent Representatives Committee (COREPER), and about 250 Committees including Social Protection Committee (SPC) and the Working Party on Public Health among others (Wiberg 1998). About 85% of the decisions are agreed at the COREPER or working groups despite the possibility for majority voting in the Council.

The European Parliament represents the people of the EU member states. The task of the European Parliament is to make decisions through cooperation procedure and co-decision procedure with the Council of the European Union. The Parliament also accepts the budget and programmes using its influence on different policies, also in the area of public health. The Parliament implements its supervisory power by examining a large number of reports on the implementation of policies, legislation and the budget, including health. The Committees, such as Social and Employment, and Environment, Health and Consumer protection are important for health and safety at work issues. The rapporteur in preparation of consideration (memorandum) has an important role to influence on the opinions given to and by the European Parliament (Raunio 1998, Goetz, Hix 2001).
European Court of Justice

The Court of Justice (ECJ) consists of 15 judges and 8 Advocates General. Each member state sends one judge. The Court of Justice is the highest and the sole judicial authority in matters of Community law. Its task is to 'ensure that the interpretation of the Treaty law is observed', ruling on conflicts between the institutions or between institutions and member states or ruling on implementation of EU legislation (Dehousse 1998). The ECJ has played a major role in shaping the EU legal system and the balance of power in the policy-making process.

From the legal point of view the ECJ has been the key for the constitutional and political development of the EU. ECJ has deepened legal and institutional integration between the member states through its processes and interpretation of the Treaty increasing EU legal competencies, overriding national legal provision, making Community law to become part and parcel of national legislation and increasing its own competence. ECJ continues to play an important role in developing European case law on social and health policy matters (Teague 2000).

In practice the implementation means that the legislation has been transposed correctly into the national legislation of the member state. In that sense the application of legislation can be divided into actual application, administrative implementation or implementation. Legal implementation usually refers to incorporation of legislation into national law. The Commission is however interested in the implementation although the responsibility is under the EU member states. The Community reach the national level in certain areas in certain conditions. First individuals and corporation can complain the Commission or European Court of Justice on non-compliance with EC law. The Commission can take its own initiative in the area of Internal Market in which it has mandate to act based on the Treaty. As the Commission is seeking to have an impact in ever larger areas of EC policy the frequency of non-implementation or problematic implementation is increasing (Andersen, Eliassen 1993).
The European Commission

The European Commission consists currently in 2005 of 25 members. The Commission is headed by a president, who is assisted by two vice-presidents. The responsibilities of the Commission include initiatives for the further development of Community policy, monitoring observance and proper application of the Community law, administering and implementing Community legislation and representing the Community in international organisations. The Commission presents proposals and drafts for the Community legislation to the Council. The Council and the Parliament may ask the Commission to draw up proposals, but the Commission has the primary power to initiate legislation in certain areas (such as the EC budget, the Structural Funds, measures to tackle tax discrimination, provision of funds, and safeguard clauses) (Goetz, Hix 2001, Andersen, Eliassen 1993, 2001, Wallace, Wallace 1996). The Commission’s role on the European Community policies in the EC pillar may be summed as an executive role as presenting proposals, a bureaucratic role as drawing up legislation and a regulatory role (Andersen, Eliassen 2001).

Directorate General of Employment and Social Affairs, section of Health and Safety at Work in the European Commission

The main policy areas of Directorate General of Employment and Social Affairs, section of Health and Safety at Work in the European Commission are employment and working life policy, including labour standards, the modernisation of work and development of social dialogue. Other policy areas are social protection, social inclusion, equality between men and women as well as equal opportunities and anti-discrimination (www.europa.eu.int).

The Council set up an Advisory Committee on Safety, Hygiene and Health Protection at Work in 1974 with representatives from national trade unions and employers’ organisations and governments. The tasks included training, research, data collection, special hazards and harmonisation of regulations for products and processes, for example (Hantrais 1995).
The new Advisory Committee on Safety and Health at Work replaced the Advisory Committee on Safety, Hygiene and Health Protection at Work (ACSHH) and the Safety and Health Commission for the Mining and other Extractive Industries (Decision by the Council of the EU 2004). As a standing body, the Advisory Committee assist the Commission in the preparation and implementation of activities in the area of safety and health at work. It facilitates cooperation between national administration, trade unions and employers’ organisations. This is performed in collaboration with the European Agency for Safety and Health at Work in Bilbao.

The tasks of the advisory committee include exchange views and experiences on existing or planned regulations, support the creation of a common approach to problems in the fields of safety and health at work, and identify Community priorities and the measures necessary for implementing them. The Advisory Committee will also highlight for the Commission areas in which there is an apparent need for new knowledge and suitable training and research measures and define the criteria and aims for preventing accidents at work and health hazards within companies, methods enabling companies and employees to evaluate and improve protection levels and give an opinion on proposals for Community initiatives (COM (2003) 346).

The committee cover both the public and private sectors. The composition of the committee should reflect the various economic sectors and the proportion of women and men in the working population. The committee will act as a tripartite body. It will consist of three full members for each Member State, i.e. one representative for each of the national governments, trade unions and employers’ organisations. Two alternate members may be appointed for each full member (COM (2003) 346).

The Committee will be chaired by the Commission’s Director General for employment and social affairs. The Chair has no vote. The European Foundation for the Improvement of Living and Working Conditions will act as an observer for the new committee. A Foundation representative will report to these meetings on ongoing work (COM (2003) 346 final), thus ensuring the continuation of the established cooperation between the ACSHH and the Foundation.
The major decisions concerning EU social policy or OHS are made in the Council of the EU. Under the unanimity rule in the core area of social policy, one country is able to block EU decision-making. The important issue is which decisions on social, health, labour or other policies are made under unanimity, qualified majority or co-decision procedures. Different processes give possibilities and opportunities to influence on the content of policy, directive or recommendations. The major part of influence is however made during the process of preparation in different committees, expert groups or workgroups in the Council or under the chairmanship of the Commission. The Commission makes initiatives and coordinates different expert and working groups in the Directorates General Social Affairs and Employment or Health and Consumer Affairs.

**European Foundation for the Improvement of Living and Working Conditions**

The European Foundation for the Improvement of Living and Working Conditions was established by a Regulation of the Council of Ministers in 1975. The increasing interest and worry on pollutions over boarders and living and working conditions encourages the Commission to set up the Foundation and its tasks were to disseminate knowledge on a systematic and scientific basis and other consequences of economic development, environmental quality and social and regional disparities to living and working conditions. Its role was to advise the Community and policy-makers with appropriate information and guidelines (Regulation No 1365/75).

The Administrative Board is made up of representatives of the governments and the social partners (the employers and trade unions) and is responsible for the development of the Foundation's work programme. The aim of the Foundation is to contribute to the planning and establishment of better living and working conditions through action designed to increase and disseminate knowledge likely to assist this development. The tasks of the Foundation are to develop and to pursue ideas on the medium and long-term improvement of living and working conditions in the light of practical experience and to identify factors leading to change. As regards the improvement of living and working
16. APPENDICES

conditions, it deals more specifically with the following issues: man at
work, organisation of work and particularly job design, problems peculiar
to certain categories of workers, long-term aspects of improvement of
the environment and distribution of human activities in space and in

The Foundation acts as an observer in the Advisory Committee on
Safety and Health at Work. A Foundation representative reports to this
Committee on the work of the Foundation (COM (2003) 346 final).
The work of Foundation contributes to industrial relations, working
conditions, living conditions and to good quality of working life to-
gether with the promotion of employment and entrepreneurship. The
promotion of quality of work means ensuring career and employment
security, maintaining the health and well-being of workers, developing
skills and competences, and reconciling a work-life balance. The Founda-
tion conducts its research work with national correspondents and leads
several European wide surveys, such as European working conditions

European Agency for Safety and Health at Work

The decision to set up an Agency for safety and Health at Work was
establishing the Agency was adopted by Council in July 1994. The Board
includes representatives of EU member states and a representative of
both employers and employees from each member state. The Agency's
objective is to encourage improvements in the working environment
through the Community bodies, the member states and those involved
in health and safety at work with the technical, scientific and economic
information for the use in the field of safety and health at work.

The European Agency for Safety and Health at Work is a complex
network organisation working with various groups and bodies. The
European Agency has set up a safety and health information network
made up of a 'Focal Point' in each EU member state. They are respon-
sible for the organisation and coordination of the national networks
and participate in the preparation and implementation of the Agency's
Work Programme. As with the other elements of the Agency structure,
these networks are tripartite, i.e. include representation from workers'
and employers' groups.
The Expert Groups consist of experts from each member state, nominated by the national Focal Point. In addition, there are three experts as observers, two representing the social partners and one the Commission. The role of the groups is to provide advice to the Agency in their field of expertise and to contribute to the Agency’s Work Programmes. Groups of experts, nominated by the national Focal Point together with observers representing each of the social partners and the Commission, provide advice to the Agency in their field of expertise and contribute to the Agency’s Work Programmes. Experts from EFTA countries participate as observers in some of the groups.

Thematic Network Groups (TNGs) are ad hoc networks of experts convened on a particular topic. Their tasks include advising the Agency in the identification and collection of information and on ways to improve practices in occupational health and safety areas; monitoring the work of the Topic Centres and ensuring avoidance of overlap with other activities. To date, four TNGs have been set up according to the 4 key activity areas of the Agency’s information projects, under the headings of ‘Occupational Health and Safety Monitoring’, ‘Occupational Health and Safety Systems and Programmes’, ‘Good Safety and Health Practice’ and ‘Research on Work and Health’. (www.osha.eu.int 2/2003). Topic Centres are consortia of national safety and health institutions to collect and analyse existing national data to support key areas of our work programme. They consist of a group of Occupational Health and Safety-expert institutions comprising one Lead Organisation and several Partner Organisations from different Member States. The work to be done and the funding available are specified in line with the Agency’s annual Work Programme. Three Topic Centres are currently in operation: Topic Centre on Research, Topic Centre on Good Practice and Topic Centre Good Practice Candidate Countries (www.osha.eu.int 5/2004).

**World Health Organization Regional Office for Europe**

The WHO Regional Office for Europe focuses its work to identify environmental health priorities in the European Region and to assess health risks. The Office also provides strategic guidance to regulatory authorities and builds capacity in the Member States for a scientifically-sound environmental health risk assessment. Its role is to develop
guidelines and normative information for standard-setting based on the best available scientific information.

Good practice in health, environment and safety management in enterprises has been leading topic of international conferences. OHS have important role in achieving good practice in health, environment and safety management in enterprises. Good Practice in Health, Environment and Safety Management in Enterprises (GPHESME) has been defined as a process of continuous improvement of health, environment and safety performance involving stakeholders inside and outside of the enterprise. Development of common criteria and indicators of GPHESME are priorities for international, national and local organizations. WHO jointly with other international organizations is expected to prepare set of criteria and indicators (WHO 1999c, Baranski 2003).

International Labour Organisation

The International Labour Organisation seeks to promote social justice and internationally recognised human and labour Rights through unique tripartite structure. The ILO formulates international labour standards in the form of Conventions and Recommendations setting minimum standards of basic labour rights: freedom of association, the right to organise, collective bargaining, abolition of forced labour, equality of opportunity and treatment, and other standards regulating conditions across the entire spectrum of work related issues. It provides technical assistance primarily in the fields of vocational training and vocational rehabilitation; employment policy; labour administration; labour law and industrial relations; working conditions; management development; cooperatives; social security; labour statistics and occupational safety and health. It promotes the development of independent employers’ and workers’ organisations and provides training and advisory services to those organisations (www.ilo.org).

The main focus of the ILO is to provide international guidelines and legal frameworks for the development of occupational health policies and infrastructures on a tripartite basis and practical support for the improvement in the workplace. ILO conventions, recommendations and resolutions in the occupational safety and health field represent international agreements between nations on issues affecting workers'
There are more than 60 international agreements to protect and promote workers’ health and improve working conditions and working environment (www.ilo.org).

Since its founding in 1919, the ILO has attempted to link increased trade with common labour and social standards. Through ILO conventions the governments can be persuaded to sign up and ratify conventions of good practice and after ratification of conventions ILO has power to seek an enforcement of them. ILO was able to support UN to convert 1948 Declaration of Human Rights into the 1966 Covenant on Economics, Social and Cultural Rights. Articles 6-10 covered the rights to work, to decent conditions and to strike and importantly (Article 9) to social security and (Article 10) the right of families to social protection and social assistance (Deacon 1997). In the internal working of ILO is tripartism that good governance requires consensus of industry, workers and government.

The ILO is oriented towards European welfare policy. The ILO favours state social security against a mixed state/private system. Some mix provisions are acceptable to agree with basic Bismarckian structure. Another challenge for the ILO is to hold the line for wage related social security when such policy increasingly reflects the interests of a reducing number of citizens. Flexible employment and globalisation creates threat to the ILO and its conventions on labour standards. The ILO is committed to promote universal coverage of at least a minimum set of protections, such as occupational safety. Competitive free trade agreements test the capacity and skills of the ILO to include into the agreements social clause to guard against social cost cutting (Deacon 1997).

The ILO SafeWork programme prepares preventive policies and programmes to protect workers in hazardous occupations and sectors to vulnerable groups of workers falling outside the scope of traditional protective measures. The programme considers governments and employers’ and workers’ organisations as best equipped to address problems of workers’ well-being, occupational health services and the quality of working life. According the programme policy and decision-makers should document and recognise the social and economic impact of improving workers’ protection. The strategy of the programme aims to create worldwide awareness of the dimensions and consequences of work-related accidents, injuries and diseases, to place the health and
safety of all workers on the international agenda and to stimulate and support practical action at all levels (www.ilo.org, ILO 2003 a, b).

The Council of Europe

The Council of Europe through its European Court of Human Rights has established supranational authority over member states in the field of human rights. A European Social Charter was created already 1961. The Council of Europe has established a European Code of Social Security as well. The Council of Europe represents a unique supranational body attempts to set rules on human rights and social and labour rights for the operation of capitalism (Deacon 1997). The Social Charter has been considered as the economic and social counterpart of the Convention on Human Rights accepted in 1949. The Social Charter guaranteed fundamental rights for workers and citizens to social, legal and economic protection. An additional Protocol was adopted in 1988 by the member states of the Council of Europe. The Protocol guaranteed four fundamental social principles, such as the rights of workers to information and consultation and to participation in the determination and improvement of working conditions and the working environment. The Charter and Protocol lacks legally binding status, but Social Charter established a comprehensive and coherent set of policy objectives, which were base for the Community Charter (Hantrais 1995).

The Organisation for Economic Co-operation and Development

The Organisation for Economic Co-operation and Development (OECD) has been called a think tank, a monitoring agency, a rich man's club and a non-academic university (www.oecd.org 5/2004). The OECD groups 30 member countries to discuss develop and refine economic and social policies. They compare experiences, seek answers to common problems and work to coordinate domestic and international policies to help members and non-members deal with an increasingly globalised world. Their exchanges may lead to agreements to act in a formal way-- for example codes for free flow of capital and services. The OECD is also known for 'soft law' -- non-binding instruments on difficult issues such as its Guidelines for multinational enterprises (www.oecd.org 5/2004).
The OECD Secretariat in Paris exchanges information and analysis between OECD governments. The organisation is one of the world's largest sources of comparable statistical, economic and social data. Parts of the Secretariat collect data, monitor trends, analyse and forecast economic developments, while others research social changes or evolving patterns in trade, environment, agriculture, technology, taxation and more (www.oecd.org 5/2004).

The OECD grew out of the Organisation for European Economic Co-operation (OEEC), which was formed to administer American and Canadian aid under the Marshall Plan for the reconstruction of Europe after World War II. OECD’s vocation has been to build strong economies in its member countries, improve efficiency, market systems, expand free trade and contribute to development in industrialised as well as developing countries.

The secretariat in Paris carries out research and analysis at the request of the OECD’s 30 member countries. The members meet and exchange information in committees devoted to key issues, with decision-making power vested in the OECD Council. The Council is made up of one representative for each member country plus a representative of the European Commission, which takes part in the work of the OECD. Each member country has a permanent representative to the OECD who meets regularly in the Council. The Council meets at ministerial level once a year to discuss important issues and set priorities for OECD work. The committees discuss ideas and review progress in particular areas of policy.

There are about 200 committees, working groups and expert groups in all. Among the committees are Economic Policy Committee, Trade Committee, Committee on International Investment and Multinational Enterprises, Insurance Committee, Competition Committee, Committee on Industry and Business Environment and Employment, Labour and Social Affairs Committee.

The OECD’s work consists of a process that begins with data collection and analysis and moves on to collective discussion of policy. Mutual examination by governments, multilateral surveillance and peer pressure to conform or reform are at the heart of OECD effectiveness. And sometimes the discussions evolve into negotiations at the OECD and OECD countries agree on rules of the game for international coop-
eration. They can culminate in formal agreements or they may produce standards and models.

The Directorate for Education, Employment, Labour and Social Affairs undertakes work on the many inter-related policy areas that can prevent social exclusion. The directorate watches employment and earnings patterns, and the annual Employment Outlook offers analysis of key labour market trends and policies. The directorate also looks at the effectiveness of health care and social welfare programmes, the role of women in the labour force and how technology affects workers.

**Trade unions**

Almost all major national trade union confederations and centres in EU Member States are members of the European Trade Union Confederation (ETUC). Outside ETUC, a number of specific national organisations for managerial and professional staff belong to the European Confederation of Executives and Managerial Staff (CEC), while a number of organisations affiliated to the European Confederation of Independent Trade Unions (CESI). Major national organisations without any European-level affiliation are rare. Also affiliated to ETUC are 11 European industry federations, which group most major EU trade unions in their respective sectors (Carley 2002).

The European Trade Union Technical Bureau for Health and Safety (TUTB) was established in 1989 by ETUC in order to monitor the drafting, transposition and application of this legislation. The TUTB provides expertise and represents the ETUC in various institutions dealing with technical standardisation. The TUTB provides expertise to the European Trade Union Confederation and the European Industry Federations on matters related to the working environment. It also coordinates trade union participation in European standardisation work and follows European policies on the assessment, classification and use of dangerous substances. ETUC supports trade unions in their dealings with European Works Councils and carries out studies and research, provides training and is building up a health and safety at work information system (www.etuc.org/tutb). In the spring 2005 ETUC reorganised its institutions under one single institution.
At national level, the pattern of trade union organisation is complex in EU Member States. In the current EU, four countries – Austria, Germany, Ireland and the UK – have the relatively simple situation of a single dominant confederation (with only relatively minor alternative organisations, as in Germany, or relatively few non-member individual unions, as in Ireland and the UK). In seven Member States (Belgium, France, Italy, Luxembourg, the Netherlands, Portugal and Spain), there are multiple competitive trade union confederations, divided (at least originally) mainly on political and religious grounds – with the number of main confederations varying from five in France to two in Portugal and Spain. In some of these countries – notably France and Italy – there are significant trade unions outside these 'representative' confederations. In the three Nordic Member States (Denmark, Finland and Sweden), the general picture is of separate confederations for different occupational groups – typically blue-collar, white-collar and professional/academic. Finally, the distinction in Greece is between confederations for the private and public sectors (Carley 2002).

Trade unions in the EU Member States have generally seen their membership falling over recent decades – according to most commentators, this is due largely to a number of common trends such as a decline in employment in traditionally high-unionisation manufacturing industry and the growth of lower-unionisation services employment, and increasing levels of 'atypical' employment. This seems to be the case relatively uniformly across the EU. However, some EU countries, such as Sweden, have only recently started to experience union membership loss, while membership losses in a number of countries have been slowed (as in Austria or Germany) or even slightly reversed (as in the UK) in the most recent years. Even where union membership losses have been stemmed, increasing employment levels in many countries have meant that union density (the proportion of those in employment who are union members) has fallen – an example is Ireland (Carley 2002).

The average trade union density in the EU, unweighted for the different sizes of the 15 countries, was, at 43.8% in 2002. Weighting the average for the differing sizes of the countries' labour forces indicated an even wider gap – the EU figure (30.4%). Union density varies considerably among EU Member States, from around 70% or more in Belgium, Denmark, Finland and Sweden to under 20% in France and Spain.
The process of European integration is fundamentally changing the setting in which European trade unions operate. Safeguarding and promote workers' rights social and collective bargaining dimensions needs to be considered in the integrated economic area. ETUC seeks to influence the European Union by making direct representations to the various institutions (Commission, Parliament, Council), and by ensuring trade union participation in numerous advisory bodies (including the Economic and Social committee, where the vast majority of the members of the Workers’ Group, come from trade unions affiliated to the ETUC). The European Works Councils Directive on information and consultation rights is among the most recent results of ETUC action.

At the same time, the ETUC seeks to establish industrial relations with the employers at the European level through the ‘social dialogue’. This is mirrored by sectoral social dialogues under the responsibility of the European Industry Federations (www.etuc.org).

Employers’ organisations

The Union of Industrial and Employers' Confederations of Europe (UNICE, founded in 1958) represents almost all the main national intersectoral confederations of private sector employers and business in the current EU member state. UNICE acts as an employers' organisation engaging in dialogue and negotiations with ETUC. UNICE as a trade/industry association promotes its members' interests in a range of areas, and in seek to influence EU decision-making in areas of relevance. UNICE's coverage of organisations representing small and medium-sized enterprises (SMEs) is arguably patchy, and a separate European-level body, the European Association of Craft and Small and Medium-sized Enterprises (UEAPME founded in 1976), seeks to represent this category of businesses, with affiliates in all 15 Member States. Since 1998, UEAPME and UNICE have cooperated closely in EU-level social dialogue and negotiations with ETUC. Furthermore, the European Centre of Enterprises with Public Participation and of

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Enterprises of General Economic Interest (CEEP founded in 1961) represents enterprises and organisations with public participation or carrying out activities of general economic interest, whatever their legal or ownership status. It is treated as central social partner organisation alongside UNICE by the European Commission, and is involved in dialogue and negotiations with ETUC (Carley 2002, Arcq et al 2003).

At the European sectoral level, there are hundreds of organisations representing business interests and industrial lobbies called European sectoral federations of employers (ESFEs). However, very few of these are employers’ organisations represent their members with regard to employment issues or have relations with trade union organisations. Most of ESFEs have specific interest only to specific regulations, directives etc. (Arcq et al 2003). The main exceptions are the organisations in those sectors where a 'sectoral social dialogue' has developed, either autonomously or at the instigation of the European Commission. There are currently 27 sectoral dialogue committees, bringing together European-level representatives of trade unions and employers for discussions on employment, competitiveness and social issues. These bodies conduct an autonomous social dialogue which is seen as a key part of the European social model. They are used by the European-level social partners to: defend joint interests; find solutions to the challenges facing their sectors; and influence European and national policies. Joint texts (opinions, declarations, codes of conduct etc) on a range of issues (for example training, human resource development, employment, fundamental rights or health and safety) have been reached in most of the sectors concerned. Thus, there are European-level bodies acting in some ways as employers' organisations in several sectors (Carley 2002).

At national level, the organisation of employers varies substantially between EU member states. At intersectoral level, in countries such as Belgium, Denmark, France, Ireland, Italy, the Netherlands, Spain, Sweden, and the United Kingdom, there is essentially a single umbrella organisation (at least for the private sector) representing the interests of companies, employers, and business/trade – though accompanied by separate SME organisations in some cases (as in France or Spain). In other countries – notably Germany – there is a division between the representation of employers’ and of business/trade interests, with separate central organisations for each. The trend, however, appears to
be towards the unification of representation of employers' and business/trade interests. Another difference at intersectoral level is that there may be a single central (private sector) body or there may be separate bodies for industry, services and in some cases agriculture (Carley 2002).

In EU member states, in terms of the role of employers' organisations, regular national intersectoral bargaining with trade unions over substantive pay and conditions issues is part of the remit of central employers' bodies in Belgium, Finland, Greece, Ireland and Portugal. Intersectoral bargaining over specific issues or procedural matters is part of the employers' confederations' role in Denmark, France, Italy, Spain and Sweden. While usually falling short of bargaining, employers' confederations have close cooperative relations with trade unions in various fora in Austria, Germany and the Netherlands, which may lead to joint texts or approaches. It is probably in the UK that the main employers' body (the CBI) has the least 'bargaining-like' role in any area (Carley 2002).

Reliable information on the rate of employers' organisation is hard to come by in most European countries. One of the few sources of comparative data on employers' organisation 'density' in the EU Member States is a 1999 European Commission-sponsored report on the representativeness of European social partner organisations, which includes estimates of the proportion of the total workforce employed by the members of some of the employers' organisations affiliated to the main European-level bodies. Taking the main private sector employers' federations affiliated to UNICE, the report gives density figures of:

1. 44% for the Danish Employers' Confederation (Dansk Arbejdsgiverforening, DA);
2. 36% for the Confederation of Finnish Industry and Employers (Teollisuuden ja Työnantajain Keskusliitto, TT) and the Employers' Confederation of Service Industries (Palvelutyönantajat, PT) combined;
3. 58% for the Movement of French Enterprises (Mouvement des entreprises de France, MEDEF);
4. 80% for the Confederation of German Employers' Associations (Bundesvereinigung Deutscher Arbeitgeberverbände, BDA);
5. 16% for the Federation of Greek Industries (SEV);
6. 22% for the Irish Business and Employers’ Confederation (IBEC);
7. 23% for Italy’s Confindustria; and
8. 38% for the Confederation of British Industry (CBI).
Overall density will be higher in most countries, due to the existence of other employers' organisations of varying sizes (Carley 2002).
16/III

List of the main legislation concerning OHS in 15 EU member states
List of the main legislation concerning OHS in 15 EU member states


France: Prevention of Occupational Risks Act. 31 December. 1991. Decree 95-680. 9 May. 1995. Government and regional civil servants, hospital workers, agricultural workers are covered by the civil service code, district codes or public health code since 1995 with OHS; for other groups OHS has been since 1982.


Greece: Presidential Decree 17/96 on integration of the European Directives into the national law amended with the Presidential Decree 159/99.

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Spain: Law 31/1995 of Prevention of risks at work; in 1997 the Regulation on preventive services approved, both of them, by the Ministry of Labour and Social Affairs, other additional law is General Health Law and Industry Law, Ministry of Labour and Social Affairs. The reform of the legal framework on the prevention of risks in the workplace (Reforma del marco normativo de la prevención de riesgos laborales) on 27 November 2003.


16/IV

Some of the monitoring schemes related to occupational health
### Some of the monitoring schemes related to occupational health

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Indicators</th>
<th>Data sources</th>
<th>Background of the scheme</th>
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<tr>
<td>2. For a better quality of work. European Union Presidency conference Brussels, 20-21 September 2001 during Belgian Presidency. Summary. European Foundation for the Improvement of Living and Working Conditions. 2001.</td>
<td>The European Foundation for the Improvement of Living and Working Conditions and its working group proposed three perspectives on quality of work: the individual (citizens need jobs that are secure, safe, interesting and which enable active social and family life), the corporate (companies need to find workers with the right skills), and the societal (society needs to promote healthy and skilled jobs to a maximum number of people). There are also three types of indicators: structural (describing the context/the framework, for example number of labour inspectors/1000 workers) situational (describing the reality of work, for example exposure to chemicals) and outcomes (the result, for example number of accidents or stress levels).</td>
<td>-</td>
<td>At the ‘For a better quality of work’ conference, the issue of quality of work indicators were discussed. The use of indicators to promote the quality of work is highlighted in the COM (2001)313. The Employment Committee of the Council worked on detailed proposal concerning indicators for each of these dimensions and the report was finalised in the autumn of 2001. Since the Lisbon summit, a greater focus has been placed on the quality of work. Traditional indicators such as occupational accidents and diseases, which tend to reflect industry-based and male dominated jobs, are not sufficient to reflect the complex nature of work in the 21st century.</td>
</tr>
<tr>
<td>3. Criteria and indicators for policy and performance of good practice in health, environment and safety management in the enterprises (GPHESME)</td>
<td>Stakeholders and policy criteria at the national level, policy criteria at provincial level and GPHESME criteria at enterprise level. The indicators are broad in concept and scope and GPHESME has long list of possible indicators.</td>
<td>-</td>
<td>GPHESME was developed under WHO through Ministerial Conference on environmental and health, HESME focal points meetings, European Environment and Health Committee meetings and other WHO networks.</td>
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**Appendix IV continues...**
### Appendix IV continues...

#### 4. Work and health country profiles

| Indicators of occupational health and safety (ratification rate of ILO key conventions; human resources in labour safety and OHS), indicators of working conditions (noise, handling of dangerous substances, asbestos and pesticide consumption, heavy loads, working at very high speed and working at least 50 hours/week), indicators of occupational health and safety outcomes (fatal work accidents, work accidents, occupational disease and perceived work ability) | administrative registers and statistics, questionnaire based surveys, expert assessment systems and observational surveys | The scheme is based on WHO/EURO request to prepare country profiles to follow with indicators occupational health and safety at the national or regional level. The publication was prepared by the Finnish Institute of Occupational Health with WHO collaborating centre in occupational health. |

#### 5. Design for a set of European Community Health Indicators: ECHI

| Demographic and socio-economic factors; health status (mortality, morbidity, generic health status, composite health status measures); determinant of health (personal and biological factors, health behaviour, living and working conditions (physical workplace exposure, mental workplace exposure, accidents at work, occupational diseases; health systems (prevention and health promotion, resources, utilisation, expenditures and financing and quality and performance) | WHO/HFA, OECD and Eurostat | The project was funded by the European Commission Health Monitoring Programme to propose a coherent set of European Community health indicators. The indicators were kept in general level and their operational definition was left to the future projects. |

#### 6. The state of occupational safety and health in the European Union

| Exposure indicators, occupational safety and health outcomes, sectors and occupations most at risks, working environment (noise, vibrations etc.), use of personal protective equipments, risk and training given by employers etc. Data based on ESWC were compared with nationally collected data and differences between them. | ESWC, national data sources from registers, surveys etc. | Published by the European Agency for Safety and Health at Work. Data is collected by the national focal points at member states based on a manual. The aims were to contribute to the development of a monitoring system for safety and health at work. |

#### 7. The Health Status of the European Union (Ferrinho et al 2003)

| Current health status (morbidity, disablement, premature mortality), determinants of health status (socio-economic determinants, health behaviours, physical environment, health promotion, health care services) | Eurostat, WHO/EURO, OECD | In 1996, the first report was based on work done by the WHO. |

Appendix IV continues...
### 8. European Occupational Diseases Statistics (EODS)

- **Questionnaire:** Filled on new recognised cases of occupational diseases and analysed by Eurostat.
- **Legal Basis:** Council Resolutions 88/c28/01 and 95/C168/01 on monitoring and prioritising preventive actions at community to improve health and safety at work. Pilot project was started in 1995 for 31 items of occupational diseases. Annual data collected on new recognised cases of occupational diseases since 2001 in 14 member states without Germany.

### 9. European statistics on accidents at work (ESAW)

- **Accident related information:** From place of accident until seriousness and consequences of the accident.
- **Harmonisation:** Data on accidents at work based on framework directive 89/391/EEC and establishment of a database to monitor trends in health and safety at work in the European Union.

### 10. European Survey on Working Conditions (ESWC)

- **State of working conditions:** Context variables, nature of work, physical work factors, work organisations, time, information and consultation, psychosocial factors, outcomes, income and payment system and work and family life.
- **Face to face interviews:** In member states.
- **Surveys:** Conducted in 1990/91, 1995 and in 2000 by the European Foundation for the Improvement of Living and Working Conditions.

### 11. The European Union Labour Force Survey (LFS)

- **Demographic background:** Employment characteristics of the main job, hours worked, second job, previous work experiences, education and training, income etc. In 1999 accidents at work and occupational diseases were collected.
- **Sample:** From the member states based on questionnaires and interviews in households.
- **Data Collection:** Has data collection since 1960. In 1998 a new framework was adopted in Council regulation No 577/98 concerning quarterly and annual results and new variables and modules. LFS is a joint effort by EU member states to coordinate national employment surveys to give information in relation to employment and unemployment trends. The data is collected by national institutes with questionnaires and Eurostat compiles the data.

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**Appendix IV continues...**
| 12. European Community Household Panel ECHP | social transfers, labour, poverty and social exclusion, housing, health and medical care etc. | Data collected annually from a household and individual respondents in member states by national data collection units | ECHP was launched in 1994 to develop comparable socio-economic statistics across member states to place citizen’s rights and employment into the centre of EU. |
| 13. OECD Health Data | health status, health care resources, health care utilisation, health care expenditures and financing, social protection, pharmaceutical market, non-medical determinants of health, demographic references and economic references. | Electronic questionnaires, data exchange with WHO, OECD | Health data has been published since mid-1980s. OECD health data base in electronic form has been published eleven times. |
| 14. Key indicators of the Labour Market ILO | labour force participation rare, employment by sector, part-time workers, unemployment, labour productivity etc. | ILO, OECD, UN, World Bank, UNIDO, EUROSTAT, UNESCO | ILO launched in 1999 a new programme on Key Indicators of the Labour Market to develop labour market indicators and improve the availability of the indicators to monitor new employment trends. |
| 15. Citizens and health systems: main results from a Eurobarometer survey. | The health of the European population was assessed on five levels in 2002: perceived health, chronic morbidity (long-standing illness), activity restriction due to a health problem, sensory and physical functional limitations. In 1996 were asked perceived health, personal experience of health services, concerns and priorities in health care. | Eurobarometer was carried out 1996 and 2002 using a random sample and face-to-face interviews. | The European Opinion Research Group, carried out the study on request of the European Commission, Directorate General Press and Communication, Public Opinion Analysis Unit. Many countries are undertaking major reforms of their health systems. The views of citizens are particularly important to test how far existing services meet needs and expectations and how the system is working in practice. |
16/V

Schematic development of EU policies
<table>
<thead>
<tr>
<th>Year</th>
<th>Intergovernmental organisation; Treaties</th>
<th>Social policy</th>
<th>Health</th>
<th>Health and safety at work</th>
</tr>
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<tbody>
<tr>
<td>1948</td>
<td>OEEC</td>
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<td></td>
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<tr>
<td>1952</td>
<td>ECSC</td>
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</tr>
<tr>
<td>1958</td>
<td>Treaty of Rome EEC and EEC 6</td>
<td>Economic and Social Committee</td>
<td></td>
<td>Health and safety at work mentioned in the Treaty</td>
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<tr>
<td>1960</td>
<td>European Social Fund</td>
<td></td>
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<tr>
<td>1961</td>
<td>The Social Charter by Council of Europe</td>
<td></td>
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<tr>
<td>1962</td>
<td>Harmonisation of social security systems started</td>
<td></td>
<td></td>
<td>Health and Safety Division in EEC Directives and recommendations</td>
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<tr>
<td>1966</td>
<td></td>
<td></td>
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<td>Covenant on Economics, Social and Cultural Rights</td>
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<tr>
<td>1967</td>
<td>EC Merger Treaty</td>
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<td>1968</td>
<td>First Report on social policy from the Commission</td>
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<tr>
<td>1969</td>
<td>EMU accepted</td>
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<tr>
<td>1970</td>
<td>Werner report on social and economic integration</td>
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<tr>
<td>1972</td>
<td>Paris First Summit Conference</td>
<td>Social policy for the Commission</td>
<td></td>
<td></td>
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<tr>
<td>1973</td>
<td>EC 9 (Denmark, United Kingdom, Ireland)</td>
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<tr>
<td>1974</td>
<td>First Social Action Programme 1974-76</td>
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<td></td>
<td>Advisory Committee on Safety, Hygiene and Health Protection at Work</td>
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Table continues...
### Schematic development of EU policies before 1988 continues...

<table>
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<tr>
<th>Year</th>
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<th>Health and safety at work</th>
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<tr>
<td>1975</td>
<td></td>
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<td>European Foundation for Living and Working Conditions</td>
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<td>1977</td>
<td></td>
<td></td>
<td>WHO</td>
<td>Health for All by year 2000</td>
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<tr>
<td>1978</td>
<td>Directives 1975-80: gender equality, transfer of enterprises and workers’ rights, health and safety</td>
<td>WHO Alma Ata Declaration</td>
<td>First Action Programme in Health and Safety 1978-</td>
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<tr>
<td>1981</td>
<td>EC 10 (Greece)</td>
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<tr>
<td>1986</td>
<td>EC 12 (Portugal, Spain)</td>
<td></td>
<td>Ottawa Charter on Health Promotion (WHO)</td>
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<tr>
<td>1988</td>
<td></td>
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<td>Healthy Public Policies by (WHO)</td>
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</table>
### Schematic development of EU policies between 1989-1999

<table>
<thead>
<tr>
<th>Year</th>
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<th>Occupational health and safety and OHS</th>
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</thead>
<tbody>
<tr>
<td>1990</td>
<td>EMU</td>
<td></td>
<td>90/269 (Manual Handling of Loads) and 90/270 (Display Screen Equipment)</td>
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Table continues...
### Schematic development of EU policies between 1989-1999 continues...

<table>
<thead>
<tr>
<th>Year</th>
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<th>Occupational health and safety and OHS</th>
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## Schematic development of EU policies between 2000-2005

<table>
<thead>
<tr>
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<th>Occupational health and safety and OHS</th>
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<tr>
<th>Year</th>
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<th>Social policy</th>
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<th>Occupational health and safety and OHS</th>
</tr>
</thead>
</table>

Table continues...
Schematic development of EU policies between 2000-2005 continues...

<table>
<thead>
<tr>
<th>Year</th>
<th>Intergovernmental organisation; treaties</th>
<th>Social policy</th>
<th>Health</th>
<th>Occupational health and safety and OHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>Constitution into force November 2006? Planning of social protection programme until 2006, when the employment, social protection and health reports are integrated into economic reports of EU. Balancing between internal market and social policy</td>
<td>Integration of health and safety, environment, e-health, public health strategies. Possible further actions based on COM (2004) 62 will focus on SMEs, public sector, policy integration, benchmarking and guidelines; qualification of personnel; coordination of directives and enforcement by authorities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VI

Typologies of welfare states

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Type of welfare state and characteristics</th>
<th>Indicators/dimensions used in categorization</th>
</tr>
</thead>
</table>
| Esping-Anderson (1990) | Liberal: low level of de-commodification; market differentiation of welfare  
Conservative: Moderate level of de-commodification; social benefits mainly dependent on former contributions and status  
Social-democratic: high level of de-commodification; universal benefits and high degree of benefit equality | de-commodification  
stratification |
| Abrahamson (1992) | Liberal welfare state model; Corporate welfare state model; Scandinavian welfare state model; Latin welfare state model | The three elements in the mix are the state, the market and civil society, which comprise the ‘welfare triangle’ |
| Leibfried (1992) | Anglo-Saxon Residual: right to income transfers; welfare state as compensator of last resort and tight enforce of work in the market  
Bismarck Institutions: right to social security; welfare states as compensator of first resort and employer of last resort  
Scandinavian Model: right it work for everyone; universalism; welfare states as employer of first resort and compensator of last resort  
Latin Rim, Rudimentary: Right to work and welfare proclaimed; welfare states as semi-institutionalised promise | poverty  
social insurance  
poverty policy |
| Castles and Mitchell (1993) | Liberal: low social spending and no adoption of equalizing instruments in social policy  
Conservative: high social expenditure and use of highly equalizing instruments in social policy  
Non-right hegemony: high social expenditures and use of highly equalizing instruments in social policy  
Radical: achievement of equality in pre-tax, pre-transfer income (adoption of equalizing instruments in social policy), but little social spending | welfare expenditure  
benefit equality  
taxes |
| Siaroff (1996) | Protestant Liberal: Minimal family welfare, yet relatively egalitarian gender situation in the labour market; family benefits are paid to mother, but are rather inadequate  
Advanced Christian-democratic: no strong incentives for women to work, but strong incentives to stay at home  
Protestant social-democratic: true work-welfare choice for women; family benefits are high and always paid to the mother; importance of Protestantism  
Late female mobilization: absence of Protestantism; family benefits are usually paid to the father; universal female suffrage is relatively new | family welfare reorientation  
female work desirability  
extent of family benefits being paid to women |

*Table continues...*

<table>
<thead>
<tr>
<th>Ferrera (1996)</th>
<th>Anglo-Saxon: fairly high welfare state cover; social assistance with a means test; mixed system of financing; highly integrated organisational framework entirely managed by a public administration. Bismarck: strong link between work position and social entitlements; benefits proportional to income; financing through contributions; reasonably substantial social assistance benefits; insurance schemes mainly governed by unions and employer organisations. Scandinavian: social protection as a citizenship right; universal coverage; relatively generous fixed benefits for various social risks; financing mainly through fiscal revenues, strong organisation integration. Southern: fragmented system of income guarantees linked to work position; generous benefits without articulated net of minimum social protection; health care as a right of citizenship; particularism in payments of cash benefits and financing; financing through contributions and fiscal revenues.</th>
<th>rules of access (eligibility) benefit formulae financing regulations organisation managerial arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonoli (1997)</td>
<td>British: Low percentage of social expenditure financed through contributions (Beveridge); low social expenditure as a percentage of GDP. Continental: high percentage of social expenditure through contributions (Bismarck); high social expenditure as a percentage of GDP. Nordic: Low percentage of social expenditure financed through contributions (Beveridge); high social expenditure as a percentage of GDP. Southern: High percentage of social expenditure financed through contributions (Bismarck); low social expenditure as a percentage of GDP.</td>
<td>Bismarck and Beveridge models quantity of welfare state expenditure.</td>
</tr>
<tr>
<td>Korpi and Palme (1998)</td>
<td>Basic security: entitlements based on citizenship or contributions; application of the flat-rate benefit principle. Corporatist: entitlement based on occupational category and labour force participation; use of the earning related benefit principle. Encompassing: entitlement based on citizenship and labour force participation; use of the flat rate and earning related benefit principle. Targeted: eligibility based on proved need; use of the minimum benefit principle. Voluntary state subsidised: eligibility based on membership or contributions; application of the flat-rate or earning related principle.</td>
<td>bases of entitlements benefit principle governance of social insurance programme.</td>
</tr>
<tr>
<td>Kleinman (2002)</td>
<td>Conservative-corporatist welfare states; Social democratic welfare states; Mediterranean model; Anglo-Saxon welfare state.</td>
<td>Classification based on trial to build single European social model.</td>
</tr>
</tbody>
</table>
### Typologies of welfares states and EU member states (Modified from Arts, Gelissen 2002; Hantrais 1995, Kleinman 2002).

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Typologies</th>
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<tbody>
<tr>
<td>Esping-Andersen</td>
<td>liberal</td>
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<td>conservative</td>
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<td>social-democratic</td>
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<td>Italy</td>
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<tr>
<td>United Kingdom</td>
<td>France</td>
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<td>Finland</td>
<td>Austria</td>
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<tr>
<td></td>
<td>Belgium</td>
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<tr>
<td></td>
<td>Netherlands</td>
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<td></td>
<td>Denmark</td>
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<tr>
<td>Leibfried</td>
<td>Anglo-Saxon</td>
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<td>Bismarck</td>
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<tr>
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<td>Scandinavian</td>
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<tr>
<td></td>
<td>Latin Rim</td>
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<td></td>
<td>France</td>
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<tr>
<td>Castles and</td>
<td>Liberal</td>
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<tr>
<td>Mitchell</td>
<td>Conservative</td>
</tr>
<tr>
<td></td>
<td>Non-Right Hegemony</td>
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<td>Radical</td>
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<td>Ireland</td>
<td>West-Germany</td>
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<td>Belgium</td>
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<td>Ireland</td>
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<td></td>
<td>France</td>
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<tr>
<td>Siaroff</td>
<td>Protestant Liberal</td>
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<td></td>
<td>Advanced Christian Democratic</td>
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<td>Protestant Social-democratic</td>
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<tr>
<td></td>
<td>Late female mobilization</td>
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<tr>
<td>United Kingdom</td>
<td>Austria</td>
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<td>France</td>
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<td>West-Germany</td>
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<td>Spain</td>
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Table continues...
### Typologies of Welfare States and EU Member States (Modified from Arts, Gelissen 2002; Hantrais 1995, Kleinman 2002).

**Ferrera**
- Anglo-Saxon: United Kingdom, Ireland
- Bismarckian: Germany, France, Belgium, Netherlands, Luxembourg
- Scandinavian: Denmark, Finland, Sweden

**Bonoli**
- British: United Kingdom, Ireland
- Continental: Netherlands, France, Belgium, Germany, Luxembourg
- Nordic: Denmark, Finland, Sweden
- Southern: Greece, Portugal, Spain

**Korpi and Palme**
- Basic security: Denmark, Netherlands, Ireland, United Kingdom
- Corporatist: Austria, Belgium, France, Germany, Italy
- Encompassing: Finland, Sweden

**Hantrais**
- Continental welfare state: Belgium, France, Germany, the Netherlands, Italy, Luxembourg
- Southern welfare states: Denmark, Ireland, United Kingdom, Greece, Spain, Portugal

**Kleinman**
- Anglo-Saxon welfare state: United Kingdom (Ireland)
- Conservative-corporatist welfare state: Belgium, France, Germany, the Netherlands, Italy (Ireland)
- Social democratic welfare state: Denmark, Sweden, Finland, Netherlands
- Mediterranean welfare state: Greece, Spain, Portugal (Italy) (Ireland)
The Europeanisation of occupational health services: A study of the impact of EU policies

Occupational health services (OHS) are part of the social and health policies of the European Union. OHS has been studied mainly as a national system, as part of a system of occupational health and safety, or as an activity and process-based service unit for employers and employees. The focus has often been on risk assessment and the prevention of diseases, injuries and accidents. OHS has also gained attention among social partners, such as trade unions and employers' organizations during bargaining and negotiations on compensations for ill health.

This study focuses on OHS in the context of the EU and on OHS as part of the work-based benefits provided to workers in welfare states. The study is a policy study on the impact of EU policies, and uses OHS as a case to demonstrate transnational legislation and governance in EU member states. The main reason for choosing the policy process perspective was an obvious need for empirical analysis of OHS in the contexts of the EU, transnational decision-making, and policy environments.

The study explores the development of OHS in 15 member states of the European Union at the turn of millennium. The study material included interviews and various types of documents.