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European Risk Observatory

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ESENER

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Executive Summary

The aim of this project was to provide insight into how the environment in which an establishment operates affects the ways in which it manages workplace occupational safety and health (OSH). The work forms part of the follow-up to the European Agency for Safety and Health at Work (EU-OSHA) European Survey of Enterprises on New and Emerging Risks (ESENER). ESENER and its secondary analyses showed that, although the European Framework Directive 89/391/EEC aims to provide workers in all European Union (EU) Member States with a common minimum level of protection from work-related risks, the precise way in which these legislative provisions translate into OSH management in the workplace varies significantly from one country to another, as well as by industry sector and organisation size. This highlights the importance of the environment in which OSH management takes place in determining the form and approach taken to such management. A number of contextual factors determine this environment, most importantly traditions of regulation, industrial relations and social protection, and their current style and character. In addition, other significant contextual factors include OSH support infrastructures (e.g. the availability and competence of specialist support services and information) and wider contextual features such as the economic climate, labour force training and qualifications, the structure of the labour market and the organisation of work.

As its starting point, the project took the well-established idea that EU Member States can be grouped in various combinations for the purposes of comparison according to features that are of particular interest to the planned analysis. On the basis of existing knowledge of the comparative contexts of OSH regulation, we identified seven groups of countries reflecting broadly similar contextual influences in terms of regulatory character and style, labour relations, social protection systems and other national regulatory, economic and social characteristics that are likely to be influential over the operation of regulatory requirements on workplace OSH management. These groups were as follows:

1. Central: Austria, Belgium, Germany, Liechtenstein, Luxembourg, Netherlands, Switzerland.
2. Nordic: Denmark, Finland, Iceland, Norway, Sweden.
3. Ireland, United Kingdom.
4. Southern/Latin: France, Greece, Italy, Portugal, Spain.
5. Eastern: Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania, Slovenia, Slovakia, Turkey.
6. Smaller Southern: Cyprus, Malta.
7. Baltic States: Estonia, Latvia, Lithuania.

These are necessarily broad groupings and, inevitably, the fit of an individual Member State within its group is imperfect in some cases. Nevertheless, they reflect in general terms the implementation of the approaches to risk management that are the basis of the Framework Directive and which form part of the trajectory of the development of process-orientated regulation on health and safety issues within the various traditions of OSH regulation across the EU. From these groups we made our selection of Member States for inclusion in the project with the intention that the countries chosen for study were both representative (of their group) and pragmatic (such that our contacts and the publically available information would allow effective study). The selected Member States were as follows:

1. Central: Germany
2. Nordic: Sweden
3. Ireland, United Kingdom: United Kingdom
4. Southern/Latin: France, Spain
5. Eastern: Bulgaria
6. Smaller Southern: Cyprus
7. Baltic States: Latvia

Methods

As part of the follow-up to ESENER, the project took the three broad areas that were the focus of the survey and its subsequent secondary analyses as its basis: OSH management; psychosocial risk management; and the involvement of workers and their representatives in these two areas. The research aimed to:

- provide a description and reasoned analysis of the most important factors affecting the way OSH is managed in the workplace (i.e. the environment); and
- consider how this environment affects these three broad areas (i.e. the influence of the environment on workplace OSH practice).

In order to achieve these aims, a pragmatic and innovative mixed-methods approach was adopted, which involved desk research, secondary analysis of the ESENER data and new qualitative data collection. For the last, we felt it was particularly important that key expertise from each of the selected Member States was dynamically combined with broader expert views at both the EU and wider international levels. To ensure this, two panels were established. Both the National Expert Panel and the Advisory Board were made up of experts from each of the Member States selected for study, with the Advisory Board also including internationally recognised experts from within and outside the EU. The project's research team prepared a guidance framework and summaries of relevant ESENER data for each of the National Experts to use to support their preparation of a paper describing how the characteristics of the regulatory framework, employment relations traditions and other key factors affected enterprises' management of health and safety at work in their Member State. These papers were circulated to the Advisory Board prior to an international workshop, at which both panels of experts and the project's research team considered and discussed the papers and the themes of the research more widely.

These workshop papers, together with our reconsideration of the ESENER data, were used as the basis for the findings and material presented in this report.

Findings

Our findings focus on ESENER's three main areas of interest, namely OSH management, psychosocial risk management and the involvement of workers and their representatives. In each case we draw out the factors that emerged as key influences in relation to differences between the selected Member States apparent in the ESENER data.

Occupational safety and health management

The first of the four secondary analyses of ESENER that preceded this project derived a composite measure of the scope of OSH management which allowed the characterisation of enterprises along a continuum. Applying this measure to our selected Member States and the regulatory groups of which they were broadly representative showed significant variation. Specifically, enterprises from Sweden and the United Kingdom, as well as those from the Nordic and Ireland and United Kingdom groups more generally, had the highest average scores, indicating the presence of the greatest number of OSH management measures, whereas those from the Baltic States, Smaller Southern and Central groups had the lowest average scores. In the Nordic countries and Ireland and United Kingdom the operation of national process-orientated regulatory standards emphasising a participatory approach to OSH management largely predates the Framework Directive by around 20 years. These differences within the ESENER data, therefore, suggest that it is not only the characterisation of the environment by goal-setting rather than prescriptive legislative approaches that is important, but also the extent and degree to which those approaches are embedded in a Member State's regulatory regime (i.e. the degree of fit between the EU process-based approach and a country's existing institutions, systems and structures). In particular, regulatory systems with a longer tradition of process-based participatory OSH management which were, therefore, least challenged by the implementation of the Framework Directive are associated with greater levels of OSH management practice implementation.

The project's national expertise confirmed this finding. However, it also suggested that, within this broad context, a number of other factors and characteristics are influential. These operate at several levels and include the perceived costs of OSH implementation and legislative compliance, comprising those perceived by employers (financial, technical and temporal costs), those perceived by employees (their job security) and those perceived by national and EU policy-makers (the economic and administrative burden on businesses); the support infrastructure available to enterprises, in terms of both specialist services and information, and labour inspectorate support, monitoring and enforcement; and the wider economic and political climate, in particular the economic crisis and associated changes in labour market and employment arrangements.

Psychosocial risk management

ESENER and its earlier secondary analyses also showed significant links between OSH management and the management of psychosocial risks. Specifically, enterprises with good management of general OSH risks also manage psychosocial risks more effectively, though the management of psychosocial risks largely lags behind that of general OSH risks. Our consideration of the ESENER data confirmed this hierarchical relationship and again showed a range of levels of psychosocial risk management measures from Sweden and the Nordic group at the highest end of the spectrum to Cyprus and the Smaller Southern countries' group at the lowest end. Taken together, these findings suggest that psychosocial risk management might be considered as an 'advanced subset' of OSH management, which, therefore, is necessarily influenced by a similar set of factors — something which our experts also confirmed. In addition, they suggested three further inter-related factors that are influential over OSH management, in particular psychosocial risk management, all of which focus on the recognition of risk and its significance to the safety, health and well-being of workers. First, traditions of national-level research into OSH both generally and specifically in relation to psychosocial risks and their management are key drivers of debate and development among policy-makers and OSH actors, as well as within society more widely, so also of national discourse on OSH definitions and priorities socially and politically. Second, the role of the social partners is central not only to this wider debate, but also to the facilitation of the practical application of research knowledge to workplace practice. Third, EU-level policy and legislation set significant markers for Member States, perhaps in particular those in which national-level traditions of research and expertise are less well established.

Worker participation in OSH management

Both OSH management and the management of psychosocial risks are closely linked to our third area of interest: worker participation in OSH management. The earlier secondary analysis of ESENER, which focused on worker representation, concluded that the combined effects of the involvement of workers and their representatives with high levels of management commitment towards OSH management were associated with reporting positively on measures of health and safety management both generally and in relation to psychosocial risks. Furthermore, that work suggested that this combination of worker involvement and management commitment was more likely to be found in countries with more embedded approaches towards participative OSH management in their regulatory systems than in countries where these approaches are the result of more recent legislative changes. Again, this was apparent in our consideration of the ESENER data, with proportionally more respondents from Sweden and the Nordic countries, and from the Ireland and United Kingdom group, reporting that this key combination of factors was present in their enterprise.

However, our findings also suggest that in countries where the EU version of participative process-based regulation sits less comfortably with Member States' own arrangements, variation reflected structural differences in those countries' labour relations systems and the level of their maturity. As a result, in some newer or substantially reformed systems the role of workplace representation is not well developed or supported in relation to OSH management (e.g. the former Soviet Bloc countries), whereas in others which are highly developed, superimposing the EU model has been made challenging by their basis around institutions, structures and processes in which the conceptualisation of OSH is substantially different (e.g. the centrality of the works council in co-determination in Germany). In addition, factors including the role of regulatory inspection, the resourcing of appropriate training and information provision for worker representatives and the presence of strong trade unions with an active engagement in health and safety issues were also identified as significantly influential.

Determinants

The ESENER data, supported by the findings of the project experts' national reports, therefore suggest that the application of national measures to transpose EU requirements in relation to OSH management is not uniform in terms of either implementation or operational outcomes. A number of contextual and environmental factors were identified as being influential over OSH management practice generally and in relation to psychosocial risk specifically, as well as over the role of worker representation and consultation in both these areas. These factors operate at a number of levels and lead to different outcomes in different Member States, reflecting the countries' various circumstances and traditions. They fall into five broad categories:

- EU and supranational influences, including:
  - the Framework and other Directives;
  - wider political and policy influences (such as the level of emphasis on OSH and the minimal implementation of, for example, the EU social partners' agreement on work-related stress);
  - the 'Europeanisation' requirements of accession; and
  - the economic crisis.
- National governance and regulation and the OSH system, including:
  - regulatory approach (in particular, the degree to which process-orientated participatory systems are embedded in traditional approaches, and structures and provisions for various forms of participation and consultation);
  - wider political and policy influences (e.g. the level of emphasis on OSH, deregulation, and the role of occupational health professionals, as well as the length and depth of research and political focus on specific areas such as psychosocial risks); and
  - the labour inspectorate (e.g. traditions and changes in relation to their provision of support, focus of attention, enforcement style and resourcing).
- Labour relations, trade unions and employers' organisations and processes, including:
  - employee voice (e.g. arrangements for worker representation and consultation and the balance of power between labour and capital); and
  - social dialogue (in particular the traditions and relative maturity of labour relations systems and social partners' support provision).
- Economic restructuring, including:
  - economic, workforce and labour market changes;
  - enterprise size;
  - costs (including costs of implementation and legislative compliance as perceived by employers and employees); and
  - wider political and policy influences (such as support for representation).
- Other related systems (e.g. social welfare, health), including:
  - the priority of and data available on OSH (e.g. workplace-level understanding of the concepts and practicalities of process-based OSH management and the availability of reliable OSH data);
  - specialist services (including their quality, independence and implications for enterprise-level expertise); and
  - insurance and other institutional agencies.

Conclusions

The project's findings identified five broad categories of determinants which operate at a number of levels and produce varying results in different circumstances. However, the single most common environmental context that all the countries we studied shared was change. Change has occurred across the spectrum of work restructuring and reorganisation and the restructuring and repositioning of the wider economic, regulatory, political and cultural contexts in which it is embedded — with consequences for the operation of general health and safety and psychosocial risk management, as well as the role of worker representation, and consequently also for the safety, health and well-being of workers.

Our findings suggest, therefore, that the determinants of OSH management practice operate within a dynamic environment. Management processes (for health and safety generally, as well as those addressing psychosocial risks specifically and the role of worker representation and consultation within them both) sit at the heart of this environment and are embedded within the proximal elements of influence found in national health and safety systems (including actors such as those representing the special health and safety interests of trade unions and employers, OSH interest groups, professional bodies and individual professionals in the OSH field, all of whom are part of the scientific, medical and legal system; the process of national discourse on health and safety management including the policies of the actors and the debates on the

reform of OSH regulation; and the processes through which problems and solutions are defined within the scientific/medical and legal system and how such definition is brought to bear upon the formal actors in national decision making on OSH). These management processes and national health and safety systems are in turn influenced by three further areas, all of which also influence each other. These three areas are:

- *Governance* in general, in which elements such as its organisation and structure, its policies on acceptable levels of deviance and compliance and on regulation/deregulation impinge on the regulation of health and safety management and therefore on its practice.
- The *relations between capital and labour,* including the structure and operation of the labour market, and changes therein, employment law, unionisation, national industrial relations' systems and the degree of corporatism evident in national systems.
- The national *economic system,* in terms of the state of the national economy, shifts in the profile of production (e.g. from goods to services in the countries we have studied) and the organisational restructuring that has been a major feature of economic development during the past 20 years.

As we have said, this environment is not static; rather, it is subject to continuing change over time, which, in recent decades, has been rapid and has profoundly influenced the determinants of OSH management practices in all the countries we have studied. Such changes have included those

- brought about by globalisation and its attendant labour market restructuring, budgetary deficits and decline in unionisation; and
- in the political composition of governments and their ramifications amongst the policies of regulatory bodies, and social, economic and (even) professional actors.

In addition, all of this is subject to influence from the EU level, as well as to other supranational influences, both within OSH policy and in the relationship of such policy to more general EU economic and social policies. Furthermore, it is important to bear in mind that these spheres of influence over the environment in which management processes are embedded impact not only on OSH management at the workplace directly, but also on each other, with the consequences of this and its combined effects also influential over workplace OSH management practices.

We have made it clear within our report that we are aware of the limitations of this research. First, as a policy-orientated project with a limited time-frame and budget, this work has been carried out as an exercise in scoping expert perspectives on OSH management policy and determinants. Rather than being the result of a specific analytical technique, this report presents a composite of those expert views, so must be taken as an expert perspective grounded on a number of evidential sources rather than a strictly evidence-based analysis. Second, the quantitative data on which the project draws have their own shortcomings. As is acknowledged elsewhere, the ESENER data are in general drawn from enterprises that are operating 'at the best end of the spectrum of OSH management'; they do not include direct measures of OSH performance and they cannot determine the quality or effectiveness of OSH management measures in place in an enterprise. Other data on health and safety experience drawn on in this report are subject to similar limitations and, as they are from a variety of sources, are not directly comparable and at best offer only a partial perspective. Nevertheless, our findings are consistent with those from a number of other sources and are supported by European injury data, which suggest that those countries that our research points to as operating at the better end of the spectrum, namely the Nordic countries and Ireland and United Kingdom, do in fact have lower injury rates. We therefore think that these findings are legitimate and robust; further, we believe that there is a strong case for using them as the basis for the further qualitative investigation of the determinants of workplace OSH practice and the relationships between them that we have identified in our analytical model as being influential within the dynamic and fast-moving environments in which such management takes place.

Finally, we think that two key messages for policy-makers emerge from our analysis. First, many of the determinants of good practice that we have identified are changing in ways that point to them being less significant in the future as positive effects on OSH. Current and future OSH strategy at the EU level needs to take some account of this. Second, the impact upon Member States of steers from the EU, whether they are regulatory, economic or political, varies enormously according to existing national infrastructures and processes already in place. From the perspective of improving good practice and reducing the harm caused by negative work exposures, this suggests that EU policy-makers need to be extremely sensitive to these issues when contemplating supranational strategies. It further implies that it is mistaken to assume that a 'common position' has been achieved with regard to the determinants of good practice across all Member States within the EU. In terms of improving the prevention of harm and the quality of the experience of work for millions of European citizens, therefore, our findings indicate strongly that there is no lessening of the need for a robust prevention strategy on health and safety at work on the part of the EU in order to provide a significant and sensitive steer for the continuation of national efforts in this respect in the future.

1. Introduction

Through a set of requirements concerning the systematic management of occupational safety and health (OSH), the European Framework Directive 89/391/EEC and its individual Directives aim to provide workers in all Member States with a common minimum level of protection from work-related risks. However, the application and operation of such provisions take place within contexts which differently characterise Member States. As a result, the precise way in which these legislative provisions translate into the management of OSH at the workplace varies greatly from one country to another, as well as by industry sector, organisation size and the category or status of worker. In addition, it varies on both an individual (e.g. according to age or gender) and a contractual (e.g. full- or part-time, directly employed/self-employed/agency or other contingent) level.

A number of factors affect this translation of legislation into practice. The most important are the regulatory frameworks and the industrial relations traditions of the different Member States, but other contextual factors are also significant, including the social protection system, and broader factors such as the economic climate, labour force training and qualifications, and the availability and competence of specialist OSH services.

In 2009 the European Agency for Safety and Health at Work (EU-OSHA) ran the European Survey of Enterprises on New and Emerging Risks (ESENER) (EU-OSHA, 2010a). ESENER involved nearly 36,000 interviews with managers and health and safety representatives. The survey covered private and public sector establishments with 10 or more employees in the 27 European Union (EU) Member States, as well as Croatia, Turkey, Norway and Switzerland. Its aim was to provide nationally comparable information on how workplaces across Europe manage health and safety. Analysis of the resulting data gave rise to a descriptive overview report (EU-OSHA, 2010a) and four secondary analysis reports (EU-OSHA, 2012a–d). Taken together [1], these analyses provide a detailed insight into three broad areas: how health and safety is managed in practice (EU-OSHA, 2012b); how psychosocial risks are managed (EU-OSHA, 2012a,c); and how workers are involved in both these areas (EU-OSHA, 2012d). Each of these analyses also highlights the importance of the context in which establishments operate, not only in relation to understanding how workplace OSH is managed in practice, but also, and particularly important in terms of the overall aims of ESENER, in assisting policy-makers in the formulation of effective measures.

This project forms part of a follow-up to ESENER and the secondary analysis reports. Its aim is to analyse the determinants of workplace OSH practice by considering the impact of key features of the environment in which establishments operate on the way in which they manage OSH. Our intention is for our findings to be broadly relevant across the 27 EU Member States, as well as Croatia, Turkey, Norway and Switzerland (the countries covered by ESENER) and the other European Economic Area countries (Iceland and Liechtenstein). A comprehensive study of all 33 countries was not possible, so our approach has been to adopt a pragmatic research strategy intended to take account of differences in the structural, regulatory, economic, political and cultural contexts between the countries.

The project took as its starting point the well-established idea that EU Member States can be grouped into various combinations for the purposes of comparison according to features that are of particular interest in any given analysis. The following section describes the groups established for this purpose and the choice of Member States selected to represent them in the in-depth analyses. Clearly, no such arrangement is entirely without exception, so the limitations of the groupings are also acknowledged.

1.1 Contextual groupings of Member States

The choice of Member States to be studied in the project required a broad overview and understanding of a number of aspects of the context and environment in which OSH management takes place. These aspects included:

- the style and character of national regulatory regimes for OSH management;
- the labour relations' contexts of OSH;
- key features of social protection systems;
- the availability and competence of OSH services;
- information provision;
- significant aspects of national and European political and economic climates;
- the will and capacity of organisations to manage OSH;
- labour markets;
- the structure and organisation of work; and
- national and local arrangements for labour force training and skills qualification.

This overview and understanding was based on a review of published research and analysis concerning both the evidence for and context of approaches to OSH management by work organisations in all 33 countries included within the project's remit. A major source for this review was the ESENER survey, supplemented by relevant findings from other European and national surveys.

Existing knowledge of the comparative European contexts of OSH regulation (see, for example, Walters, 1996a, 2002, 2008; Walters and Jensen, 2000; Westerholm and Walters, 2007; Walters et al., 2011a,b; EU-OSHA, 2012d) enabled us to discern seven groups of countries reflecting broadly similar contextual influences in terms of regulatory character and style, labour relations, social protection systems and other national regulatory, economic and social characteristics that are

[1] Eurostat (http://epp.eurostat.ec.europa.eu).

likely to have some influence on the operation of regulatory requirements on OSH management within establishments. They included a Central group, a Nordic group, Ireland and the United Kingdom, a Southern/Latin group and a group of Eastern Member States, along with a group of Smaller Southern Member States and a Baltic States group:

1. Central: Austria, Belgium, Germany, Liechtenstein, Luxembourg, Netherlands, Switzerland
2. Nordic: Denmark, Finland, Iceland, Norway, Sweden
3. Ireland and United Kingdom
4. Southern/Latin: France, Greece, Italy, Portugal, Spain
5. Eastern: Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania, Slovenia, Slovakia, Turkey
6. Smaller Southern: Cyprus, Malta
7. Baltic States: Estonia, Latvia, Lithuania

This classification was derived by regarding the implementation of the approaches to risk management that are found in the Framework Directive as part of the trajectory of the development of process-orientated regulation on health and safety issues in the EU (and more widely in countries such as Australia and Canada). This had antecedents, especially in the Nordic and United Kingdom systems and, in addition, was influenced by the parallel development of standards for health and safety management systems (see Walters, 2002 and Walters et al., 2011a for a fuller account of the development and implementation of the Directive; see also Walters, 1996b, 1998). These latter developments can also be linked to the growth of interest in quality management systems internationally (see Walters et al., 2011b).

A combination of these factors leads to the conclusion that, for at least two of these groups, namely the Nordic countries (Group 2) and Ireland and the United Kingdom (Group 3), the operation of national process-orientated regulatory standards emphasising a participatory approach to OSH management largely predates the Framework Directive by around 20 years. On this basis there is a strong case for also including the Netherlands in this group, because it too had introduced a process-orientated regulatory framework long before the adoption of the Framework Directive in a sequence of regulatory changes which were acknowledged to be influenced both by the Robens Report and the Health and Safety at Work (HSW) Act in the United Kingdom and by Nordic provisions (Walters, 2002). However, elements of the provisions for participative OSH management in the Netherlands are quite different from those in both the United Kingdom and Nordic models. Their emphasis on the central role of the works council in this respect aligns them more with the Central group (Group 1).

The Ireland and United Kingdom and Nordic groups of countries also have other longstanding features that are supportive of process-orientated participatory approaches to arrangements for health and safety, including well-established industrial relations cultures in which the role of trade union representation, negotiation and consultation, as well as longstanding provisions for trade union-appointed health and safety representatives, are prominent, as is a relatively high trade union density and strong union bargaining power. Although in countries like the United Kingdom these last features have been considerably eroded in recent decades, their legacy is arguably still felt in terms of the OSH management culture, especially in larger unionised enterprises.

Other groups of countries came later to the process-orientated regulatory standards that typify the Framework Directive, and in many cases their adoption of the Directive required a complete overhaul of national provisions — such as in some of the Southern/Latin countries such as Italy, Spain and Greece (Group 4) and in some Central countries such as Germany (Group 1). The countries in these groups (1 and 4), along with the Eastern countries (Group 5), retained an older model of OSH regulation in which specification standards and prescription often combined with a more confrontational and rigid regulatory culture than was the norm in the countries in the Nordic and Ireland and United Kingdom groupings (Groups 2 and 3). Arguably, they also had more highly regulated employment relations systems in place in which the freedoms of collective bargaining to determine negotiated compromises were less evident, and therefore the environment for the generation of participative approaches to health and safety management may have been constrained. As we have already said, these are oversimplifications and there are numerous exceptions, but, if they are even broadly true, some differences in outcomes between the countries we have categorised in Groups 2 and 3 and the rest would be expected; indications of such differences were apparent in the secondary analyses of the ESENER data (see, for example, EU-OSHA, 2012d). We explore these differences in greater detail in Chapters 3–5.

Of course, the development of a regulatory orientation towards process-based standards for health and safety is itself influenced by a host of other determinants in the regulatory, political and economic environments of the countries concerned, as well as by external influences, such as the effects of membership of the EU. In the section that follows we briefly describe our rationale for the selection of countries from the broad groupings above in which we examine the national contexts in which OSH management occurs. In addition, we outline something of the features of the historical development of the national environment in which regulating health and safety takes place in the countries we have chosen to study and which might also influence the approach to OSH management in practice. Much of the detail of these outlines is drawn from the national experts' reports that were written for this project (see Chapter 2 and the Annex).

One feature of environment and context that we acknowledge to be incomplete in our analysis concerns the effects of the wider legal systems in place in different EU countries and, related to this, the overlap between these effects and those of different systems for compensating work-related harm.

The reasons for these omissions are primarily the absence of evidence of their possible effects on managing workplace health and safety. Of course, there are substantial differences in the legal systems represented, for example by the British 'common law' system in comparison with the Roman law basis of many continental European legal systems. From the existing evidence, however, it is not clear whether these differences impact significantly on the ways in which approaches to managing health and safety have developed and are operated within workplaces in these countries ([2]), beyond those such as procedural differences in the relations between public authority inspectors and the courts, which are addressed in the following pages.

Although it is not unreasonable to assume that fear of successful large compensation claims may be a motivator for employers to at least have documented procedures in place to defend themselves against such claims, the evidence for this effect is scant. Also, the effects of the courts are somewhat hidden by the common practice of insurance companies settling such claims out of court. At the same time, it is becoming increasingly expensive to take such claims to court, and falling trade union membership may mean a reduction in such traditional support. But, here again, research and other evidence of these developments and their connection with arrangements at the workplace to implement OSH management is scarce.

Nor is it clear whether or not the involvement of the courts in different approaches to compensating work-related harm impacts on its prevention by influencing the nature of workplace arrangements for managing health and safety. Although we know, for example, that there has been some convergence between social insurance-based compensation systems and those based more on private litigation in recent years (see, for example, Walters, 2007), in terms of the extent of the involvement of the courts, here again it is not clear from the available evidence whether or not these changes also impact on preventive arrangements at the workplace level. As we discuss later in this report, although it is obvious that insurance-based compensation systems provide incentivisation schemes to encourage preventive arrangements at workplaces in some countries, the relationship between such systems and the courts is unclear.

1.2 Selection of Member States

Our selection of Member States from these seven groups was intended to be both representative (of the countries within the group) and pragmatic (such that our contacts and the publically available information would allow effective study).

([2]) See Fookes et al. (2007) for an interesting attempt at comparison.

1.2.1 Germany

There are several fairly obvious reasons for identifying Germany as an important country from the Central group (Group 1) in which to study contextual and environmental influences on OSH management in more detail. Aside from the size and significance of the German economy and the comparative success with which it has retained its manufacturing base, its approach to regulating OSH is distinctive in several respects. To appreciate their significance and the reasons why Germany has an OSH system with features that have been especially challenging for the adoption of the 'European' approach, it is necessary to pay some regard to the historical development of the administration of German economic and social affairs. To begin with, private law has been of fundamental importance, for both labour law and OSH regulation, because it has enabled individual employees to make legal demands that their employer fulfils his or her duties according to their contract of employment (as opposed to public law, whereby, for example, the statutory accident insurance associations may determine employer obligations). As a result, both individual and collective private law (e.g. the works council (1920), works constitution (1973) and collective bargaining) have become increasingly important. The regulatory and institutional frameworks for labour relations in Germany and the co-determinism that has underpinned many of the policies in this area for much of last half century or more, while not unique in the Central model, are probably more highly developed in Germany than elsewhere and present further departures from the regulatory models on which EU goal-setting approaches to the participative management of OSH are arguably predicated.

In terms of the approach of public regulation to OSH, the territories that constitute modern Germany include some with a long industrial and regulatory intervention history. Public regulation of OSH in Germany can be regarded as dating from the Prussian Child Labour Act of 1839. Provision for obligatory factory inspection followed in 1853, and the establishment of the statutory accident insurance associations in 1884/5. Other key milestones include the 1891 Workers' Safety Act, the Working Time regulation of 1918, the 1920 Works Council Act and the 1925 Ordinance on Occupational Diseases. More recent developments have included an Act on OSH experts in 1973/4, the 1994 Working Time Act and the 1996 OSH Act, which implemented the Framework Directive.

The dual nature of the regulatory system in which the social insurance organisations play such an important role (themselves created with a framework for self-administration by entrepreneurs within social insurance institutions with a strong state influence), and the sectoral nature of their organisation, has led to a highly differentiated system in which there is more than the usual integration of prevention, rehabilitation and return to work, but also significant problems of duplication and challenges for coordinated prevention strategies. The federal nature of the German state has added

further to this complexity in relation to both state regulatory practices and the institutional infrastructures involved.

In combination, these features resulted in a comprehensive system for surveillance and advice for companies, but no single regulatory provision in which the general obligations on employers, or employees' duties or rights, in relation to OSH were comprehensively but clearly stated until the mid-1990s, when the country was obliged to implement the provisions of the Framework Directive. The enforcement of OSH legislation is also split between a number of institutions: the 16 federal states oversee employer compliance with public OSH legislation, while the Statutory Accident Insurance Associations oversee employer compliance with both the 'autonomous' and public OSH legislation. Both parts of the system now cooperate within the Joint German OSH Strategy (see below).

Superimposing the rationale of EU measures on OSH onto the embedded regulatory and institutional structure has been a rather uncomfortable process that in recent years has required some fairly fundamental policy shifts and rethinking in Germany. In 2003 a politically driven debate on its future was initiated and further fuelled by the European Commission's strategy of 2007–2012 on health and safety. The outcome was a compromise: the Joint German OSH Strategy, which was integrated into the German OSH Act at the end of 2008. Key to this strategy is the intensified cooperation between the two pillars of the dual system through binding targets and joint institutions. In relation to the Framework Directive, stakeholders (the state, statutory accident insurance associations and social partners) have agreed on the following: the preference of federal law in implementing EU legislation; avoiding double regulation within the dual system between state and autonomous legislation; clarity in the development of technical rules for OSH legislation; and flexibility in implementation for companies. This has led to the readjustment of regulations and technical rules and the cutback of regulations by statutory accident prevention and insurance associations. Moves have also been made to harmonise these rules, including specific requirements for appointing safety officers and company doctors for all sectors of industry. In larger organisations safety officers can be employees, while small and medium-sized enterprises (SMEs) can appoint consultants or external services.

These are all important reasons to examine the institutional and regulatory context and environment for goal-setting EU approaches in Germany.

1.2.2 Sweden

In the case of the Nordic grouping (Group 2), all these countries have similar social democratic traditions, strong welfare provisions, relatively significant trade union presence and involvement in OSH, and a similar history of process-based, goal-setting approaches to regulating OSH management in a participative way. Indeed, in several respects this last feature predates the requirements of the Framework Directive and was a significant influence upon them. Similarly, the broad definitional understanding of OSH in terms of the 'work environment' was also longstanding in these countries. Moreover, while there are substantial differences between them, it is arguable that they have more in common in their historical approaches to the organisation of prevention services and to compensation for work-related harm than they do with other EU countries on these matters. Because of its size, we chose Sweden as our example of a Nordic country for an in-depth study.

In the century between 1870 and 1970 the Swedish economy was transformed from that of a poor agricultural country to one of the world's richest, with high levels of manufacturing. Since the 1970s, many public sector (mainly female) jobs have been created. Despite the oil crisis and increased competition in the 1970s and 1980s, which led to slower economic growth, unemployment remained relatively low. The high level of social welfare provision typical of the Nordic social democratic model meant that, in 2010, 45.8% of gross domestic product (GDP) was redistributed to citizens as pensions and social insurance. However, politically, the social democrat dominance has given way to more neoliberal policies, which have increased in prominence since 1976, the income gap has grown and there have been other effects similar to those found elsewhere in Europe, including more emphasis in governance towards neoliberal decentralisation and quantitative performance measures, with increasing privatisation. Since 2006, much of the labour market has been deregulated, making it easier to outsource, enhancing the role of supply chains in production and the use of casual and/or imported labour.

Social dialogue is a fundamental feature of the 'Nordic model' and arrangements to achieve it are longstanding. The social partners participated in a tripartite governance of labour and social policies including safety at work prior to the 1920s. The unions and social democrats initiated a series of work reforms in the 1970s, which still form the basis of labour law, including union representation on company boards; shop stewards' right to take paid time for their function; lay-off rules on first in and first out; and co-determination (i.e. union rights to information and consultation). Worker representation on health and safety has been a legal right since 1912. Although economic and political conditions have changed, unions and employers still retain significant influence and continue to cooperate. Policies on the work environment are consensus orientated and primarily aim to advise and persuade employers to assess and address risks. Since the 1942 agreement on general safety, the social partners have 'owned' work environment policies and dominated initiatives.

Sweden joined the EU in 1995. In general, national regulations have required little adaptation. However, industrial relations have been affected by EU decisions, particularly in relation to posted workers where they undermine the Nordic model of settling minimum wages and most other working conditions through collective agreements rather than by law. This risks

creating a dual labour market in which the phenomenon of social dumping for migrant workers is a likely consequence. This is a significant challenge since non-Swedish EU citizens make up 11% of the workforce, with another 9% originating from other countries. Generally, the power balance in the political economy has shifted from labour towards capital, with more precarious jobs and neoliberal labour market policies. Globalisation has led to increased numbers of foreign employers with more authoritarian management and a lower priority for the work environment, less willingness to cooperate with unions and safety representatives (which are weaker) — particularly in the case of small foreign firms carrying out short-term work in Sweden. In combination with the import of labour and social dumping that often includes poor risk prevention, this may erode the work environment system and weaken employers and employees as actors for effective prevention. Fractured corporations, outsourcing and downsizing lead to increasing numbers of small firms with fewer preventive capacities.

The Work Environment Act (1978) covers all conditions and actors, giving broad requirements and duties not just to employers, but also to producers, importers, designers and so on. The provisions also apply to the self-employed. Mandatory OSH management was introduced as the primary OSH strategy in 1993 — this effectively transposed the Framework Directive and goes further by stipulating a feedback and learning loop of internal audit and improvement and giving workers stronger participation rights. These provisions were updated and renamed SWEM (systematic work environment management) in 2001. With SWEM, provisions combine process and material requirements, with risk assessment as a basic requirement. Since the 1990s, material provisions have been replaced by overarching performance-orientated ones — resulting in a reduction in regulations of about one-third. Coverage by occupational health services, once a prominent feature of the Swedish approach, has reduced from 80% of those at work in 1989 to 65% in 2011, with those in the private sector and small firms less likely to be covered. For most employers hiring services, the main focus is now on health checks, health promotion and rehabilitation, rather than prevention. Sector-orientated occupational health services (e.g. in construction and transport) were abolished in 1993 when the services were deregulated. However, some are still active in risk assessment and prevention, particularly among larger firms where employers have a preventive focus. Employers' organisations have objected to union calls to make health services mandatory, but the social partners jointly want to strengthen their preventive orientation, while the government focus is on their role in the reduction of social insurance costs.

Worker compensation is part of the public insurance system. However, following the economic crisis in the early 1990s, compensation entitlements have been reduced. The right to sue employers was abolished together with no-fault liability insurance. Further insurance restrictions have been imposed since 2006, and the great majority of perceived work-related ill health is not reported. It is harder for women to get compensation for stress and musculoskeletal disorders (MSDs) than men for accidents. Research in the early 2000s into increases in sickness absence and early retirement pointed to psychosocial risks as a major cause of the rising costs of social insurance pay-outs, which led to a number of political initiatives including more labour inspectorate resources and instructions to focus on these risks. However, the policy of the current government has been to focus on getting people back to work through reducing their rights and benefits.

Public funding for research, information and training was substantial historically, but has significantly reduced recently, though these activities continue with the help of joint union and employer funding.

The labour inspectorate has experienced repeated upheavals in organisation and funding. Inspections have become more reactive, with more coordinated campaigns on selected risks or industries, though the inspectorate continues to visit around 6% of all workplaces per year. Five per cent of visits in 2011 were to the self-employed and 72% to small workplaces. In response to a recent Senior Labour Inspectors' Committee (SLIC) report (SLIC, 2008), there are moves to rate employers using qualitative checks and publish the results. The inspectorate produces a great deal of information. Overall, although the inspectorate is often effective in its efforts to improve work environments, it has been more successful in making employers reduce technical risks than in raising their general ability to detect and reduce risks. Inspection of psychosocial health mainly relies on SWEM. Although traditional risks have been reduced, organisation and psychosocial risks and MSDs persist. The regulation and inspection of these risks is acknowledged to be challenging and not specified in statutory provisions. Cuts to inspectorate budgets and consequent shortened inspection time may have reduced focus on these complex tasks.

1.2.3 United Kingdom

The United Kingdom has a number of fairly unique features that are especially relevant to the remit of the study. Like the Nordic countries (but for different reasons), its approach to goal-setting, process-based regulation of OSH management is longstanding and predates the Framework Directive by more than a decade. Trade union influence in the United Kingdom was at its height when this approach to OSH management was developed and has declined subsequently; nevertheless, arrangements for worker representation remain integral. It has also experienced a strongly neo-liberal political and economic environment, both prior and subsequent to the introduction of EU measures, which has provided strong contextual influences on regulation and regulatory inspection of OSH. Although the United Kingdom has a long history of industrialisation, in the twenty-first century its economy is post-industrial, increasingly globalised, service-based and private sector dominated. It has been strongly affected by the economic crisis from 2009, and has been undergoing radical austerity measures since the

present coalition government was elected in 2010, some of which have explicitly targeted reducing public expenditure on regulating OSH management through administrative reforms and political moves towards deregulation, along with the political profiling of health and safety by the government as a bureaucratic burden on business and personal freedom.

Other significant contextual factors include the reorientation of inspectorate policies to acknowledge broader relationships between work and health; deregulation of the labour market; decline in worker representation and collective bargaining (as a result of union decline); and changes in the structure and organisation of work and the labour market in which there has been an increase in work in smaller firms, part-time work, agency and contingent work, an increase in flexible working and just-in-time production techniques, significant work intensification, rising levels of overqualification and underuse of skills, and increasing labour market polarisation. There are also significant problems in relation to youth unemployment, more women, older and migrant workers in the labour force, greater outsourcing to supply chains and a shift away from manufacturing, engineering and mining towards the services, with fragmentation and consequent devolution of managerial responsibility (but not necessarily authority) also taking place.

These factors need to be set against the background of a long industrial tradition, early development of a process-based approach to OSH regulation and the strong trade union influence at the time of this development, which ensured inclusion of worker representation.

The United Kingdom has over 200 years of experience of regulation and regulatory inspection of OSH. The inspectorate is the oldest in the world, originating as a requirement of the 1833 Factory Act. It also has a longstanding occupational insurance system dating back to the Workmen's Compensation Act 1897. The current system covers those paying income tax (with the exception of the self-employed, who have a voluntary scheme). Victims also have the right to sue under civil law. In addition, employers have a duty to insure themselves against occupational injuries' liability.

The Robens Report (1972) led to the HSW Act (1974). This statute remains in force and provides a framework of process-based regulatory standards in which duty-holders' responsibilities are generally defined. It introduced the United Kingdom's goal-setting approach and so represented a significant shift from prescriptive to process-based regulation. There is no general requirement to provide access to an occupational health service in United Kingdom provisions and there has been a decline in occupational hygiene specialists in recent decades (reflecting the decline in manufacturing and the extractive industries and heavy engineering, as well as the fragmentation of large organisations and privatisation). However, there has been an increase in the number and activity of general health and safety practitioners. Support for rehabilitation and return to work, like the compensation system, is relatively weak.

The HSW Act also defines the structure and functions of the labour inspectorate (the Health and Safety Executive (HSE)) and its tripartite Executive Board. The regulator's remit, which is limited to work-related health and safety, includes inspection and compliance, policy formulation, and science and technology (i.e. both carrying out research and providing advice). Successive governments since the late 1970s have repeatedly reduced its budget (see the United Kingdom report for details). Consequently, the number of inspectors fell substantially, along with inspections, investigations and enforcement measures. Funding for research and information has been greatly reduced. Currently, the government is aiming to cut inspections by at least a further third and to continue deregulation. There is also some evidence that the decline in access to union representation extends to representation on health and safety measures, and there is no evidence to suggest that statutory measures to provide consultation and representational rights for non-trade unionists have had any significant impact.

Despite these trends in reduced resourcing and deregulation, there has been a fall in serious injuries and fatalities, reflecting in large part the decline in employment in hazardous industries and substantial increases in the health effects of psychosocial risks, especially those associated with services work (which traditionally employs more women).

1.2.4 France

France was selected as one representative of the Southern/Latin group (Group 4). In many respects its regulatory style, and to some extent its geography, are typical of the Latin model, but in others, especially in relation to the size and structure of the economy, it is more typical of larger western European Member States such as Germany and the United Kingdom.

As in other EU Member States, there has been a recent shift towards casual work and a corresponding impact on job security and working conditions, with growing numbers of SMEs, increased work rate, variable working hours, lack of autonomy, and lack of support for their health and well-being reported by French workers. According to 2010 figures, 11.6% of the working population is self-employed, 11.9% are in temporary work, 76.5% have permanent work and 17.9% work part-time. In 2000, 7% of companies and 2.4% of the workforce were involved in undeclared work. In 2005 there were approximately 5 million immigrants living in France: 45% from other EU countries, 39.5% from Africa, 12.7% from Asia and 3% from Oceania. Migrant workers are typically concentrated in the building sector (14.9%), business services (10.3%) and services to private individuals (15%). Forty per cent of migrants are in unskilled jobs and over one-third of female migrants work part-time. Increased physical demands of work, as well as increased work intensity, low autonomy and limited collective support are also reported by respondents to surveys. Trade union membership (8%) is very low by comparison with many other EU countries. However, a paradox of French labour relations is that the representation of unions within firms (41% in the private sector) is quite high and the role of the trade unions in the labour market and in health and safety is significant and substantial.

In terms of OSH, France has significant historical differences from other countries in relation to the role of occupational medicine and towards compensation systems for work-related harm, as well as the trajectory of its relatively recent reforms to operationally accommodate the requirements of the Framework Directive. Labour law first addressed industrial accidents in the nineteenth century by protecting young women and children in the mining industry. This was strengthened in the early twentieth century by the introduction of mechanisms for employer liability. The state plays a pervasive and leading role in the preparation of policy guidelines and regulations. In 2008 the labour inspectorate had one inspector for every 9,300 employees, and spent about two-thirds of its time on company visits. Joint health and safety committees are also important constituents of the structural determinants of health and safety management in France.

The social security system recognises and pays compensation for occupational accidents and illnesses. At the heart of this system is the historically central role of the occupational physician, which, since the implementation of the Framework Directive, has, to some extent, given way to a central role for employer-funded occupational health services. The pivotal position of occupational medicine stems from the post-war period in which organisations providing compensation and aiming to improve working conditions were founded, as were the institutions of the occupational physician, the National Institute for Occupational Health and Safety and the National Agency for Working — ensuring that the role of the physician was deeply embedded in the French system.

In recent years there have been significant changes to employment law in France, and health and safety has become a national priority as a result of EU pressure and the asbestos crisis. Despite these changes, a significant gap remains between experiences in small firms and those in larger ones. Recent developments in this respect include the first Occupational Health Plan, which was launched in 2005 with the aim of reforming and improving the visibility of occupational risk prevention mechanisms. The plan highlighted the crucial role of the social partners. It enabled the coordination of training measures and information campaigns at a regional level and established conditions for public–private collaboration on research. The second plan (2010–14) was marked by a drive to involve all stakeholders and put workers at the heart of the prevention approach.

Despite these developments, differences in frequency and severity of injuries between sectors continue to raise questions about the quality of prevention in some areas. Job insecurity is a further powerful threat to the improvement of working conditions, with concern expressed about the possibility of a dual labour market being created in which there would be an increase in the number of workers who were significantly exposed to serious risks and for whom existing prevention mechanisms would be either irrelevant or inapplicable.

1.2.5 Spain

We selected Spain as a second Southern/Latin country, for several reasons. First, it was one of the EU Member States that deliberately used the opportunity of the Framework Directive to undertake a major reform of its regulatory system for OSH. Second, it is a relatively large Mediterranean economy. Third, it has considerable regional autonomy with a resulting dynamic between central and regional regulatory contexts. Fourth, it has been especially affected by the current economic crisis: unemployment reached 22% in 2011, with younger workers particularly affected (40%). The rapid evolution of the current situation of economic crisis in Spain is a major concern. Data from 2009 showed that the decline in the number of employees in that year (815,500 people) occurred mainly among workers with temporary contracts (668,000 in all sectors). Again, decreases affected young workers more than other groups (in 2009 more than 180,000 workers aged 16–29 years lost their jobs). The unemployment rate for foreign workers was also much higher than for Spanish workers (30%). The huge influx of migrant workers to Spain has been a relatively recent phenomenon, with the number of foreign-born workers increasing nearly fivefold during the first decade of the twenty-first century (from 2.3% in 1999 to 10.8% in 2008). According to European statistics ([3]), Spain is in the lowest position in the context of a crisis which is affecting all countries, but for which it seems that not all were equally prepared and/or do not have a similar ability to overcome the situation. By 2009 unemployment in Spain had doubled in five years (from 9% in 2005 to 18%), a greater increase than in most other countries. The proportion of temporary contracts is the highest in Europe at almost 24%, which is twice the EU average (11%).

This background of the recent crisis obviously presented institutions for social protection with major challenges. Such institutions appeared and began to consolidate OSH initiatives at the end of the nineteenth and start of the twentieth centuries, including the Act of Occupational Injuries, the Regulation of Occupational Safety and Health and the creation of the labour inspectorate. Occupational medicine also became a regulated profession around this time. However, the Spanish Civil War (1936–39) stopped or significantly slowed many developments and the subsequent dictatorship (1939–77) meant that some of the conventional aspects of modern OSH systems, such as the representation of workers in OSH management, were virtually non-existent. Similarly, occupational medicine was restricted to caring and rehabilitation (i.e. no workplace surveillance or prevention). The separation between occupational conditions, hygiene and safety at work under the Ministry of Labour on the one hand and occupational health under the Ministry of Health on the other also dates from this period. The specialty of occupational medicine was not formally defined in Spain until 1984, and was initially regarded as a 'lesser' medical

([3]) Eurostat (http://epp.eurostat.ec.europa.eu).

specialism; subsequent regulation (2003–05) improved the training programme for occupational physicians. The specialty of occupational nursing was defined for the first time in 2005 and remains severely limited and 'symbolic'.

Health and safety technicians have a central role in Spanish OSH activities. Prevention services must be accredited and able to offer services in occupational medicine, occupational safety, industrial hygiene, occupational ergonomics and applied psychosociology. As technicians' training was not mandatorily university based until 2010, there have been ongoing concerns about quality (which, despite the change to training, remain).

Spain joined the EU in 1986. This quickly led to a number of new and key legal provisions on OSH, mostly derived from EU Directives. The Framework Directive is transposed by Law 31/1995, which introduced substantial changes in OSH structure and practices. These included a requirement to systematically plan and organise OSH activity, as well as the creation of structures for workers' participation. Safety representatives were introduced for the first time, and health and safety committees were required in establishments with 50 or more workers. Since this point, the emphasis on workers' rights for participation in all aspects of OSH protection has been constant.

The labour inspectorate has one inspector for every 10,000 workers and, as in France, it is a generalist inspectorate with additional functions to OSH. In 2006, nearly 300 technicians were employed to strengthen the inspectorate's functions on OSH compliance at the autonomous community level. OSH professionals suggest that more resources are needed for inspection and that training and specialisation needs to be intensified.

1.2.6 Bulgaria

Perhaps the most challenging countries in which to study contexts and environmental determinants of OSH practice are those of the former Eastern Bloc (Group 5). In many respects they are a disparate grouping and this is reflected in the results of ESENER (see, for example, EU-OSHA, 2010a). However, they share a relatively recent adoption of EU measures on systematic OSH management. Their imposition of these and other reforms to bring them more in line with the EU-15 model of 'Europeanisation' has meant change of quite a fundamental nature in the orientation of regulatory strategies on OSH and a rapid move from prescriptively based approaches to regulation to those that are more process based. Of course, these were part of other, much larger, reforms that took place in many of these countries at the same time in the Europeanisation project. They also followed quite rapidly on the heels of even greater reforms in the economic and regulatory context and environment in these states occasioned by the move many of them made from a controlled economy to a capitalist one following the demise of the Soviet Bloc. All this makes for a significant contextual and environmental challenge for the workplace and organisational implementation of the EU goal-setting approach to OSH management. Reliable published, detailed, critical research analysis on the operation of EU measures on OSH in these countries is relatively limited, as are good contacts. From this group we chose to study the context and environment in which organisational health and safety management is undertaken in Bulgaria.

In Bulgaria the economy and industry contracted following the collapse of the socialist system and the loss of the Soviet market in 1989. Standards of living fell by about 40%. In addition, United Nations sanctions against Serbia (1992–95) and Iraq took a heavy toll on the Bulgarian economy. Despite some recovery in the first half of the 1990s, the economy collapsed again during 1996 due to disastrous economic and other policies, which led to massive inflation and currency collapse. Following a programme of economic reform from 1997, the European Commission declared that Bulgaria had a 'functioning market economy' in October 2002, and the country joined the EU in 2007. In order to attract foreign investment, the government lowered corporate tax rates to 10% (reportedly the lowest in Europe). The country was badly affected by the economic crisis, in particular in the mining, metalwork and metal extraction, chemicals, construction and production of construction materials, clothing and textiles, real estate and tourism sectors, with falls in GDP (down 5.5% for 2009) and foreign investment (down 40%), and increases in unemployment (up to 10.2% in 2010) and corporate bankruptcy (17% of companies went bankrupt by mid-2009).

The labour market has therefore undergone dramatic change since the start of the dismantling of the centrally planned economies in 1989. High inflation, the absence of a modern social framework and mass redundancies severely undermined living standards. The population decreased by nearly 15% in 20 years with young and especially skilled workers moving abroad for work, resulting in a fall in the active workforce. There are also increasing numbers of new workers with no qualifications (up from 45% to 53% in the last five years), and continued rising unemployment. But during the last years of the transition Bulgaria has generally embraced democratic changes and is now setting clear priorities for its future. This includes the harmonisation of Bulgarian legislation with the EU model — including on health and safety.

EU membership necessitated the adaptation of people and institutions, and of the mentalities of both workers and employers. Preparation for accession involved acceptance of the basic rights of workers' representatives and EU principles of health and safety at work. The Framework Directive is transposed into Bulgarian law by the 1997 Law on Health and Safety at Work — developed after consultation with the social partners and effective from 1 January 1998 — and in 2008 Bulgaria adopted a National Strategy on Safety and Health at Work (2008–12). A relatively recent independent labour inspectorate, along with the comparative immaturity of independent trade unions — and fears among their representatives about losing their jobs if they insist on, for example, exercising their rights to call for risk assessment and recent rights in relation to representation on working conditions committees and in accident investigations — represent further challenges for effective OSH management.

1.2.7 Cyprus

Smaller Southern peripheral EU economies, such as those of Cyprus or Malta (Group 6), are arguably different from other countries because of their size, and it is possible that a focus on larger EU economies, such as those that dominate our selection, risks missing the situation and contexts of very small countries. There may be, for example, initiatives that are specific to addressing these contexts. We included Cyprus in the project for these reasons.

A large proportion of workplaces are micro (often family run) businesses, and rates of self-employment and undeclared work are comparatively high. Challenges for prevention therefore include the problems of micro-enterprises, the self-employed and undeclared work, as well as the ageing population and immigration — there are more accidents among migrant workers (four non-EU nationals were killed in 2010 compared with one Cypriot).

The first law on the protection of workers was enacted in 1947 under the British, and the legacy of British rule remains evident in some Cypriot institutions. The framework for modern OSH began with the 1956 Factories Law, which was limited to specific sectors. Tripartite cooperation is exercised at national, regional and local levels and the first attempt to form a Pancyprian Safety Council was made in 1964, while the Health and Safety at Work Law was enacted in 1996 as part of the policy to harmonise the legal framework with EU legislation prior to achieving membership. It was amended most recently in 2011. Draft regulations covering medical examinations and health surveillance are currently in preparation. The Social Insurance Scheme, which was first introduced in 1957, relies heavily on state support and applies to all employed and self-employed workers. It is funded through contributions from employees, employers and the state.

The Labour Advisory Board is the highest tripartite advisory body in Cyprus and is the forum for the discussion of social protection legislation and policy. The Department of Labour Inspection is responsible for surveillance of health and safety at work. The Pancyprian Safety and Health Council is a tripartite consultative body on health and safety, which advises the Minister on all health and safety matters. This council, which was set up in 1988, reviews national OSH policy. The Safety and Health at Work Law covers employees, the self-employed and others (agency workers, etc.). It also imposes requirements on designers, manufacturers, importers and sellers, and covers all workplaces. General duty provisions are included in the Health and Safety Law and extend to consultation with employees' representatives on OSH issues and the preparation of written risk assessments.

Cyprus joined the EU in 2004, adopting the euro currency in 2008. The provisions of the Framework Directive that were not included in the original text of the Safety and Health at Work Law have been introduced under the Safety and Health at Work Law in the Management of Safety and Health Issues at Work Regulations of 2002, while external OSH services were established further to accession to the EU in 2004.

1.2.8 Latvia

Although they are former Eastern Bloc countries, we have placed the Baltic States in a separate category (Group 7), as the literature on these countries suggests that they are not entirely typical of other former Eastern Bloc states (see, for example, Woolfson, 2007). From within this category we chose to include Latvia in our study.

Latvia is one of the smallest post-communist countries, with some 2 million inhabitants. Since its independence from the Soviet Union, along with its Baltic neighbours of Estonia and Lithuania, its governments have applied neoliberal policies of economic and social reconstruction with particular enthusiasm (Pabriks and Purs, 2002), and at least until the 2008 global financial and economic crisis with apparent success. In terms of domestic social development, however, this has meant only limited provision of welfare state and social protection systems (Aidukaite, 2011). Today, Latvia is also among the least advantaged of the newer EU nations, with among the highest rates of income inequality (as measured by the Gini coefficient), a declining birth rate and high rates of emigration, with approximately 200,000 people, or one-tenth of the population, currently living abroad (Dennis and Guio, 2004; EurLIFE, 2005; Lulle, 2009; Eurostat, 2012).

The economic crisis was felt severely in Latvia. From yearly growth in GDP of over 8% from 2000 to 2007, GDP decreased 17.9% by the fourth quarter of 2009. The government introduced a particularly harsh austerity programme with massive cuts in wages, public spending and social provision. Unemployment reached 17.6% in 2009, with youth unemployment approaching 40% by 2010.

Even before the crisis, Latvia had long working hours, low basic salaries, gendered wage distribution and 'informalised' employment. Since the crisis, the use of part-time and temporary contracts and informal payment systems has accelerated. Labour relations laws cover only those with contracts. Official statistics do not cover the 'self-employed' (though these are often actually employees). Only a fraction of accidents are reported, with under-reporting particularly prevalent among SMEs — something that may have been exacerbated by recent changes in the registration system (changes that were intended to reduce paperwork and improve reporting). Reporting of occupational diseases is also very poor, and there is a shortage of occupational medicine specialists and restrictive classification systems and registration procedures.

In the prelude to EU accession, Latvia enacted a new law on 'labour protection' in the early 2000s, which required significant changes in the organisation of labour protection at the enterprise level and intended to strengthen the legal responsibility of company managers and provide for the establishment of a labour protection function within companies (Eurofound, 2003).

In addition to these current challenges, to understand the emergent determinants of workplace OSH in Latvia, as with Bulgaria, some account must also be taken of the influence of the previous nearly 50 years of the Soviet era.

2. Research design and methods

The project was designed to provide an insight into how the context and environment in which an establishment operates affects the way OSH is managed. To facilitate this, as described in the previous chapter, eight Member States were selected as being representative of seven groups of countries with broadly similar contextual environments in terms of regulatory character and style, labour relations, social protection systems and other national regulatory, economic and social characteristics that are likely have some influence on the operation of regulatory requirements on OSH management within establishments. A multi-method approach was used, which included desk research, secondary analysis of the ESENER data and new qualitative data collection. The project was carried out in two phases: the in-depth study of each of the selected Member States and the synthesis of this in-depth material into a thematic consideration of the determinants of workplace OSH practice. We felt that, in order to achieve this, it was crucial to ensure that key national expertise within each of the selected Member States was combined with broader expertise at both the EU and wider international levels. In order to make the most effective use of the project's relatively limited resources and timeframe we therefore decided to hold an international workshop to bring together expertise at all of these levels to discuss and compare environments, contexts and determinants of workplace OSH practice.

2.1 Objectives

This project was commissioned by EU-OSHA in 2011 as a policy-orientated study into how the environment in which an establishment operates affects the way in which it manages OSH. In so doing, its objectives took account of the effects of several broad aspects of this environment. They included:

- The style and character of the national regulatory regime for OSH management — in particular, the extent to which the regulatory environment could be described as being characterised by process-based (goal-setting) requirements as opposed to prescriptive ones and the length of time such approaches have been embedded in the style and character of the regulatory systems for OSH in the Member States concerned; and the importance of inspection, criminal prosecution and administrative sanction, and the influence of civil procedures for compensation.
- The labour relations context of OSH management — the relevant legislation addressing worker representation and consultation on OSH and that influencing direct participation in OSH; and the key features of labour relations' systems in different Member States (such as the extent and form of trade union penetration, the role of workplace representation, national, sectoral and local arrangements for social dialogue, the position of OSH in trade union and employers' organisation policies, and the support provided for directly informing and consulting with workers in workplace relations).
- Key features of social protection systems — including relevant features of the compensation systems in place for work-related harm, as well as those covering sick leave, invalidity, return to work and rehabilitation and recent developments in national policy associated with these, which may influence the environment in which organisations make arrangements to manage OSH.

The project also considered a range of other contextual and environmental factors that were regarded as significant influences on OSH management within organisations. Specifically in this respect, it considered national infrastructures for OSH support (such as the availability and competence of OSH services, training and information provision) in the countries studied, and relevant aspects of the national and European political and economic climates, as well as societal attitudes to OSH, in as far as they may have a bearing on the will and capacity of work organisations to manage OSH. Similarly, and for the same reasons, the research considered features of the labour market and the structure and organisation of work in different Member States, as well as national and local arrangements for labour force training and for skills qualification that were deemed to be relevant to the creation and operation of arrangements to manage OSH.

In meeting these objectives, the project's aims were twofold:

- To provide a description and reasoned analysis of the most important factors affecting the way in which OSH is managed at the workplace, i.e. the environment.
- To consider how this environment affects the three main areas that were the focus of ESENER: OSH management, the management of psychosocial risks and the involvement of workers, i.e. the influence of the environment on workplace OSH practice.

To achieve these aims a pragmatic but innovative research strategy, which used a mixed-methods approach, was adopted. We outline this strategy below. This is followed by three chapters in which we explore the effects of the contextual determinants outlined above upon health and safety management practices in the eight countries we studied. For evidence of these practices the project draws substantially on the findings of ESENER (including the secondary analyses).

2.2 Research team

The Cardiff Work Environment Research Team (CWERC) was supported by two expert panels (see Annex for details of the members of each panel):

- The Project National Expert Panel, which was made up of at least one expert from each of the eight Member States selected for detailed study.

- The Project Advisory Board, which was made up of an expert from each of the eight Member States selected for detailed study and two internationally recognised experts — one from within the EU and another from outside the EU.

Members of the Project National Expert Panel were each asked to provide a paper giving detailed national contextual descriptions and analyses for their Member State using a variety of sources (see section 2.3). The Project Advisory Board provided both quality assurance and assistance in framing the project's wider analytical contexts and relevance.

2.3 Research strategy

As a follow-up to ESENER and its secondary analyses, this project took the three broad areas that were the focus of these earlier studies as its starting point:

- OSH management in the workplace;
- psychosocial risk management in the workplace; and
- the involvement of workers and their representatives in both these areas of risk management.

ESENER data were used in two ways. First, data on each of these three issues from the ESENER survey that were relevant to the study were identified; second, the approaches taken in each of the secondary analysis reports (which dealt with these three issues in more depth) were reapplied to subsets of the ESENER data. This allowed us to make comparisons, using the two considerations of the data, both between the selected Member States and between the groups of countries that they were chosen to represent.

In addition, the CWERC research team prepared a guidance framework outlining the key areas and issues to be considered (see Annex), together with a summary of the relevant ESENER data, for each of the selected Member States. These documents were provided to national experts to support them in preparing their paper and described how the characteristics of the regulatory framework, employment relations traditions and the other key factors affected establishments' management of health and safety at work in their Member State. National experts were also encouraged to use available quantitative and qualitative data and to consult with key informants as appropriate. The papers written by the national experts were circulated to the Advisory Board prior to the workshop, at which they were presented and discussed (see section 2.4). Following the project workshop, national experts were able to revise their papers in the light of comments made both at the event and subsequently as part of their review by the project's international expert. The final versions of each paper are reproduced in the Annex.

(4) The national expert for Spain was unable to attend the workshop. However, following a meeting before the event, one of the CWERC team was able to present the paper instead.
(5) With the exception of the advisor for Bulgaria, who was unable to attend.

These papers, together with the consideration of the ESENER data, form the basis of the findings and material presented in this report. In addition, we have drawn on a number of other sources, which are identified in the text. The findings and materials are presented in the three following chapters, which focus on the three broad areas that were the subjects of ESENER and its secondary analyses.

2.4 Project workshop

The project's international workshop was held at Cardiff University on 9 and 10 May 2012 (see Annex for details of the programme and attendees). National reports from the eight selected Member States were presented by the national experts (4). In addition, the advisor for each of the selected Member States presented his or her comments on the national expert's paper (5). Following the national experts' and advisors' presentations, all the workshop participants contributed to a wider discussion of the themes emerging from the papers and presentations. These included:

- the regulatory frameworks and industrial relations' traditions found in different Member States and the style and character of the national regulatory regimes for OSH and those for wider social protection;
- the infrastructure for OSH support (such as the availability and competence of OSH services, training and information provision);
- compensation systems and arrangements concerning sick leave and invalidity; and
- the nature and style of arrangements of labour relations.

Attention was also drawn to other wider contextual factors, such as national and European economic climates, features of the labour market, the structure and the organisation of work in different Member States, and national and local arrangements for labour force training and skills qualification. Participants regarded all of these factors, in varying degrees, as important determining factors in workplace OSH practice. In addition, workshop attendees were clear that these contexts both influenced and were influenced by developments at the EU level and that this occurred differently and with different degrees of importance in different Member States.

These factors, and the last dynamic, are considered and analysed in the following chapters, which present the project's findings.

2.5 A note on the ESENER data and their use in this report

Large-scale surveys such as ESENER gather a substantial quantity of comparable data from very many respondents over a wide geographical area. This confers considerable power. Nevertheless, at the same time, as with all surveys of this kind, limitation is conferred by its methodology on

the representativeness of its findings. There are significant problems of interpretation and meaning that need to be acknowledged in any international survey in which respondents' views are sought concerning national and local arrangements to implement requirements that have been made at a supranational level. They may result in terminology having different meanings in different countries. Sometimes this even applies to the fundamental institutions and stakeholders involved in OSH management. For instance, what is actually meant by health and safety specialist, representative, trade union or labour inspector varies considerably between Member States and impacts on their functions. Real but subtle operational differences are even more difficult to discern at this level of abstraction. This has been discussed in detail in relation to ESENER elsewhere (see, for example, EU-OSHA, 2012d). Most significantly for this report, the ESENER data in general are drawn from establishments that could perhaps most accurately be described as operating at the 'best end' of the spectrum of OSH management. This is apparent from some of the comparisons made in the following pages between the ESENER findings and those of local-level surveys. Whilst we acknowledge this important limitation of the data and it implications, ESENER's substantial strength in this instance is that it provides comparable data for the whole of the EU. Our approach, therefore, has been to focus on the ESENER data in this comparative way. In this respect, while we present proportions in the chapters below, our primary interest is in how Member States and groups of countries compare with each other rather than in the absolute level of any specific measures for OSH management. To this end, while we acknowledge that, like any transnational survey (as well as many national ones), the ESENER data are neither entirely robust nor comprehensive, we feel they are suitable for our purposes. We have therefore used them for this reason and also because findings in both the original survey and its secondary analyses suggested the need for such an exploration of contextual determinants.

3. Workplace occupational health and safety management

The European Council Directive of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (89/391/EEC) is known as the Framework Directive. It laid down general principles concerning the prevention and protection of workers against occupational accidents and diseases. These general principles of prevention made risk assessment the key element of OSH management and defined its main components as including the development of a coherent overall prevention policy; the prevention, assessment and elimination of risks, as well as documentation of these processes and periodic reassessment of workplace hazards; and the informing, consultation, involvement and training of workers and their representatives. The ESENER survey asked managers about each of these three areas. In addition, it included a subset of questions on how establishments applied these components to psychosocial risks.

This chapter focuses on the determinants of workplace OSH management. It considers in particular the development of a coherent overall prevention policy and the assessment of risk, and examines the wider determinants of approaches to these issues in the countries studied. Before addressing these detailed features of OSH management practices, however, it is worth looking more generally at issues of OSH management in the countries selected for our study and their possible relationship to contextual determinants.

3.1 Occupational safety and health management measures

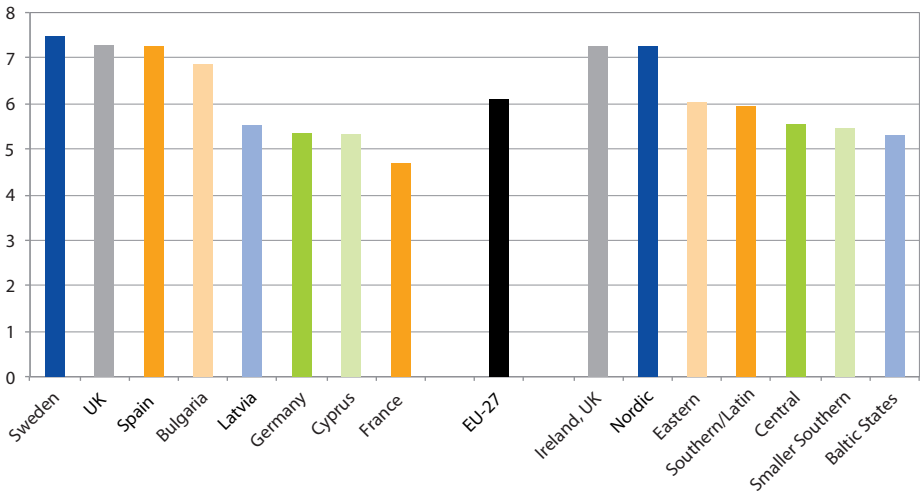
The research team that carried out Lot 1 of the ESENER secondary analysis focused on how health and safety is managed in practice (EU-OSHA, 2012b). Using the basic steps of an OSH management system as a starting point, they constructed a single variable expressing the scope of management of OSH risk that allowed the characterisation of establishments along a continuum. The OSH management steps included policy development; organisational development; planning and implementation; measuring and assessing the main risks to the organisation; and measuring the effectiveness of OSH interventions. The variable they constructed was a composite of nine factors included in the ESENER data in which a higher score indicated the presence of a greater number of OSH management measures. The most frequently reported components of the index were the implementation of an OSH policy, discussion of OSH in high-level management meetings, the involvement of line managers in OSH management and regularly carrying out risk assessments. The analysis showed that 'country' was one of the variables most strongly associated with OSH management, with the mean number of factors varying from around five at the lower end of the scale (in Greece, Switzerland and Turkey) to just under eight at the highest end (in Sweden, the United Kingdom and Ireland) (EU-OSHA, 2012b).

Given this variation by country, a similar range within the composite OSH management score would be expected across the Member States included in this project and across the groups they were selected to broadly represent. This is apparent in Figure 3.1, which shows the highest scores in the Nordic and Ireland and United Kingdom groups and the lowest scores in the Baltic States, Smaller Southern and Central groups. Scores for the individual Member States follow a broadly corresponding pattern, with higher scores for Sweden and the United Kingdom and lower scores for France, Cyprus, Germany and Latvia. This supports the suggestion that regulatory contexts and characteristics are influential over OSH management. In particular, it points to the two areas where the operation of national process-orientated regulatory standards emphasising a participatory approach to OSH management largely predate the Framework Directive (Nordic and Ireland and United Kingdom) as having the greatest number of OSH management factors in place. This suggests that the depth with which this kind of approach is embedded is significant.

However, Figure 3.1 also suggests that factors beyond our measure of regulatory context and style are influential — and also highlights the limitations we have already acknowledged of the necessarily broad nature of our groupings and their imperfect fit in some cases. For example, we have allocated both Spain and France to the Southern/Latin group, yet their mean composite OSH management scores are very different. The higher score for Spain perhaps reflects the country's strategy of using the Framework Directive as an opportunity to undertake major reform of its OSH regulatory system, while the lower score for France may be the result of the struggle the country underwent to operationally accommodate the Framework Directive — reflected, for example, in the internal conflict and debate within national institutions that it prompted and which we discuss in more detail below. These differences, of course, also highlight the importance of studying more than one Member State from this group.

Similarly, the relatively high score for Bulgaria is in contrast to the scores for other countries in this group (such as the Czech Republic, Poland and Hungary, where mean scores are a little over 6 — see EU-OSHA, 2012b) and, while not inconsistent with some of the other measures shown elsewhere in this report, is difficult to explain, particularly in the light of the national report. The Lot 1 secondary analyses also identified industry as significantly associated with the OSH management composite score, with OSH management indicators more widely reported in industries such as construction, mining and health and social work, as opposed to public administration and real estate. One possibility, therefore, is that the Bulgarian score may reflect the country's highly industrial past. Although

Figure 3.1: **Application of the Lot 1 OSH management composite score to the selected Member States and the regulatory style groups: mean scores**



the country's economy was badly affected by the economic crisis, in particular in relation to its manufacturing, extractive and construction industries, approximately one-third of the population is still employed in industry ([6]). Nevertheless, the former Eastern Bloc countries, and indeed the Baltic States, have all had to implement fundamental changes to the nature and orientation of their regulatory strategies and systems in order to implement the Framework Directive. As the national reports for Bulgaria and Latvia make clear, this has meant a rapid change from prescriptive to process-based approaches as part of a much wider political, economic, regulatory and social process of reform to move the countries from controlled economies to European-style capitalism. The lower scores apparent for these regulatory groups is, therefore, likely to be a reflection of the ongoing challenge faced by the countries that are included in these groups to implement the goal-setting approach to OSH management.

The relatively low score for Germany may also reflect the scale of change required to adopt the goal-setting approach as a result of the country's distinctive approach to OSH regulation. As the national report explains, the dual nature of the regulatory system and its relative distance from models on which goal-setting participatory approaches are based, in combination with its federalism, has presented a number of challenges to implementing the Framework Directive. Though these are now being addressed through the Joint German OSH Strategy, it has taken some time, as well as a number of fundamental policy and regulatory changes, to achieve this compromise.

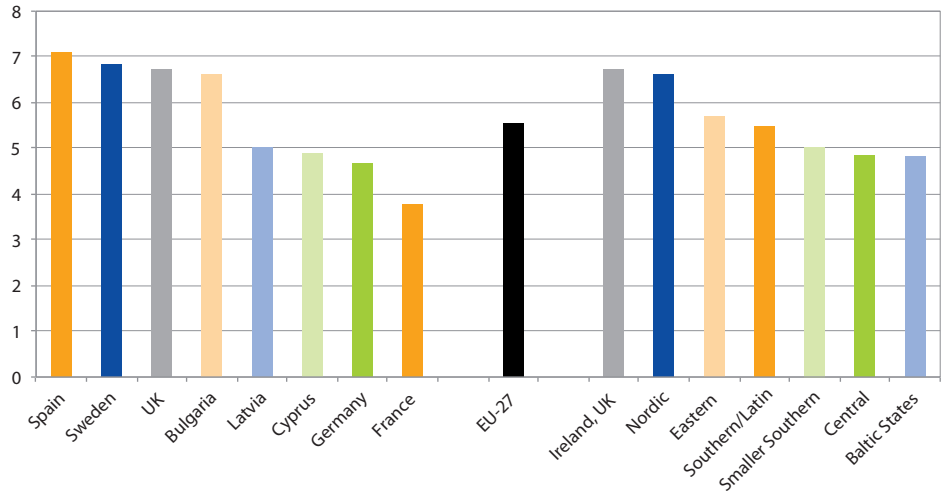
The composite score for Cyprus is similar to that for Germany. In this case it seems likely that the country's economy, in particular its very large proportion of micro-businesses, is significant. As the Lot 1 secondary analysis report makes clear, establishment size is very strongly associated with OSH management, with smaller establishments reporting fewer OSH management measures compared with larger establishments. However, the analyses also suggested that in some countries even the smallest establishments report high levels of OSH management practice, which the authors concluded 'suggests that if a sufficiently "favourable" environment can be created, the extent of OSH management among smaller establishments could be substantially increased' (EU-OSHA, 2012b).

Again, this difference by enterprise size is one we would expect to see across the Member States and the groups they were selected to represent in this study, and Figure 3.2 shows that this is the case even among the smallest enterprises covered by ESENER (i.e. those with 10–19 employees). Here, again, it is the Ireland and United Kingdom and Nordic groups in which the smallest enterprises report the greatest number of OSH management measures, lending further support to the suggestion that regulatory style and character, and in particular the depth with which a process-based participatory approach is embedded, is especially influential. In addition, as before, the significance of other factors is suggested, in particular by the scores of the individual Member States. For example, while the pattern of scores is similar to that seen for all enterprises, with the highest scores for Sweden, the United Kingdom, Spain and Bulgaria (Figure 3.1), in this case the order of those Member States is changed, with Spain now highest (Figure 3.2). This may be a reflection of the relatively high level of use of external prevention services in Spain which provide coverage particularly for the country's many small and micro-enterprises, something which is also the case in Bulgaria (see Figure 3.5 for proportions of respondents reporting the use of external prevention services).

The composite score identified in the Lot 1 secondary analyses is a measure of the number of OSH management practices enterprises report having in place. However, it cannot gauge

([6]) World Bank (2012) figures (www.tradingeconomics.com/bulgaria/employment-in-industry-percent-of-total-employment-wb-data.html);
industry includes mining and quarrying (including oil production), manufacturing, construction and public utilities (electricity, gas and water).

Figure 3.2: **Application of the Lot 1 OSH management composite score to the selected Member States and the regulatory style groups: mean scores for enterprises with 10–19 employees**



the quality of these measures; that is, it cannot distinguish between a 'tick-box' exercise and a truly thorough and effective practice. This is a theme that most of the national reports return to frequently and is something we discuss below in relation to the detailed features of OSH management practice covered in the following sections.

3.2 Prevention policies

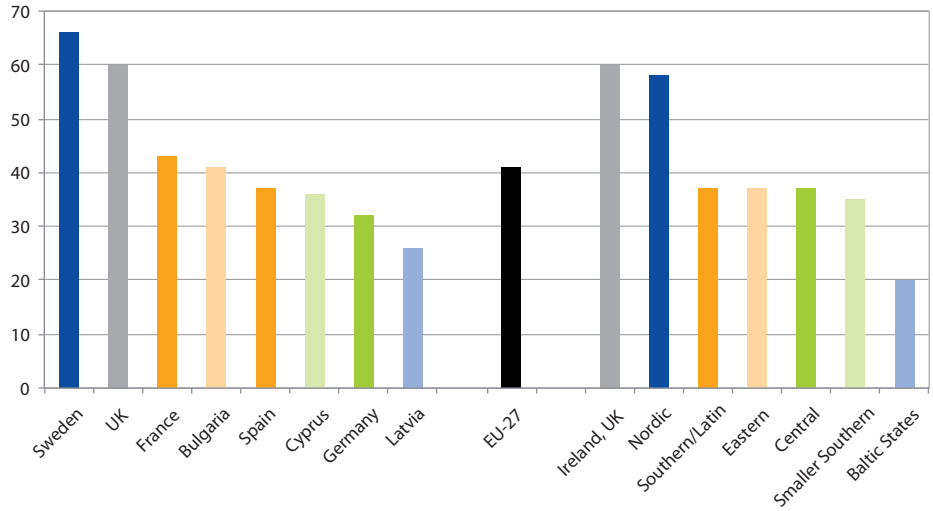
We now turn to the detailed features of workplace OSH management practice, beginning with the development of a coherent overall prevention policy. ESENER included a number of key questions about this issue which focused not only on the establishment of a prevention policy, but also on the extent of that policy's impact and the level of senior management involvement with health and safety generally. These questions included:

- Is there a documented policy, established management system or action plan on health and safety in your establishment?
- In practice, how much of an impact does this policy, management system or action plan have on health and safety in your establishment? Does it have a large impact, some impact or practically no impact?
- Are health and safety issues raised in high-level management meetings regularly, occasionally or practically never?
- Overall, how would you rate the degree of involvement of the line managers and supervisors in the management of health and safety?

The proportion of respondents answering these questions positively was highest among those from the Nordic and Ireland and United Kingdom groups in each case. Sweden and the United Kingdom were consistently among the countries with the highest proportions of positive responses for each question, with Latvia and the Baltic States group generally among the lowest. To illustrate this, Figure 3.3 shows responses to the third question.

Again, therefore, the regulatory context is clearly important here. However, the national reports also pointed to a number of

Figure 3.3: **Proportions (%) of respondents reporting that health and safety issues are regularly raised in high-level management meetings**



other issues that were influential in particular national situations. These fell into three broad groups: the perceived costs of implementing OSH management measures and complying with legislative requirements; the support infrastructures available to enterprises; and changes in the structure of the labour market and employment relations.

3.2.1 Costs of OSH management

The costs of implementation and compliance were identified as influential at a number of levels. First, at the enterprise level, OSH management is frequently seen as costly both financially and in terms of other key resources such as time. The national report for Latvia, for example, quotes an observer as describing the response by employers to a new health and safety law as 'non-controversial'. The report goes on to explain this by citing an informed commentary on the new legislation:

> *Employers appear to understand the importance of labour protection and make efforts to ensure the health and safety of their employees. However, an 'ideal' health and safety system which complies fully with all the relevant legislation is expensive, and therefore regarded as impossible to provide by almost all companies in Latvia. Many employers thus implement the law only incompletely, in order not to damage the operation of the company.*
> (see Latvian national report, Annex)

Similarly, a labour inspectorate survey of managers in the United Kingdom suggested that the majority (60%) felt that health and safety requirements were overbureaucratic and half (50%) felt they were expensive to implement ([7]); while in Bulgaria, where OSH legislation is made up of nearly 100 Acts, it is also widely seen as difficult to implement. This view of OSH legislation as bureaucratic, complex and costly is often also linked to an emphasis on 'formal' compliance, with the production of policies in enterprises simply a 'tick-box' exercise of little or no appreciable quality or effectiveness. This is sometimes the case in Spain, for example, where the national report suggests that such emphasis results in excessive bureaucracy and 'defensive prevention', whose real benefits in terms of OSH are described as 'dubious'. The authors define 'defensive prevention' as the positioning of preventive actions by enterprises and OSH service providers in such a way as to avoid inspection and sanction. OSH legislation, therefore, is not applied in the light of technical knowledge, experience or common sense, and becomes an end rather than a means. The national report's authors go on to suggest that this might be because the legislative framework in Spain now is the result of EU membership and a conscious and deliberate overhaul to meet the requirements of the Framework Directive, rather than the result of a more 'natural' internal process of maturation in social, political, scientific and professional terms (Uberti-Bona and Rodrigo Cencillo, 2006). In fact, concerns about policies being more of a paper exercise are apparent even in Sweden, which ESENER suggests is consistently at the highest end of the spectrum of OSH management practices. The Swedish national report concludes that SWEM policies and practices often exist more 'on paper than is required for real prevention'. The author suggests that the widespread continued presence of workplace risks and their consequences is evidence of this — something that we return to in section 3.4.

Of course, it is not only employers that are concerned, at the enterprise level, about the costs of implementing OSH management procedures and practices and of complying with OSH legislation. The national reports also suggest that this is an issue for employees. In this case, however, the potential cost is their employment. For example, the quote used in the Latvian report and reproduced above finishes as follows:

> *Their employees, in whose interests the health and safety system operates, agree to their rights being violated in order to maintain their jobs.*
> (Latvian national report, Annex)

Similarly, a number of the reports refer to employees concealing work-related illnesses for fear of losing their jobs (see, for example, Bulgaria).

These enterprise-level concerns about costs among employers and employees are clearly exacerbated by national economic climates and, in particular, the economic crisis. This has had a widespread and deep impact across all Member States, particularly the Baltic States, former Eastern Bloc countries and those in Southern Europe such as Spain and Greece. Radical austerity measures have been introduced in a number of countries, often accompanied by swingeing deregulation of both labour markets and OSH legislation. In the United Kingdom, for example, the Löftstedt Inquiry (Löftstedt, 2011) has recommended rationalisations anticipated to lead to a removal of about one-third of existing regulatory provision, while the Prime Minister has declared 'war on the excessive health and safety culture that has become the albatross around the neck of business' and vowed to 'kill it off for good' (Safety and Health Practitioner, 2012). These attempts by national governments to stimulate economic growth clearly reflect a perceived cost of OSH management implementation (and the enforcement of enterprises' compliance with legislation — see below). This is perhaps most apparent in Latvia, where the government has told regulators to 'suspend' OSH regulation for the duration of the crisis.

In fact, these national concerns are echoed at the European level. The European Commission, for example, has argued that 'the importance of reducing unnecessary administrative burdens increased with the economic crisis', since SMEs in particular 'need quick relief' (CEC, 2009: 4). This seems to be part of a broader agenda emanating from some parts of the EU of reduced administrative burdens on business, signalling a shift in emphasis away from safety and health in the workplace in order to stimulate a still-elusive economic recovery.

([7]) www.hse.gov.uk/statistics/pdf/survey-data-brief.pdf

The result of these national- and European-level pressures has been a widespread shift in the balance of power between workers and employers (see, for example, the national reports on Latvia, Sweden and the United Kingdom), which has potential consequences both for the management of OSH in the workplace and, consequently, for the safety, health and well-being of workers.

3.2.2 Support infrastructures

These concerns about cost are, of course, closely linked to the second of the three broad groups of influences on prevention policies: support infrastructures. They have, for example, affected labour inspectorates in many Member States in terms of their budget and resources, areas of emphasis and approaches to enforcement.

Numbers of inspectors vary significantly across the Member States. The national reports suggest that these range from one inspector for every 7,050 workers in Germany to one inspector for every 17,000 workers in Sweden. In many cases, the existing levels of coverage are the result of significant cuts. For example, in Sweden the inspectorate budget was cut by one-third from 2006. Similarly, in Latvia it has been cut by over 50% — there are now 117 inspectors for over 93 000 micro-enterprises employing 873,000 persons (with small and micro-enterprises comprising 85.3% of employers and 79.3% of employees in Latvia). In the United Kingdom the number of inspectors fell by 12% between 2002 and 2008 and the number of enforcements fell by 38% between 2003/4 and 2005/6 (Tombs and Whyte, 2010). These kinds of cuts, of course, impact not only on inspection and enforcement, but also on inspectorates' capacity for providing support for OSH management. This is apparent in the shift away from proactive and towards reactive visits to enterprises described in many countries. In Germany, this has extended to something of a reduced desire to enforce the complex legal OSH provisions, while the OSH activities of the Spanish labour inspectorate have been described as inadequate, biased and even arbitrary (Uberti-Bona and Rodrigo Cencillo, 2006), resulting in calls there for more resources, training and specialisation. Any impact of reduced labour inspectorate capacity for the provision of support for OSH management, of course, is likely to vary by Member State. For example, among the countries included in this project, the ESENER survey showed that, while 75% or more respondents from Latvia, Sweden, the United Kingdom and Bulgaria reported using health and safety information from the labour inspectorate, proportions from Cyprus, France, Spain and Germany ranged from 57% to 41%.

Budget cuts have also led to a change of emphasis for a number of inspectorates. This has included, for example, focusing on particular sectors and/or enterprises that are identified as being particularly risky. However, perhaps the most profound shift of this kind has been among those inspectorates that have responsibility for the area of undeclared or illegal work. Many of these inspectorates have moved a significant proportion of their efforts and resources into focusing on this area. In many cases this has been in response to government pressure, which is aimed more at reducing this sector of the economy in order to boost revenue rather than as a means of reducing the significantly higher levels of occupational illness and injury experienced by its workers (see below). In France, for example, 9.1% of inspectors' time was spent on illegal work in 2008; while the Latvian inspectorate has substantially increased its focus on illegal employment at the expense of OSH management, with current plans to further improve its capacity in this regard.

A number of inspectorates have also shifted their enforcement approaches. In Latvia, enforcement has moved away from fines and towards warnings, with fines now issued only when a direct threat to life can be established. In contrast to this, formal sanctions are also rare in Sweden, where the inspectorate uses information and advice as its main strategy, with most employers complying with the non-binding requirements of inspection notices. However, this is a product of the very longstanding Swedish tradition of consensus-orientated policy, with the inspectorate's approach being primarily to advise and persuade enterprises to comply (something that is robustly supported by extensive social dialogue — see Chapter 4). Here, to support this advisory role, the inspectorate produces a great deal of information and material. This is true of a number of other inspectorates (see, for example, the national reports on Cyprus and the United Kingdom), particularly those that have links to research and development, either directly or indirectly, in their countries (such as the United Kingdom and Sweden). However, as the author of the Swedish national report points out, even in such countries where information and knowledge are available, few employers have the resources and skills necessary to locate, access, interpret and implement it — particularly as contact with inspectorates is declining.

Support is also available to enterprises through a number of external service providers. Again, there is considerable variation across the EU in how these services function, whether enterprises are obliged to use them, how they are monitored and, consequently, their standard and quality. For example, in Bulgaria employers have been obliged to provide employees with occupational health services since 2008. Labour inspectorate figures from 2010 suggest that most (97%) have done so, primarily through an external provider, with the principal focus being on workplace prevention. However, these services are widely regarded as being of generally poor quality, with many employers seeing their obligation as a formality, so hiring the cheapest possible service. Similarly, in Sweden employers are required to ensure that they have adequate work environment competence, which means the use of external services if enterprises do not have sufficient internal capacity. However, this is something that the inspectorate rarely enforces because it considers that most of the available external services lack the necessary competence in SWEM.

In addition to concerns about the quality of support services, their independence has been the focus of considerable debate in Spain. As the national report describes, Spanish accident insurance firms, which act as partners of the social security system, cover occupational accidents and disease among all employees and some self-employed workers. They are employers' associations and defined as private non-profit entities. Following Law 31/1995, they gained huge prominence as the main supplier of OSH services to companies. As a result of fears about this monopolisation, they are now required to organise their OSH services through prevention societies, and have regrouped from over 150 associations in the early 1980s to 22 in 2007. They are involved in the management of 90% of occupational accidents and diseases, and their prevention societies act as OSH services for over 50% of all Spanish companies (Rodrigo, 2007). Although their resources and coverage, particularly of the very many micro-enterprises, puts them in a potentially strong position on OSH, they tend to favour the interests of the employer, so have had ongoing conflicts with unions and workers (though there are now some moves towards greater democratisation and involvement of the unions in the management of the insurance companies).

3.2.3 Labour market and employment arrangements

In fact, micro-enterprises and SMEs are becoming increasingly widespread across a number of EU Member States, which is one aspect of the changes in the labour market that many of the national reports identify as influential over OSH management both generally and specifically, including in relation to prevention policies. For example, in Bulgaria 98% of enterprises are SMEs and they employ 76% of the workforce. Similarly, some of the national reports point to relatively high levels of self-employment, which, in some cases, represent an increase over time; for example, 17% of Cypriot workers are self-employed, while in Sweden self-employment nearly tripled between 1981 and 2010 — it is currently 11% and continues to rise (with 15% on temporary contracts). A recent report suggests that, though the overall proportion of self-employed workers is stable in Europe, there has been a marked recent growth in the numbers of self-employed people working in the construction and services sectors (EU-OSHA, 2010b). These kinds of developments are significant because of the growing body of evidence showing that small enterprises are proportionally more dangerous. Research on United Kingdom manufacturing, for example, shows that workplace size is a significant influence on trends in occupational injuries, with SMEs accounting for proportionally higher rates of major injuries than larger enterprises (Nichols et al., 1995; Nichols, 1997; Walters, 2001). Similarly, recent figures for the construction sector (for the five years between 2003/2004 and 2007/2008) show that two-thirds of fatalities were among the self-employed or those working for firms employing 15 or fewer workers, and, similarly, that two-thirds of accidents occurred on small sites (with 15 or fewer workers), making it very clear that those working for smaller firms in the industry are at greater risk (HSE, 2009a). This increased susceptibility and vulnerability among the self-employed and those working in the smallest enterprises, and the recent increase in their numbers, is something that has been acknowledged as an area of 'over-arching' concern at the European level (see, for example, DG Employment, Social Affairs and Inclusion, 2012). This interim evaluation of European OSH strategy goes on to suggest that 'there is likely to be an increasing requirement for attention to the health and safety needs of the self-employed and those in micro-businesses'. EU-OSHA has also drawn attention to the increasing importance of capturing accurate OSH data for these groups, particularly given their relatively high levels of representation in high-risk sectors such as agriculture and construction (EU-OSHA, 2010b).

Levels of non-standard or contingent employment have also risen virtually everywhere, in particular following the economic crisis and as a consequence of widespread labour market deregulation. For example, in Spain 24% of workers now have temporary contracts. Both SMEs and contingent workers are, of course, groups that are traditionally very difficult for inspectorates to reach and frequently have relatively low levels of representation (see Chapter 4), making workers particularly vulnerable. Several of the national reports point to significant differences in terms of OSH management within these groups. For example, workers in the United Kingdom are more likely to have received recent training if they are employed by a large organisation (ONS, 2010). Similarly, the Latvian report presents evidence showing that more than 20% of workers in SMEs are not provided with any OSH measures as opposed to around 7% in large companies (Vanadzins and Matisane, 2011). The report's authors go on to point out that workers in SMEs generally receive fewer OSH-related benefits (such as health insurance), and that even such basic OSH-related activities as workplace health and safety training (an obligatory requirement for employers in Latvia) have been provided for fewer workers in SMEs than in larger companies (Vanadzins and Matisane, 2011: 7).

As discussed above, illegal or undeclared work is also seen as a significant problem in a growing number of countries. This is an area that is frequently blurred with that of migrant workers, whose numbers are also rising in a number of areas and who are often illegally employed. Of course, accurate figures are hard to come by in both these areas. However, in Cyprus, an estimated 25% of the workforce is involved in undeclared work, while in Latvia pre-crisis estimates were 15–45% of the workforce, though by 2009 over half of employees reported that they would be prepared to receive 'envelope' wages (The Baltic Course, 2009). Estimates from France suggest that 30,000–40,000 undocumented migrant workers enter the country annually. Both illegal work and migrant employment are typically concentrated in sectors such as construction, hospitality and private services. They are frequently associated with increased risk to the workers involved, and also often fall beyond the reach of inspectorates. In addition, as the Latvian report points out, informal payment systems have important negative effects on employee rights to social security, sickness benefits and pension entitlements.

These are a few examples of aspects of labour market and employment arrangements that are influential over OSH management. Their discussion here is limited, but these are themes that we return to in a number of places elsewhere in this chapter and the rest of the report. However, it is important to be clear at this point that changes in these areas have been rapid in recent years, and traditional systems of OSH management and its oversight have often struggled to keep pace with them (for an in-depth discussion of these issues, see Walters et al., 2011a).

3.3 Risk assessment

In terms of risk assessment, ESENER included measures of:

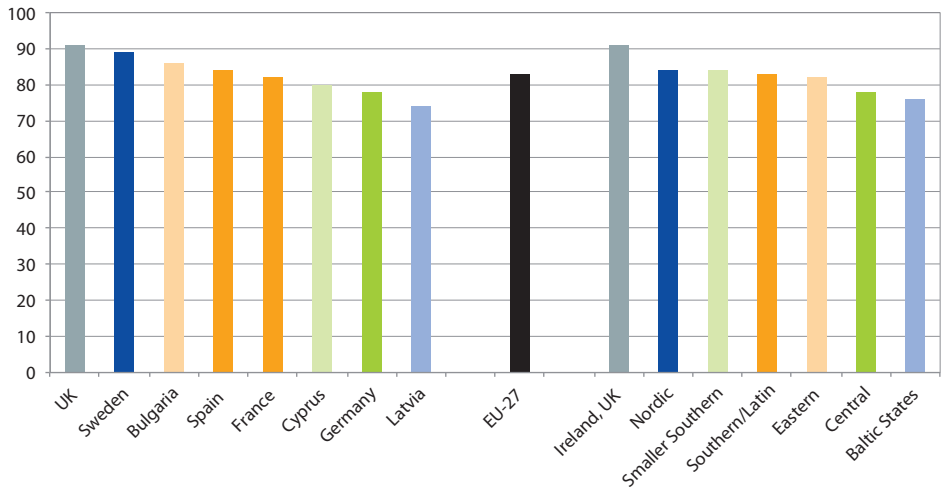
- Regular checks as part of a risk assessment or similar measure.
- Those involved in such checks (i.e. in-house staff and/or external contractors).
- The occasions on which such checks were carried out, including:
  - following a change (in staffing, layout or work organisation);
  - in response to a request from employees; and
  - at regular intervals (i.e. without specific cause).
- The areas routinely considered in these checks, including:
  - equipment and the working environment;
  - the way in which work is organised;
  - long or irregular working hours; and
  - employee–supervisor relationships.
- Actions taken as follow-ups to these checks, including:
  - changes to equipment or the working environment;
  - changes to the way work is organised;
  - changes to working time arrangements; and
  - provision of training.
- Reasons for not carrying out such checks, including:
  - lack of expertise;
  - too time-consuming or expensive;
  - legal obligations too complex; and
  - unnecessary because the enterprise has no major problems.

There is insufficient space here to go through each of these measures. However, as an example, Figure 3.4 presents the proportion of respondents from the selected Member States and the seven regulatory style groups reporting that checks as part of a risk assessment or similar measure are carried out at regular intervals in their enterprise (i.e. without specific cause). It suggests a gradient from the Ireland and United Kingdom group at the higher end of the spectrum to the Baltic States at the lower end, again supporting the suggestion that regulatory context and characteristics may be influential.

Nevertheless, the national reports also identified a number of other factors that may be influential over workplace risk assessment. These included implementation, but also focused on the extent to which risk assessment is understood at the enterprise level and, relatedly, the effectiveness with which it is carried out. In relation to implementation, ESENER suggests that this is generally high (e.g. 87% of EU-27 respondents reported that checks as part of a risk assessment or similar measure were carried out in their enterprise). However, some of the national reports present substantially lower figures, highlighting the limitation with ESENER (and other similar surveys) referred to earlier that the respondents tend to be from enterprises at the better end of the OSH management spectrum. In terms of the understanding of the concept of risk assessment at the enterprise level, and consequently its quality in practice in the workplace, these are of course areas that surveys such as ESENER are not designed to measure. Nevertheless, they go to the heart of the effectiveness of workplace OSH management and are areas that the national reports highlighted as particularly important.

Almost all of the national reports referred to two main areas of influence over risk assessment. Both are closely related to those discussed in sections 3.1 and 3.2 because they concern the provision and availability of support and information for enterprises in relation to risk assessment, and the specific problems encountered by micro-enterprises and SMEs.

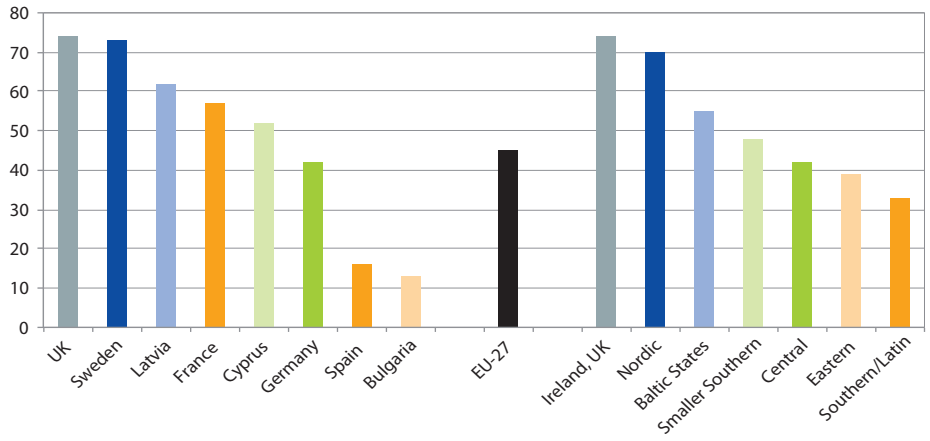
Figure 3.4: **Respondents reporting that checks as part of a risk assessment or similar measure are carried out at regular intervals: proportions (%)**



3.3.1 Support for risk assessment

One of the key differences among Member States in terms of risk assessment is the extent to which assessments are carried out in-house, by external service providers or by a mixture of these two. The issue of who carries out risk assessments, of course, is key to the provision of support, with different kinds of advice and guidance required in relation to these two approaches. As both their national reports make clear, risk assessment is most often carried out externally in Bulgaria and Spain — something that is also clear from the ESENER data (Figure 3.5).

Figure 3.5: **Respondents reporting that risk assessments are carried out by their enterprise's own staff: proportions (%)**



In Bulgaria, labour inspection activity figures for 2010 suggest that 98% of all enterprises have an established risk assessment programme and 95% carry out assessments. However, the national report's author suggests that in most cases risk assessments are carried out by occupational health services and that there are very serious concerns about the quality of these services' work, with assessors frequently not qualified. As a result, risk assessments are often inadequate and are carried out simply as a 'formality'. The report points out that, while oversight of occupational health service providers is under the remit of the Ministry of Health, the Executive Agency of the Labour Inspectorate, which is better qualified to inspect external services, monitors their activities. This seems to contribute to a more general feeling among labour inspectors referred to in the report that OSH management activity is increasing and improving in quality, with better quality risk assessment and infrastructural support for OSH management significant factors in this change. Nevertheless, the tendency towards a 'tick-box' exercise of frequently poor quality among external service providers remains of significant concern, particularly as ESENER suggests that Bulgaria has the second lowest level of risk assessment or workplace checks made by an enterprise's own staff (13%, with only Slovenian respondents reporting a lower level (at 8%)).

In Spain, risk assessment is also mainly carried out through external services, most often via employers' occupational health insurance systems; according to data from the latest Spanish Working Conditions Survey (Almodovar and Pinilla, 2009), 73% of companies use external services. In this case, the report's authors point out that, as a result, OSH planning and management with the company's own resources and expertise are virtually non-existent, at least outside larger enterprises. In addition, not only has the quality of external services been questioned (see the Spanish national report), but the widespread reliance on them has been repeatedly referred to as a cause of the lack of integration of occupational risk prevention in companies, a phenomenon that experts identify as one of the main obstacles to progress in the field of health and safety at work in Spain (Velázquez, 2009). The report's authors go on to suggest that, while the obligation of the employer 'to integrate' occupational risk prevention into its day-to-day management of the company is clearly established in Law 31/1995, as well as in the Framework Directive, the responsibility for OSH should be assumed by the employer only; yet in practice this is far from the case.

The Bulgarian and Spanish situations raise the interesting question of how the use of external services to carry out risk assessments fits within the Framework Directive's principles of prevention and protection through a coherent overall policy. More fundamentally, as the Spanish report's authors point out, the use of external services reduces the need to maintain in-house expertise, which must also impact on the position of health and safety generally within an organisation's business and priorities. Generally, this practice has been identified as problematic in the literature elsewhere and has been the subject of debate in the courts of other countries too, where it has been argued that such practices do not fit with the Framework Directive's intent regarding the integration of a participative approach to workplace assessment and OSH management.

On a more fundamental level it is also perhaps an extension of the phenomenon that Nordic researchers identified during the 1990s when they coined the phrase 'sidecar effect' to describe the marginalisation of OSH management that occurs in practice when the system for addressing health and safety is peripheral to that dealing with core management issues (Frick

et al., 2000: 254) ([8]). Again, this is something that has potential consequences for workers' protection and their safety, health and well-being.

In contrast to Bulgaria and Spain, most risk assessment in France is carried out in-house. Here, risk assessment was introduced by the transposition of the Labour Code in late 1991 and made a legal requirement in 2001/2002. As the national report explains, this not only gave employers responsibility for risk prevention, but also introduced the idea that this is a multidisciplinary activity, prompting institutional reform of the country's occupational health services. In-house risk assessment has also required the development of a number of support mechanisms. For example, the labour inspectorate has fostered an additional advisory role over the last decade, providing information, guidance and support for both employers and employees and their representatives. In fact, this development led to a debate in France over the appropriateness of this new dual role for the inspectorate as both monitor and advisor. Risk assessment continues to be a substantial part of the inspectorate's workload, with 13.5% of inspectors' time spent on it in 2008. Advice, information and training are also provided by the insurance agencies and research and prevention organisations, both of which are funded by the social partners, while occupational physicians, which have been a mandatory requirement for all companies since 1946, also participate in risk prevention by providing advice and producing documentation, which is made available to employees, detailing all risks. In a further attempt to make risk assessment and OSH management more generally part of the core of enterprises' business, the 2010 Social Security Finance Act (which was effective from 2012) has taken a carrot-and-stick approach by providing subsidies to companies, particularly SMEs, that invest in risk prevention while raising the contributions of those that do not.

The ESENER data suggest that the United Kingdom has the highest level of in-house risk assessment of our selected Member States. A recent United Kingdom survey also seems to confirm ESENER's figures, showing particularly high levels of risk assessment implementation: 89% of establishments with a written health and safety policy in place (which itself represented 93% of the survey's sample) reported that the policy included a risk assessment procedure, with 94% of respondents overall claiming to be operating some form of risk assessment, either as part of a health and safety policy or as a standalone procedure (IES, 2006). There was, however, variation with size: a greater proportion of large and medium-sized organisations reported having risk assessment procedures in place, and all aspects of 'good' risk assessment behaviour were more common among large and medium-sized establishments. Furthermore, although the majority of organisations (regardless of size) operated a regular programme of risk assessments, they were not always comprehensive and in some cases not all areas of work or all groups of employees were included. The report's authors commented that there was 'considerable variation in understanding of the concept' of risk assessment across their sample. This suggests a more complex picture than the simple, and positive, 'headline' proportions in ESENER; something that is supported by a survey of Engineering Employers' Federation members (Hinde and Ager, 2003). The survey showed that, while 95% of respondents reported that risk assessments were carried out, just 14% felt they were very effective and one-third (34%) said they needed improvements (only just over half (51%) described them as adequate). Here the authors concluded that 'the key elements of risk assessment and health and safety training are likely to be in place but many companies perceive they are ineffective' indicating 'a high level of awareness, but a difficulty in implementing these areas successfully' (Hinde and Ager, 2003).

Problems, therefore, are apparent in relation to not only the implementation of risk assessment, but also its quality and, perhaps most crucially, its understanding and acceptance as a concept central to OSH management. This seems to be the case, for various reasons, across Member States, but it is also something that is exacerbated by enterprise size.

3.3.2 Risk assessment in small and medium-sized enterprises

Many of the national reports point to SMEs as a 'special case' not only in terms of OSH management generally, but also specifically in relation to risk assessment. For example, in the German Index of Decent Work survey (2008) 52% of respondents working in enterprises with fewer than 20 employees reported that no risk assessments have been carried out. In fact, in Germany this difference is also apparent when comparing part-time with full-time workers (38% and 41% of men and women, respectively, working part-time reported no risk assessment compared with 45% and 46%, respectively, of those working full-time (Index of Decent Work, 2008)).

Similarly, in Latvia a recent survey (Vanadzins and Matisane, 2011) indicated that a full risk assessment was made in only 27% of enterprises with 1–10 employees (micro-enterprises), 54.8% with 11–49 employees (small enterprises), 65.2% with 50–249 employees (medium-sized enterprises) and 55.2% with 250 and more employees (large enterprises). Although these figures represent an increase in recent years, as the Latvian report points out, they are derived from employers' self-reported data, which are liable to be overestimates. Larger enterprises more often use the services of specialist organisations in the assessment of workplace risks, and this is an increasing trend in Latvia, financed by the European Social Fund. Entrepreneurs can apply for a free assessment of working environment risks and the programme also assists in elaboration of labour protection plans including informing employees about labour protection issues (Eurofound, 2011). Vanadzins and Matisane (2011: 7) conclude, with regard to risk assessment, that 'the employers of SMEs are not really interested in health and safety of their workers and are not willing to take help even when it is free of charge'.

ESENER suggests that Latvia has the lowest level of regular risk assessment and Sweden one of the highest (see Figure 3.4). Indeed,

([8]) Although Frick himself attributes the first use of this term to Aminoff and Lindstrom in 1981, it attained more widespread use during the 1990s.

all the evidence presented in this report thus far suggests that Sweden is particularly advanced in terms of OSH management generally. However, even here the author of the national report suggests that most small firms have really only just started to comply with the requirement for risk assessment included in SWEM in the country. This step forward perhaps reflects the inspectorate's continued efforts to improve the abilities of employers to detect and reduce risks, which seems to have led to a gradual improvement in the quality of risk assessment generally since 2006.

These few examples illustrate the particular problem of risk assessment among SMEs — something that is surely not helped by recent moves at both the national level (e.g. United Kingdom) and from some European quarters towards exempting SMEs from risk assessment requirements. Arguably, however, the problems encountered by smaller enterprises in relation to risk assessment are not really different to those experienced more generally; rather, they are significantly exacerbated by the lack of resources in SMEs and the problem of their reach by regulatory and other systems providing support and monitoring. Fundamentally, though, regardless of enterprise size, difficulties centre on understanding the concept of risk assessment and its pivotal role at the heart of an OSH management approach that is integral to an enterprise's business and priorities. This is apparent from figures cited in the Latvian report (Vanadzins and Matisane, 2011), which show that almost half of the employers that had some serious problems with complying with OSH regulations agreed with the statement that 'My business has nothing to do with health and safety — it is absolutely safe'. This is also reflected in the ESENER data, which show that 85% of respondents from Latvia reported that workplace checks as part of a risk assessment or similar measure were not regularly carried out as they were unnecessary because the enterprise had no major problems. The Latvian report's authors point out that its Labour Inspectorate has indicated that most violations concern the order of the internal supervision of the working environment and has suggested that some employers do not accept the evaluation of working environment risks at an enterprise as a basis for the creation of a functioning labour protection system or a safe working environment.

3.4 Occupational safety and health performance

The aim of the Framework Directive is to encourage improvement in the safety and health of workers at work. In laying down principles of prevention and protection of workers against occupational accidents and diseases, its intent is to improve enterprises' OSH performance. This is an area that, for a number of practical reasons, ESENER could not include. It is also an area fraught with difficulties in terms of the availability, coverage and reliability of statistical data — something which a number of the national reports describe and demonstrate in detail.

3.4.1 Accidents

Most of the national reports suggest that accident rates are steady or are actually falling, which is consistent with recent European Commission findings ([9]) (DG Employment, Social Affairs and Inclusion, 2012). The national reports go on to point to a number of reasons for this, though improved prevention is only one. In Spain, for example, the Occupational Accident Prevention Programme (Benavides et al., 2011), which focused on enterprises with high accident rates, led to a 12% reduction in non-fatal injuries (Gil et al., 2010). Similarly, the Swedish national report suggests that prevention has improved, as reflected in lower accident rates. Other reasons behind these encouraging headlines, however, concern, on the one hand, changes in employment patterns and the structure of Member States' economies and, on the other, problems with the data.

In relation to the former, a number of the national reports' authors suggest that employment in the more hazardous industries has declined (e.g. Sweden and the United Kingdom), and in some cases that production rates generally have fallen (e.g. Bulgaria). In terms of the latter, several of the national reports suggest that some areas are simply not covered by their country's national statistics. For example, there is generally no information about accidents to those engaged in undeclared or illegal work (e.g. Bulgaria, Spain). Similarly, in many cases the self-employed are excluded (e.g. France, Latvia) or barely represented (e.g. Spain), and those in precarious (contingent) work are frequently inconsistently represented (e.g. Spain).

In addition, some national reports suggest that accidents are deliberately concealed by some employers in an effort to keep their insurance costs down (e.g. Bulgaria, where these problems are further exacerbated because of the substantial number of uninsured employers). Similarly, reporting is simply poor in some cases, particularly among SMEs (e.g. in France and Latvia). In Sweden, for example, one-third of accidents which involved the worker taking sick leave were not reported to the work compensation insurance system (AV, 2010a), while in the United Kingdom under-reporting of accidents was estimated at about 50% for 2010/2011 ([10]).

A number of the national reports also point to higher accident and fatality rates among immigrant workers (see, for example, the national reports for Cyprus, Sweden and the United Kingdom), reflecting their employment in more hazardous sectors, their links to illegal work, and ongoing communication and management problems. This is consistent with a recent literature review on migrant workers, which found that, although studies' findings 'are somewhat contradictory' many 'suggest that immigrants' jobs entail higher risks for accidents and that migrants are more often involved in occupational accidents' (EU-OSHA, 2007a: 29).

([9]) Scoreboard (2009) shows that, with the exception of the three-year trend for France (which was increasing), both three and 10-year trends for rates of occupational accidents were decreasing for each of the Member States included in this project (DG Employment, Social Affairs and Inclusion, 2012).

([10]) www.hse.gov.uk/statistics/overall/hssh1011.pdf

3.4.2 Illness

Rates of occupational illness and disease are frequently described as even more difficult to accurately collect and record than those for accidents. This is often linked to the reporting and data collection systems themselves, which can be complex (e.g. France, Latvia) and sometimes limited in terms of recognised conditions (e.g. France, Latvia) — which, in Sweden, has led to even lower reporting levels (Toren, 2010). A great deal of occupational ill health, therefore, is simply not recorded. The Spanish national report, for example, cites García et al. (2007), who suggest that an estimated 75% of occupational diseases are not reported — a figure which rises to 95% for some conditions. Similarly, the Swedish report suggests that 77% of illnesses are not reported to the work compensation insurance system (AV, 2010a). Nonetheless, national- and European-level surveys suggest that workers continue to feel that work impacts on their health and well-being. For example, 52.5% of Latvian Eurofound (2010) respondents reported that work negatively affects their health and only 11.2% described themselves as very satisfied with their working conditions.

In particular, this too reflects changes in employment patterns and economic structures in a number of Member States. Several of the national reports identify increases in occupational illnesses such as musculoskeletal and psychosocial disorders. For example, in Sweden in 2009 41% of women reported neck or back pain and 36% shoulder or arm pain, with corresponding figures for men of 28% and 25% (AV, 2010a,b). In the United Kingdom, Labour Inspectorate figures for 2010/2011 show that 1.2 million working people suffered from an illness they believed was caused or exacerbated by work, with 0.5 million people representing new cases. Increases in the levels of occupational illnesses such as MSDs and mental ill health have been associated in particular with the kinds of changes in the organisation and structure of work experienced in the United Kingdom, as elsewhere in the EU, in recent years. This is clearly shown by surveys, including United Kingdom research (e.g. Smith et al., 2000; Stansfeld et al., 2000), and is an area to which we return in Chapter 5.

3.5 Conclusions

The ESENER data suggest some substantial differences between the Member States included in this study, and between the groups they were selected to represent, in terms of workplace OSH management both generally and in relation to the detailed features of OSH management practice of which it is made up. The pattern of these differences broadly supports the suggestion that OSH management is at least in part determined by the context and characteristics of the regulatory approach in which it is developed. Specifically, regulatory systems with a longer tradition of process-based participatory OSH management are associated with greater levels of OSH management practice implementation.

Within this broad context, a number of other factors and characteristics also seem to be influential. These are apparent and operate at all levels from the enterprise to the European level (and beyond). This is clearly shown in terms of the perceived costs of OSH implementation and compliance, which are felt at the enterprise level by both employers and employees in terms of resources (financial, technical and temporal) and job security, respectively; the national level by governments proposing deregulatory or 'relaxing' approaches to ease the perceived burden of OSH management on business; and the European level, in the same way as national governments. Necessarily, perceived costs at all of these levels are influential over decisions in the workplace about how, and indeed whether, to implement OSH management practices.

The support infrastructure available to enterprises is, of course, also influential over these decisions. Differences here often reflect varied arrangements and requirements in relation to the use of external services and, of course, their quality and standards. This in turn has implications for the levels of internal expertise maintained in enterprises, and, as a consequence, also potentially for the relative position of OSH management within their priorities. Similarly, the level of support, monitoring and enforcement required from inspectorates varies in these situations. This is an area that has been profoundly affected by the economic crisis in particular, with inspectorates across the EU experiencing changes in their resourcing, emphasis and enforcement approaches.

In addition, the economic crisis is broadly linked to changes in labour market and employment arrangements, which are also significant influences over OSH management in the workplace. In particular, the ways in which people are employed are changing rapidly, as is the make-up of the workforce. The numbers of people working in SMEs, self-employment, illegal employment, or in part-time or contingent employment have increased, as have proportions of migrant workers. Both these changes are significant because implementation of OSH management practices is often lower in these situations; their quality is also often lower, and they are generally further away from systems of support, monitoring and representation. All of these factors put workers at greater risk — something that is borne out by the OSH performance statistics presented in a number of the national reports.

Key determinants of workplace OSH management, therefore, include regulatory context and character, perceived costs of OSH management implementation and legislative compliance, available support infrastructures and wider economic and political conditions. All of these are influential over the extent to which enterprises understand the significance of, and are able to make, OSH management an integral part of their operation.

This is of increasing importance given the widespread moves away from the traditional employment and work arrangements for which OSH management approaches and their support mechanisms were designed.

4. Worker participation in workplace occupational health and safety management

The Framework Directive treats consultation with workers and their representatives as central to its vision for regulating the management of occupational risks. The Directive's requirements in this respect include rights to consultation, information and balanced participation for workers and their representatives in making arrangements for health and safety, as well the right to withdraw in the event of danger and protection from victimisation for taking such action. This is not especially new, however, as provision for representative worker participation was present in the legislative requirements of most Member States before the adoption of the Directive. There was, nevertheless, considerable divergence in the style and centrality of consultation and representation envisaged in these measures, particularly reflecting different cultures of labour relations evident in the countries in the study. The Directive demonstrated the EU legislators' sensitivity to these differences, as well as those in the wider labour relations practices in which they were embedded and which influence their practice by including the phrase 'in accordance with national laws and/or practice' to qualify its requirements.

Such awareness was prescient since, perhaps more than many other elements of regulatory requirements on managing workplace risks, the practical application and operation of those on worker representation and consultation in these matters are clearly both determined by the nature of such systems and affected by change in the wider elements of the political economy which influence them. As previous research has already shown, the mere existence of variations in regulatory requirements in this respect is, therefore, but one determinant of practice (see, for example, Walters and Nichols, 2007).

An indication of these wider determinants was evident in the findings of the secondary analysis of ESENER, and its authors concluded that, while the combined effects of the involvement of workers and their representatives with high commitment towards OSH management are associated with reporting positively on measures of health and safety management and their resulting process and outcomes, 'these conditions are more likely to be found in countries with more embedded approaches towards participative OHS management in their regulatory systems than in countries where these approaches to regulating OSH management are the result of more recent legislative changes' (EU-OSHA, 2012d). They went on to note that it would be unlikely that such differences were solely the consequences of regulatory style, but that they were caused by a combination of factors that include regulation, but also embrace something of the organisational and labour relations cultures in different countries (or in some cases in different sectors within countries), as well as wider economic and political features of the countries concerned. They indicated that their results were no more than suggestive of these possible differences, and recommended that further research should be undertaken to explore these issues.

This is the purpose of the present chapter. It begins with a brief account summarising what is understood from previous research about the role of consultation and representation on health and safety, before considering the evidence of the presence of wider determinants of practice in this respect, drawn from the experiences provided by the eight case study countries. The chapter discusses the extent to which such evidence is useful in explaining the differences observed in empirical data.

4.1 Consultation and representation of workers in arrangements for health and safety management — the third leg of a three-legged stool?

The secondary analysis of ESENER data on worker representation and consultation on health and safety included a detailed review of existing research on the extent and operation of these arrangements, as well as the workplace determinants of their effectiveness (EU-OSHA, 2012d: 18–28). It is not intended to repeat that review here; however, several of the important points that emerged from it are relevant to the present inquiry and can be briefly stated.

The review emphasised that any discussion of consultation and representation of workers on health and safety needs to begin by being clear about what is meant by these terms. In particular, there is a need to distinguish between representative forms of consultation on health and safety and those that involve more direct methods. Most of the regulatory provision, as well as research on the effectiveness of representation and consultation in health and safety at work, are concerned with the former, as indeed was ESENER. Consequently, it is with this form that we are also mainly concerned. However, direct methods of consultation on health and safety are important in a number of respects, and although in some workplaces managers may try to promote them as alternatives to representation, in others they occur alongside representative forms ([11]). Significantly, from the perspective of the present study, we note that previous research indicates that the form that worker participation takes may be influenced by wider

([11]) See, for example, the recent EU-OSHA review (EU-OSHA, 2012f), which describes cases of good practice in worker/worker representative participation from a series of the Agency's reports on a variety of topics, and concludes that 'a wide range of methods and practices have been used by organisations, using both direct and indirect/formal and informal approaches, to cultivate active participation of worker participation' (p. 160).

determinants. For example, early Nordic research on direct participation showed how its operation was dependent on the labour market position of the workers involved, as well as on the presence and workplace power of trade unions (Gustavsen and Hunnius, 1981). Writing later, Walters and Frick (2000) argued that representative and direct consultation could be seen as different forms of participation occurring along the same continuum, their operational position on this continuum being determined by a variety of influences operating within establishments including managerial attitudes, trade union influence, the extent and nature of training and so on — even the personalities of the key players involved. They also suggested that forms of participation were additionally influenced by determinants acting upon the establishment from outside, such as purchasers, regulatory inspection, wider labour regulation, the support of trade unions, employers' organisations, bipartite or tripartite consultation bodies, sector- or local-level institutions and so on, as well as organisations, trends in wider labour relations and the economy more generally. Others have suggested that a better quality of 'worker engagement' — a form of direct consultation aimed at improving safe behaviour and workplace safety culture — may be achieved when it is supported by trade unions as well as managers and where representative forms of consultation are also involved (Lunt et al., 2008). With a somewhat different perspective, in contrast to these earlier findings, and perhaps rather more pessimistically, Nichols and Walters (2009) have pointed out that, in the United Kingdom, there is evidence from successive Workplace Employee Relations Surveys to suggest that direct methods of consultation are being increasingly used in workplaces, while the extent of representative forms of worker participation in workplace OSH appear to have declined in parallel with those of worker representation more generally and under the influence of the same wider economic/political determinants.

We will return to the influence of wider determinants in the following section, but first it is important to indicate that the findings of the review of the research literature undertaken by the authors of EU-OSHA (2012d) on worker representation and consultation on health and safety strongly emphasise that it is a broadly effective element of arrangements to manage OSH. The weight of the evidence found in the international literature is in line with the idea that better health and safety outcomes are likely when employers manage OSH with representative worker participation and that, in various ways, joint arrangements, trade unions and worker representation on health and safety at the workplace are associated with such outcomes. The secondary analysis of the results of the ESENER survey confirmed these findings, as well as shedding further light on what works in workplaces in which some support is found for participative approaches to health and safety management. It pointed to conclusions at four related levels:

- Worker representation is more common in larger organisations and in those operating in the public sector. It is also more likely in workplaces where health and safety, and the views of workers, are seen as a priority.
- Formal management of traditional health and safety risks is not only more likely, but is also more likely to be perceived to be effective, in workplaces where there is worker representation and where there is also a high level of management commitment to health and safety.
- Psychosocial risk management is also more likely in workplaces where there is worker representation, particularly where there is also high management commitment to health and safety. In addition, this is more likely to be perceived to be effective in workplaces where employees are involved in the psychosocial risk management process (which is, itself, more common in organisations which also have worker representation in place), again particularly in combination with high management commitment to health and safety generally.
- Management of both traditional and psychosocial health and safety risks, and the perceived effectiveness of that management, are both more likely in workplaces in which workers' representatives have both an active and a recognised role and are provided with sufficient resources.

This said, previous research has indicated that effective arrangements for consultation and representation on OSH are not ubiquitous in workplaces generally and their existence is restricted to those where a set of particular preconditions apply. These include not only a legislative steer, but also its support through regulatory inspection, trade union engagement and the presence of the will and capacity on the part of employers and managers for participative approaches to OSH management, which in turn lead to well-trained and informed worker representatives with adequate time and support to undertake their functions as well as a management that is responsive to their representations. The authors of EU-OSHA (2012d) were therefore at pains to draw a distinction between indications of the presence of some form of arrangement for representation and consultation on OSH and that of the presence of effective arrangements. They argued that their analysis of the ESENER results supported this distinction in as far as its results demonstrated the same relationship between management commitment to OSH and the consultation of workers' representatives necessary for effectiveness, shown in other studies to be a prerequisite for effectiveness. This is a relationship which is highly dependent on the influence of the context in which it occurs. These conclusions are an important point of departure for the present study, in that they highlight the importance of context to the relationship between worker representation and effective OSH risk management. In the following section we present a further exploration of the role of context in determining the extent and outcomes of worker consultation and representation in arrangements for OSH management in the eight countries we studied.

4.2 Wider determinants of practice in the European Union

Before looking at the ESENER analysis to identify patterns in the relationships between the presence of representation and OSH management that might be explained by national determinants in the eight countries we have studied, it is perhaps worth bearing in mind that the practice of worker representation in health and safety involves several elements of industrial relations, legal provisions and economic conditions. These have combined in different ways over many years to produce structures and processes, which, although they may share superficial appearances, in reality have very different, nationally determined, meanings for the operation of worker representation. For example, in some EU Member States, such as the Netherlands and Germany, works councils occupy a central position in health and safety representation, with safety representatives and safety committees occupying a secondary position if they even exist at all. In other countries, while works councils exist and play an important role in employment relations generally, there are special arrangements for representation and consultation on health and safety. France, for example, emphasises the role of joint safety committees in this respect in its legislation, while other countries such as the United Kingdom and Sweden have regulatory provisions for both health and safety representatives and joint safety committees. Some authors have suggested that such a classification can be the basis for comparing approaches to the role of worker participation (see Barnard, 2000 and, for a more detailed analysis, Korostoff et al., 1991). However, the reality is that the industrial relations cultures of countries such as Germany and the Netherlands or the United Kingdom and Sweden play such an important role in determining practices in the operation of such measures that comparison based on similarities or differences in legal provisions alone is almost meaningless (see Walters and Freeman, 1992; Walters et al., 1993; Walters and Frick, 2000).

Despite this general caveat, Walters (2002), in an analysis of the origins and implementation of the Framework Directive, noted that measures to transpose it may nevertheless have had some impact on these systems. For example, although the architects of the Directive generally eschewed the opportunity to harmonise national provisions upwards in terms of specific requirements on worker representation ([12]), in countries in which works councils dominated the representative structures for health and safety, the Directive may have had such an effect indirectly. In both Germany and the Netherlands existing co-determination rights meant that the scope for the role of works councils in representation on health and safety was broadened considerably as a consequence of the transposition of the Directive. Thus, in Germany, since employers' responsibilities were extended to 'the adaptation of labour to the individual', so was the works council's rights to co-decision on this issue. Similarly, in the Netherlands legislation on the rights of works councils has enhanced their legal position on prior consultation on risk assessment and their rights of approval over the choice of OSH services under the Work Environment Act.

In terms of more specific changes to regulation, however, there was a considerable range of effects. In the national reports for the present study we have noted that in the EU-15 countries, for the most part, changes were relatively small. There was little change in the situation in Sweden, where provisions for consultation and representation of workers on health and safety already went considerably further than the Directive in areas such as rights of representatives to stop dangerous work and to represent workers in small enterprises. There was also little change to systems already in place in France or Germany, where in the former Joint Health and Safety Committees and staff representatives were the main players in arrangements for consultation and representation on health and safety in place since the Auroux Laws of the early 1980s. In Germany, as noted above, works councils were the main form of representational institution and the transposition of the Directive simply extended their brief. However, in the United Kingdom the transposition of the Directive led indirectly to significant changes in the regulatory approach to worker representation since, as a result of rulings of the European Court of Justice on an analogous situation concerning information and consultation in relation to collective redundancies, the Government was forced to extend legislative rights of representation on health and safety as required by the Directive to all workers (not only those in recognised trade unions, as was the case under the Safety Representatives and Safety Committees Regulations 1977). Only in Spain was the transposition of the Directive used as an opportunity to introduce a new participative approach to OSH, with the creation of both health and safety (prevention) delegates and joint health and safety committees. The prevention delegates are provided for even in workplaces where works councils are not required by law.

Among the Eastern European and Baltic accession countries, changes to regulation on worker representation and consultation were altogether more substantial and mixed with the wider reforms of the transition from planned economies to capitalist models with the demise of the Soviet Bloc. In the case of arrangements for worker representation and consultation on health and safety in Bulgaria, transposition of the Directive led to provisions requiring arrangements to establish joint committees on working conditions at the enterprise level and to appoint worker health and safety delegates. In Latvia the law on Labour Protection was enacted in 2000 in order to meet a range of EU requirements including those of the Framework Directive. However, in both cases it remains far from clear that these regulatory changes have had a significant impact on the practice of worker representation and consultation on OSH (see below).

In Cyprus, where trade union density is comparatively high, the changes as a result of transposition formalised the system for

([12]) They could, for example, have borrowed from the Swedish provisions' rights for safety delegates to stop dangerous work, or rights for trade unions to appoint regional representatives to cover workers in small enterprises.

the appointment of health and safety representatives and joint health and safety committees as part of wider changes to the statutory infrastructure for joint and tripartite consultation on health and safety overall.

However, while the Directive may have had some effects on national regulatory systems, it is another matter to determine what effects these changes have had on their application at the workplace level. In this respect, it is highly likely that characteristics of national industrial relations systems (of which representation in health and safety is one subset) will dominate the influences on operational outcomes.

4.3 Evidence from ESENER

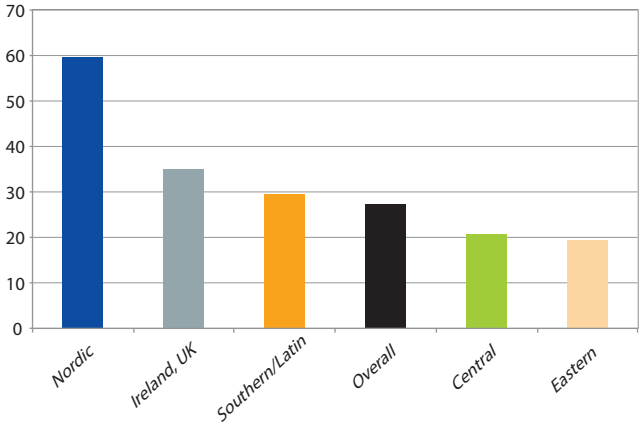
EU-OSHA (2012d) compared the ESENER data on various measures of worker representation on, and management commitment to, health and safety by both sector and country. As they note in their report, the sectoral comparisons showed nothing that was especially surprising.

The ESENER data report (EU-OSHA, 2010a) categorises sectors into three broad groups: producing industries (including mining and quarrying; manufacturing; electricity, gas and water supply (utilities); and construction); private services (including wholesale and retail; hotels and restaurants; transport, storage and communications; financial intermediation; real estate; and other service activities); and public services (including public administration; education; and health and social work).

The highest proportions of establishments in which management commitment and worker representation were combined were found in the public services sector (34%) and the lowest in the private services sector (23%). Further comparisons of these data were made by enterprise size and the pattern remained broadly consistent for smaller firms, with the highest proportions of high management commitment combined with worker representation found in public services and the lowest proportions in the private services sector. Among medium-sized and large enterprises the highest proportions were in the producing industries sector and the lowest proportions were in the public services sector. This suggests that the differences between sectors were not solely compositional effects caused by the distribution of workplace size, but there were other determinants that were also influential. As the authors of EU-OSHA (2012d) note, there is nothing especially surprising about these findings. They are consistent with previous national studies which have observed a propensity for greater trade union presence and joint consultative arrangements in utilities, the public sector and manufacturing, as well as high levels of management commitment to OSH and participative arrangements in many of the sectors embraced by the 'producing' category. We would therefore argue that, at the sectoral level, context and environment are important determinants of the presence of arrangements associated with participative approaches to OSH and that this relationship operates in much the same way as it does for the presence of wider labour relations practices in different sectors. Differences in the proportions of establishments in different size ranges are obviously an important determinant, but so are differences in other factors such as the labour relations cultures in different sectors and the presence of arrangements for other forms of representation and joint consultation. However, more detailed and qualitative comparative study would be required to explore these issues further and the ESENER data are not sensitive enough for this purpose.

Turning to comparative findings by country, the authors of EU-OSHA (2012d) noted that comparisons of proportions of enterprises reporting the combination of both high levels of management commitment to health and safety and both forms of worker representation resulted in the top 10 Member States, with the most frequent of such associations featuring all the Nordic countries and Ireland and United Kingdom, with the top three being Norway, Sweden and Denmark.

Figure 4.1: **Proportions (%) of both general and specialist OSH worker representation* in combination with high management commitment to health and safety by country group (after EU-OSHA, 2012d)**

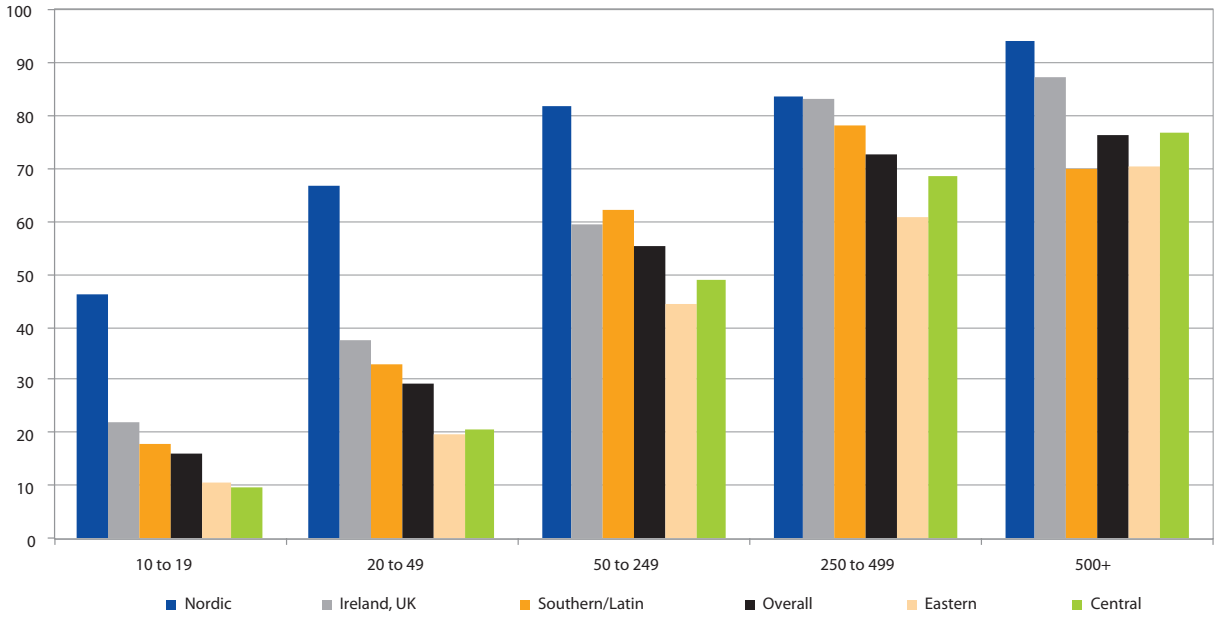


**Forms of worker representation: General — works council and/or trade union representative; Specialist OSH — health and safety committee and/or health and safety representative.*

Further analysis, using a combination of regulatory and other factors to divide EU Member States into similar national groupings as we have used in the present study, clearly showed that the Nordic countries as a group were substantially in advance of the rest of the groupings in terms of an association between levels of management commitment to health and safety and forms of worker representation, followed by the United Kingdom and Ireland, as is reproduced in Figure 4.1. Broadly speaking, the same patterns emerged when analysis by sector was added to that by country group ([13]).

([13]) Although there were some differences between the sectoral patterns (see EU-OSHA, 2012d: 47).

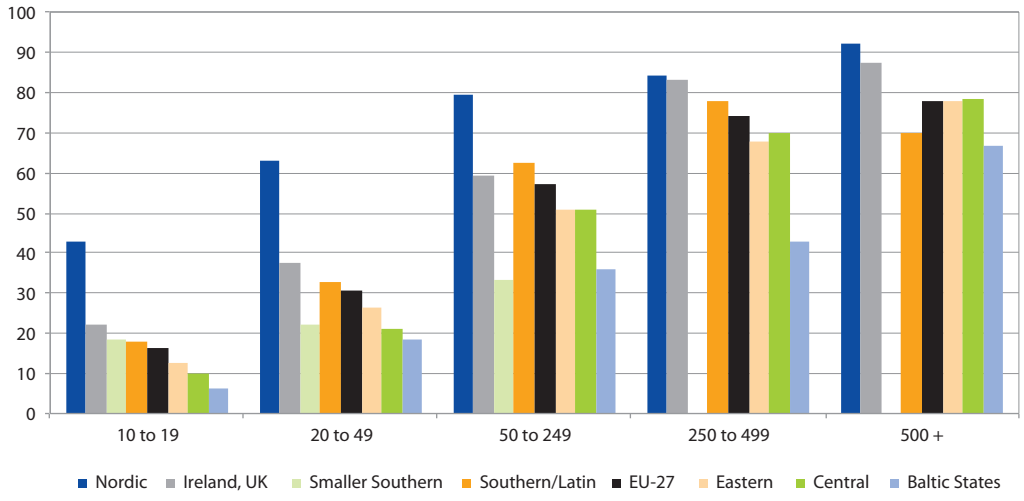
Figure 4.2: **Proportions (%) of both general and specialist OSH worker representation* in combination with high management commitment to health and safety by country group and enterprise size (after EU-OSHA, 2012d).**



**Forms of worker representation: General — works council and/or trade union representative; Specialist OSH — health and safety committee and/or health and safety representative.*

Moreover, the authors of EU-OSHA (2012d) demonstrated that these differences also largely held for different workplace size-bands. Although, as we might expect, the proportion of workplaces with this combination of factors increases by enterprise size, it is also clear that the pattern by country group is broadly consistent across the enterprise size-bands, with the Nordic countries having the highest proportions at each level and the United Kingdom coming next in all cases bar one, and the Eastern countries having the lowest proportions at each level (except the smallest where the Central countries were marginally lower). In addition, however, the differences from highest to lowest are much greater among the SMEs. For example, among those with workforces of 20–49 people, 67% of Nordic enterprises report having high management commitment and both forms of worker representation in place compared with 20% of Eastern countries (a 47-point difference), while comparable figures among those with workforces of 500 or more were 94% and 70%, respectively (a 24-point difference), as is shown in Figure 4.2.

Figure 4.3: **Proportions (%) of both general and specialist OSH worker representation* in combination with high management commitment to health and safety by regulatory group and enterprise size**



**Forms of worker representation: General — works council and/or trade union representative; Specialist OSH — health and safety committee and/or health and safety representative.*

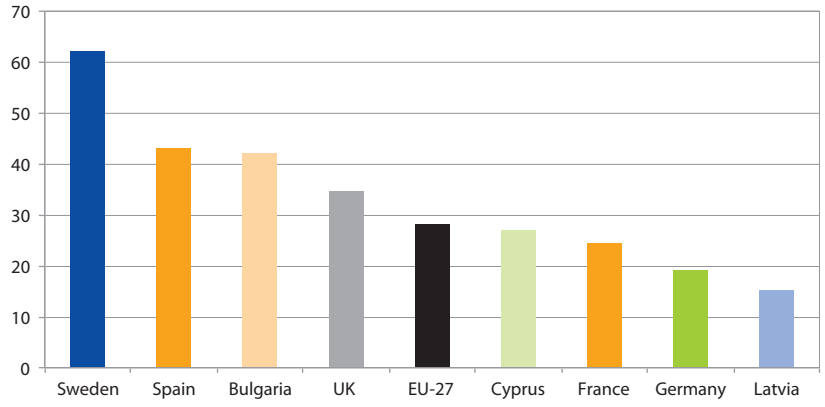
This led the researchers to the conclusion that, for at least two groups of EU Member States, namely the Nordic countries and Ireland and United Kingdom, the operation of national process-orientated regulatory standards emphasising a participatory approach to OSH management were supported by national determinants of practice in ways that were not the case, or not so much the case, for other groups of countries. This is borne out when the groups used in the current study are considered (Figure 4.3). These groups differ from those used in the earlier research in two respects: first, the Baltic States are now included as a separate group and, second, the Smaller Southern countries (Cyprus and Malta) have been grouped separately. As a result, Figure 4.3 should be interpreted cautiously because of small numbers of large organisations in some of the groups, particularly the new ones.

These findings are borne out less well by the ESENER data specific to the countries in the present study, as Figure 4.4 demonstrates. Sweden has the greatest proportion of cases of OSH worker representation in combination with high management commitment. The United Kingdom, however — for reasons that are not entirely obvious — has slipped to fourth place, behind Spain and Bulgaria, while the remaining countries follow more or less the same pattern as that for the groups they represent (Figure 4.1). We suggest that these differences in ranking between the groups and the individual countries taken from them are a reflection of various artefacts of the data on individual countries, and in this case the national groupings are perhaps more representative when trying to understand contextual causes of the differences observed. It may be, for example, that the reason for Spain's prominence in Figure 4.4 is associated with the considerable efforts the trade unions (especially the confederations UGT and CCOO) have made to ensure the engagement of worker delegates with health and safety management and through the support of the health and safety technicians widely deployed by these unions among the establishments most likely to be represented in the ESENER sample. However, the appearance of Bulgaria in third position here is anomalous and does not sit well with the reflections in the national report (see Annex), which suggest that while there may have been some structural reforms in relation to trade union representation on health and safety in the country, the reality for many is that 'trade union representatives do not exercise their rights because they are afraid to lose their jobs'.

Possible further light is thrown on the situation if Figure 4.4 is compared with Figure 3.3 (percentage of respondents reporting that health and safety issues are regularly raised in high-level management meetings) in the previous chapter. Spain seems to have good OSH representation and high management commitment, but health and safety issues are not regularly raised in management meetings, whereas the United Kingdom has less OSH representation and management commitment, but health and safety issues are regularly raised in management meetings. It may be that this difference is further related to the greater presence of in-house OSH expertise in the United Kingdom, while in Spain (and also Bulgaria) this expertise is more frequently from an external service provider. Thus, in the United Kingdom, although Figure 4.4 gives the appearance of greater representation and management commitment in Spain and Bulgaria, the practical reality in many workplaces may in fact be the other way round.

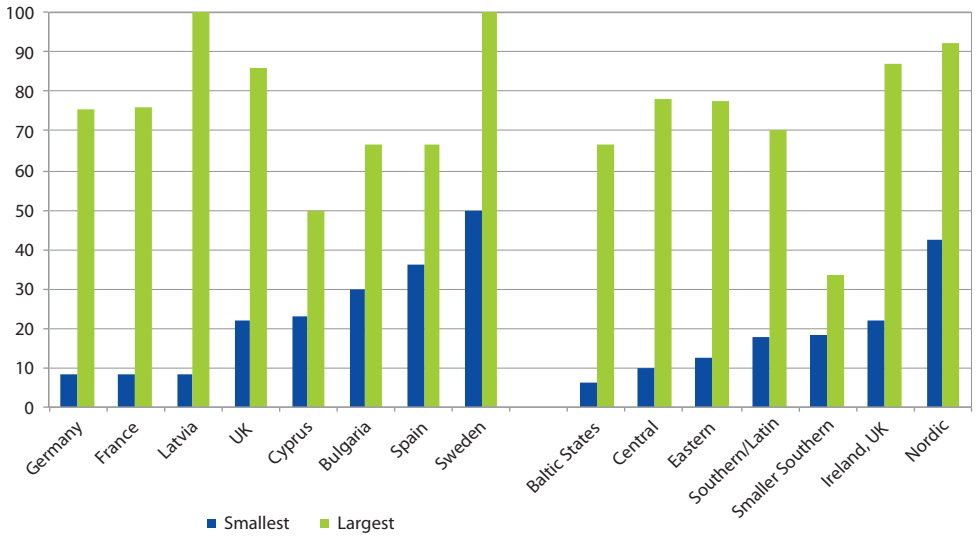
Another way to 'see' the impact of context across the range of enterprise size is to consider the difference between the smallest (10–19 employees) and the largest (≥ 500 employees) enterprises over the selected Member States and

Figure 4.4: **Proportions (%) of both general and specialist OSH worker representation* in combination with high management commitment to health and safety by country**



**Forms of worker representation: General — works council and/or trade union representative; Specialist OSH — health and safety committee and/or health and safety representative.*

Figure 4.5: **Establishment size-related differences in representation and management commitment to OSH: proportion (%) within the smallest (10–19 employees) and largest* (≥ 500 employees) enterprises**



**Smaller Southern group: largest enterprises had 50–249 employees.*

the regulatory style groups (Figure 4.5) ([14]). A relatively small difference indicates consistency across enterprise size bands, but only if the starting point is also relatively high does this suggest comparatively more favourable OSH management contexts within smaller organisations. Comparisons suggest substantial differences between Member States and regulatory style groups in terms of difference between the smallest and largest enterprise band sizes. The narrowest differences are apparent for the Smaller Southern, Nordic and Southern/Latin groups. However, only in the case of the Nordic group is the proportion of respondents from the smallest enterprises reporting representation and management commitment relatively high (43% compared with 18% each for the Smaller Southern and Southern/Latin groups). Although this must be interpreted cautiously, it suggests that favourable 'contexts' can be fostered in which even the smallest enterprises are likely to include some kind of participative or consultative approach to preventive action on OSH issues. Furthermore, the measures for Lots 1, 2 and 3 are highly correlated. This is in part because there is some overlap in the variables used in these three lots, but it also confirms the suggestions of strong links between general OSH management, psychosocial risk management and worker representation (EU-OSHA, 2012c,d) — something we also discuss in relation to psychosocial risk management in Chapter 5. Within the EU-27, workplaces with both forms of worker representation in place and high levels of management commitment to health and safety (Lot 2), therefore, have significantly higher mean Lot 1 and Lot 3 scores than workplaces without this combination of factors (Lot 1: 7.76 (standard error (SE) ± 0.02) compared with 5.38 (SE ± 0.02), $p < 0.0001$; Lot 3: 3.30 (SE ± 0.02) compared with 2.21 (SE ± 0.01), $p < 0.0001$); and the Lot 1 and Lot 3 scores were correlated (Spearman's rho = 0.51; $p < 0.0001$).

4.4 The effects of context

In seeking contextual explanations for these findings, one obvious place to start is with the implementation of the regulatory requirements they are intended to reflect. While all EU countries have transposed the provisions of the Framework Directive, they have done so at different times and with differences in detail, reflecting the flexibility allowed by the Directive's wording to be 'in accordance with national laws and/or practices'. As we have already pointed out, process-based and participatively orientated regulatory requirements on OSH management largely predated the Framework Directive by around 20 years in both Sweden (as in other Nordic countries) and the United Kingdom. They also both have other longstanding features that are supportive of process-orientated participatory approaches to arrangements for health and safety, including well-established industrial relations cultures in which the role of trade union representation, negotiation and consultation as well as longstanding provisions for trade union-appointed health and safety representatives are prominent, along with comparatively high trade union density and strong union bargaining power. Although in countries like the United Kingdom the latter features have been considerably eroded in recent decades, their legacy is arguably still felt in terms of the OSH management culture, especially in larger unionised enterprises. The findings in relation to small firms are also particularly interesting given the combination of comparatively high trade union density in these firms in Sweden and the systems for regional health and safety representatives that have also been in well-established operation there for more or less as long as process-based standards have been in place (see Frick and Walters, 1998).

Other contextual influences which would help to explain the clear lead displayed by both Sweden and the United

([14]) Comparisons for some Member States must be considered with caution because of small numbers of respondents from the larger enterprise bands (e.g. Cyprus and Latvia) and, further, because in some of the countries appearing in Figure 4.4 a lower enterprise band has been used in place of the 500+ employees band.

Kingdom in relation to the association between worker representation and management commitment to health and safety arrangements apparent in the ESENER findings are more difficult to link to firm evidence. They are nevertheless important in understanding why, in these countries, there appears to be a greater association between these matters than is found elsewhere. The combination of longevity with which such approaches have been practised, and the fact that they do not occur in a regulatory vacuum but are embedded in a host of wider provisions — such as the General Duties of the Health and Safety at Work Act 1974 in the United Kingdom, and in Swedish Work Environment Acts since the 1960s — is a partial further reason for the extent of their operation in workplaces.

More fundamentally, in both countries it is necessary to look beyond regulation to understand its impact. In the case of Sweden, the significant role of worker representation and consultation on the management of the work environment within workplaces has its antecedents in the historic agreement between the peak trade union and employers' organisations at Saltsjöbaden by which, in 1938, they originally sought to jointly govern labour relations, including those on health and safety, as much as possible without the interference of the state. Subsequently, Swedish corporatism, building on this agreement in the development of the so-called 'Swedish model' of social democracy, further embedded the notion of joint arrangements in labour relations not only at the workplace but ranging widely throughout social, political and economic affairs (Johansson, 1989: Chapter 5; Sund, 1994).

In the United Kingdom, by contrast, corporatist institutions in the economy took longer to establish themselves. Trade unions and employers, however, eschewed state intervention in labour relations and tried to maintain the independence of free collective bargaining. At the same time, one of the defining features of British labour relations during the period of post-war compromise was the substantial growth of workplace worker representation, independent of any statutory means to support it. Indeed, such was the power and independence of shop stewards that they were the focus of the reforming efforts of successive governments from the 1960s onwards. This meant that by the time statutory provisions were introduced to appoint health and safety representatives and joint health and safety committees under the HSW Act in the mid-1970s, it was in an environment in which workplace representation was already well established and a powerful force in labour relations and the wider political economy. It was also the main reason why trade unions were given the right to appoint health and safety representatives, rather than workers being given a more general right to elect them (see Walters, 1996c).

Although their political origins may be somewhat different in the United Kingdom and Sweden, in both countries the roles of trade unions and employers in the structures and institutions that drive policy on health and safety in these countries have been well established for a long period of time. In Sweden especially, social dialogue on the work environment is longstanding, and its role has been firmly embedded as an important driver of the range of institutions involved in its governance for many decades. The situation in the United Kingdom is less consensual, perhaps, but the respective roles of unions and employers' organisations are nevertheless strongly evident as major influences on the politics of regulatory policies and the practical implementation of preventive strategies. Moreover, since the implementation of the HSW Act in the mid-1970s, these roles have been institutionalised through an extensive network of bipartite and tripartite committees at both subject and sectoral level, set up to advise and consult with the Health and Safety Commission — itself a tripartite body. In this way, not only are the interests of workers represented at all levels in the infrastructure of the health and safety system, but they are fundamental to its successful operation. It would be surprising indeed if some of the effects of this were not seen at the workplace level.

Trades unions in both countries have highly developed systems for training workplace representatives and have invested substantial resources in these systems and in the content and delivery of training. Provision is also substantially greater than is found elsewhere (see Raulier and Walters, 1995; Walters, 1996d; Walters and Kirby, 2002).

We would argue, therefore, that in these two countries it is the workplace effects of the resilience of the power of labour that were established at the time of the introduction of measures on worker workplace representation on health and safety that best explain the situation we have observed in the ESENER findings. Of course, such resilience is being rapidly eroded and more detailed study shows its effects, as Nichols and Walters (2009) have argued in the United Kingdom and Frick (2011) has also indicated in Sweden. We will have cause to return to these developments in the last chapter of this report.

In contrast, the position of representation and consultation in relation to OSH management arrangements does not seem to be especially influenced by the existence of particular models of preventive service, which are substantially different in the two countries (see Westerholm and Walters, 2007 for a comparative account). Nor does it seem to be affected by systems for the compensation and amelioration of harm arising out of work, which also differ markedly in the two countries. It might be anticipated that the role of regulatory inspection plays a part in promoting the association. Indeed, support from regulatory inspection was one of the preconditions identified by Walters and Nichols (2007) for the effective operation of systems of worker representation in health and safety, but strong evidence of the role of such support is not available in either the United Kingdom or Sweden.

As already noted, the range with which the frequency of association between high levels of management commitment and arrangements for representation occurs in other countries in our study makes for less clear distinctions between them

in terms of differences in the national contexts that might be influential. This said, the national reports in the Annex offer several reasons why national contexts may be limiting influences in this respect. For example, it is clear that former Soviet Bloc countries have undergone a major transition in the role of trade unions in OSH. The labour relations' systems that are now in place do not have the maturity of their counterparts in western European countries, regardless of regulatory style. The orientation towards a greater role for workplace representation and consultation on OSH such as is anticipated in the Framework Directive is also itself relatively new in these countries. Moreover, as the national reports for both Bulgaria and Latvia make plain (see Annex), representation on health and safety matters is not always welcomed by employers in workplaces in these countries and, especially in the current economic climate, fears for their job security may promote reluctance among workers to actively take up this role.

It is further evident that the large proportion of small workplaces in Cyprus, as well as the country's relatively recent membership of the EU, may have led to weaker arrangements for formal representation on health and safety in these workplaces, as well as comparatively limited development of management arrangements in this respect, too. The national report on Cyprus makes clear that despite the relatively high levels of trade union representation in the country and strong arrangements for consultation at national levels, one of the major challenges for the health and safety system involves raising awareness among both employers and employees concerning approaches towards the prevention of injuries and ill health and the role of management arrangements in improving health and safety (see Annex).

The relatively low position of France in the sequence of countries in Figure 4.3 may reflect the comparatively recent reforms of the French health and safety system, which bring it more in line with EU norms, as well as the low trade union membership in the country. However, as is discussed in the national report, worker representation and consultation on health and safety is longstanding in France. Although union membership is low, the presence of union representation in French workplaces is high and activity on worker representation on health and safety is generally quite widely reported. Similarly with Germany, which features only just before the former Soviet Bloc countries in Figure 4.3, the relatively recent origin of the reforms to the German health and safety system bringing it more in line with EU standards may be partially responsible for its comparative position. However, the differences in the German system in which the role of works councils in joint arrangements is highly developed and where co-determination rights are operated through this means rather than though the activities of health and safety representatives, may have resulted in some anomalies in the ESENER data in this respect.

More than anything, therefore, the ESENER data on the countries that occupy the middle ground in Figure 4.3 suggest the need for closer scrutiny of the relationships between worker representation and consultation and the effective operation of arrangements for health and safety management in these countries in order to properly understand the role of wider national contexts in influencing outcomes. Comparative qualitative studies are necessary to achieve this.

4.5 Conclusions

In sum, the extent to which worker representation and consultation in health and safety management would appear to have developed successfully in more establishments in some countries than in others is, at least in part, determined by how well the EU version of process-based regulation is embedded in the national approaches to regulating OSH in different countries. In groups of countries with regulatory styles such as those represented by Sweden and the United Kingdom, this development is longstanding. Indeed, it predates EU provisions in this respect by nearly two decades and, as Walters (2002) argued previously, such national approaches were themselves hugely influential in guiding the content of the EU provisions. This meant that the EU model contained no surprises and no significant challenges in terms of the changes required to either infrastructure or process when the requirements of the Directives were transposed in these countries. This was less the case in other countries in which EU provisions sat less comfortably with their own arrangements. There were several main reasons for this and they have been outlined in this chapter and documented in greater detail in the national reports in the Annex. They include the immaturity of labour relations systems in some countries and the presence of mature, but structurally different, systems in others. Thus, in former Soviet Bloc countries the extent of recent change in institutions of labour relations is considerable, but even some southern European states have labour relations systems that are far less longstanding and mature than those of northern and western European countries. In many of these newer (or substantially reformed) systems, the role of workplace representation is not well developed or supported in relation to OSH management. In other countries there may be highly developed and mature systems for labour relations in place but they are based around institutions, structures and processes in which the conceptualisation of workplace representation on OSH is substantially different — the centrality of the works council in co-determination in Germany is a case in point. It is not clear what effect such differences have on the role of worker representation on health and safety. Although useful in identifying differences in some indicators, large-scale quantitative surveys such as ESENER are unlikely on their own to provide answers to this question. More detailed qualitative and comparative study is required.

As well as an appropriate regulatory environment and mature labour relations (and all that goes with this in terms of history, culture, economic policy and strong trade unions, etc.), other supportive elements for worker consultation and representation in the national environments are likely to include the role of regulatory inspection, the resourcing of appropriate training for worker representatives and adequate means to provide them with information. Much of this is provided by trade unions, which implies a further need for strong trade unions with an active engagement in health and safety issues both inside and outside

the workplace. Again, to an extent, patterns in the responses to the ESENER survey and other surveys reflect this.

This said, in the national reports there are indications of further determinants at work. As is also the case in relation to OSH management generally, as well as on psychosocial risks, these are associated with changes in the structure and organisation of work and the political and economic policies that have helped facilitate them. It is clear from all the national reports, including those of countries such as Sweden and the United Kingdom, that these changes are ubiquitous and their effects erode many of the preconditions that support past and present levels of worker representation on health and safety management. We return to a more detailed consideration of their effects in the final chapter of this report.

5. Psychosocial risk management

5.1 Psychosocial risk management: measures, drivers and barriers

The main focus of the ESENER survey was on new and emerging risks. In particular, the survey concentrated on psychosocial risks, specifically on phenomena including work-related stress, violence and harassment. Two of the secondary analyses lots, therefore, concerned psychosocial risk management, considering both the management of psychosocial risks overall (EU-OSHA, 2012c) and drivers and barriers for psychosocial risk management (EU-OSHA, 2012a).

Using a similar approach to that taken in Lot 1 (which focused on effective OSH management — see Chapter 3), the authors of EU-OSHA (2012c) constructed a composite score of six psychosocial risk management factors. These factors were:

- the use of a psychologist;
- the presence of procedures to deal with psychosocial risks;
- the provision of training for employees on dealing with psychosocial risks;
- informing employees about psychosocial risks and their effect on health and safety;
- informing employees of whom to address in case of work-related psychosocial problems; and
- the use of information or support from external sources on how to deal with psychosocial risks at work.

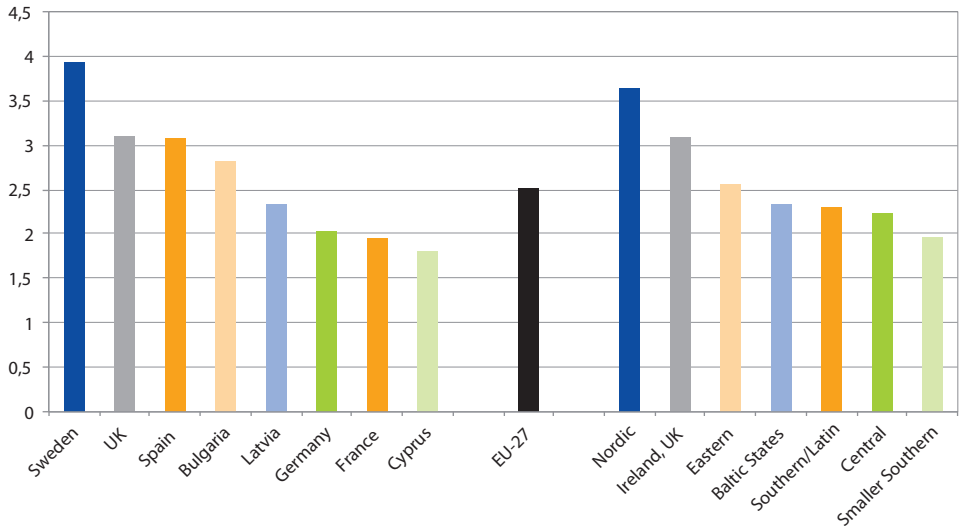
The authors concluded that, on the whole, establishments seem to be taking systematic approaches to the management of psychosocial risks and, further, that the application of a risk management approach appears to be empirically justifiable (EU-OSHA, 2012c). They also found a strong link between OSH risk management generally and psychosocial risk management, with establishments with good management of general OSH risks also managing psychosocial risks more effectively; though, in addition, the analysis suggested that the management of psychosocial risks generally lags behind that of general OSH risks. Importantly, from the point of view of the current study, the authors of EU-OSHA (2012c) concluded that:

- There were stark differences between the frequency of components of their composite measure between countries (the most frequently used measures were the provision of training and ensuring that employees know whom to address — third and fifth in the list above).

- The country context matters a lot but is difficult to capture; 'economic conditions and wider awareness and acceptance in society of psychosocial risks are probably more important explanatory variables not readily captured' by surveys such as ESENER (p. 12).

These conclusions suggest that considerable variation in the Lot 3 composite measure should be apparent between the Member States studied in this project and the wider regulatory groups they were selected to represent. Figure 5.1 shows that this is the case, with the highest levels of psychosocial risk management measures in Sweden and the Nordic group and the lowest levels in Cyprus and the Smaller Southern group. This is also consistent with the pattern of findings apparent in relation to OSH management generally (see Chapter 3), which supports the strong link between risk management generally on the one hand and psychosocial risk management specifically on the other; and also highlights the influence of regulatory characteristics and context. Again, however, it is apparent, as the authors of EU-OSHA (2012c) suggest, that other factors are also important, with, for example, a large difference between countries from the same regulatory group (e.g. Spain and France (Figure 5.1); and Bulgaria (Figure 5.1) and Hungary (mean score of just over 2 (EU-OSHA, 2012c)).

Figure 5.1: **Application of the Lot 3 psychosocial risk management composite score to the selected Member States and the regulatory style groups: mean scores**



Consideration of the individual components of the Lot 3 measure also show that the EU-OSHA (2012c) authors' finding of stark differences between countries is apparent for our selected Member States and their regulatory groups. As an example, Figure 5.2 shows that respondents in the United Kingdom and Sweden, and from the Ireland and United Kingdom and Nordic regulatory groups generally, were very much more likely than those from elsewhere to report that their establishment had a policy in place for at least one of the psychosocial risks on which ESENER focused (work-related stress, violence and harassment).

The Lot 3 secondary analysis also showed that, in addition to country, the size of the establishment was another very strong determinant of the scope of psychosocial risk management, with smaller establishments reporting fewer psychosocial risk management measures than large establishments and, again, great differences in the frequency of individual components of the composite measure by organisation size (EU-OSHA, 2012c). Figure 5.3 shows the composite score for the smallest establishments included in ESENER (those with 10–19 employees). Considerable variation is apparent across the Member States and regulatory groups, with the pattern of difference very similar to the overall mean scores for psychosocial risk management (seen in Figure 5.1). This suggests that, in countries such as Sweden where psychosocial risk management measures are more prevalent overall, this greater prevalence extends to even the smallest enterprises.

Figure 5.2: **Presence of at least one policy for psychosocial risk management: proportion (%)**

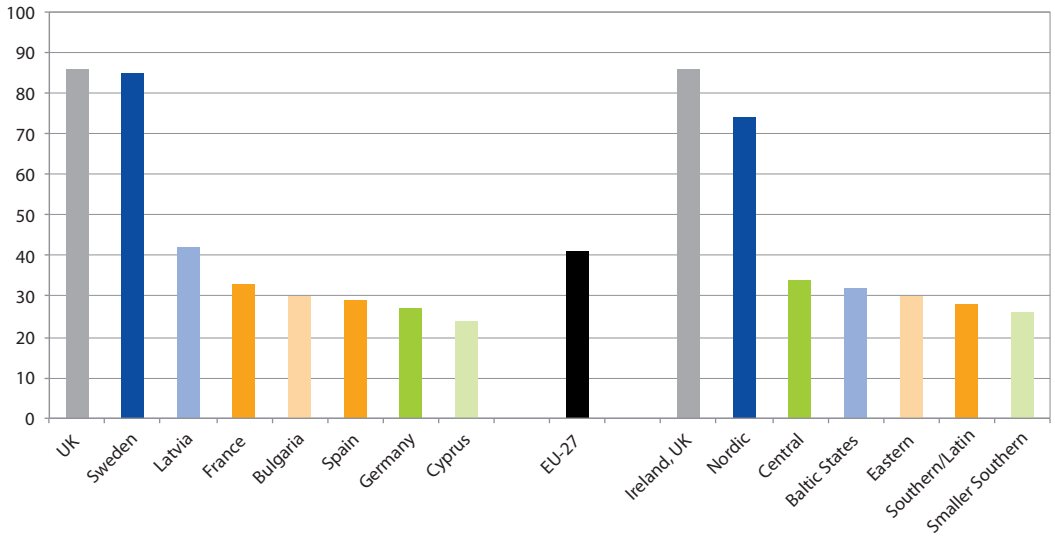
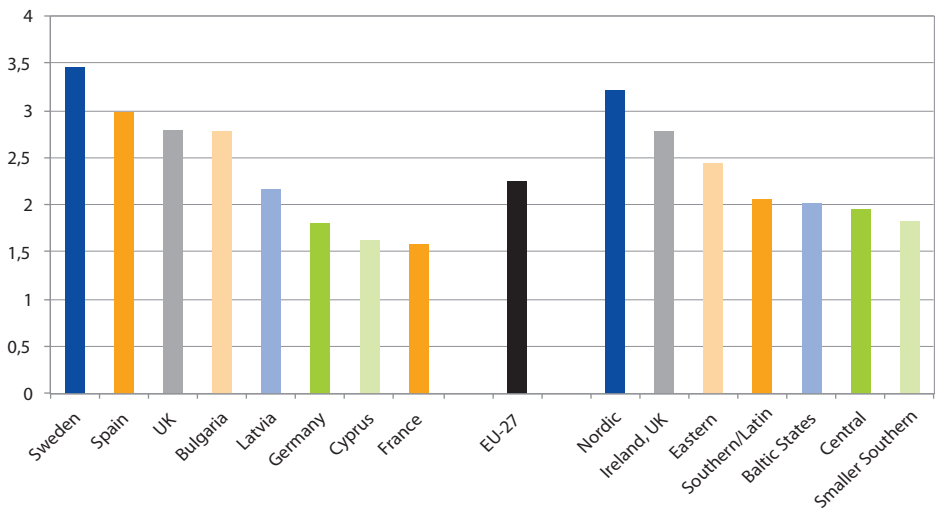


Figure 5.3: **Application of the Lot 3 psychosocial risk management composite score to the selected Member States and the regulatory style groups: mean scores for establishments with 10–19 employees**



Lot 4 of the secondary analyses identified drivers for and barriers to psychosocial risk management (EU-OSHA, 2012a). Key drivers included:

- the implementation of good practice in OSH management;
- concern of psychosocial risks;
- requests from employees; and
- high levels of absenteeism.

In terms of barriers, key factors included:
- lack of technical support and guidance; and
- lack of resources.

There is insufficient space here to present details of each of these drivers and barriers for our Member States and regulatory groups. However, taking requests from employees and a lack of technical support and guidance as an example of each, Figures 5.4 and 5.5 again show clear differences. Respondents from Sweden and the Nordic group were most likely to report that requests from employees were a driver of psychosocial risk management and least likely to report that a lack of technical support and guidance was a barrier, while those from Cyprus and the Smaller Southern group were at the opposite end of the spectrum in each case.

The importance of requests from employees as a driver emphasises the significance of employee participation, which, as Chapter 4 clearly shows, is something that is particularly strong in Sweden and the Nordic countries. The significance of lack of technical support and guidance as a barrier is something that has already been acknowledged, with an SLIC campaign ([15]) recognising that consideration should be given to the potential influence of labour inspectors in this regard, and EU-OSHA also highlighting the importance of having OSH service providers properly trained in psychosocial risk management practices (EU-OSHA, 2012e). It is also not surprising that this is a particular issue in the smaller Member States, especially those like Cyprus that have economies dominated by micro- and small enterprises, which, in addition to being difficult to reach, are frequently in need of support in most areas such as the management of new and emergent risks. However, Figure 5.5 suggests that lack of technical guidance and support is also a significant issue in France, which could not

Figure 5.4: **Requests from employees as a driver for psychosocial risk management: proportion (%)**

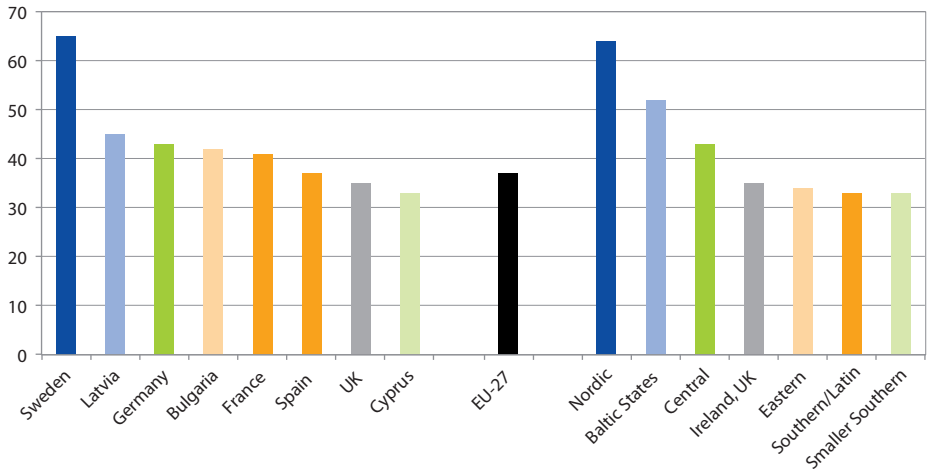
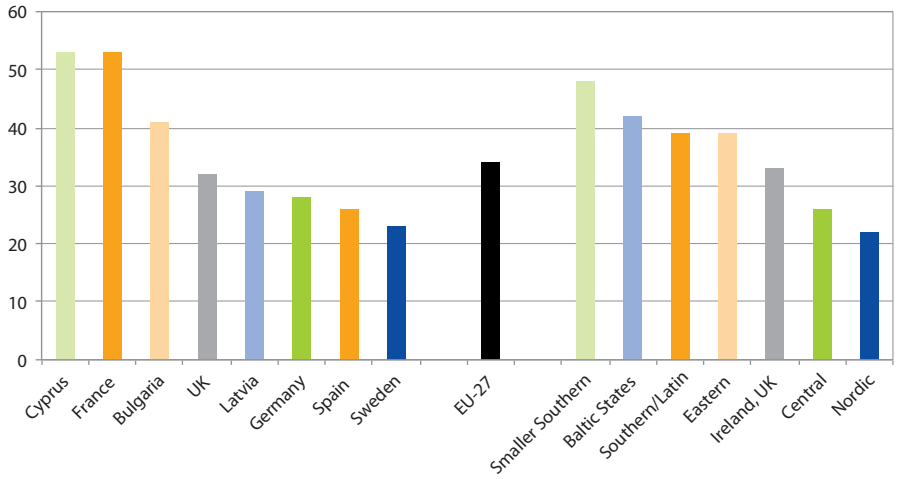


Figure 5.5: **Lack of technical support and guidance as a barrier to psychosocial risk management: proportion (%)**



([15]) The Committee of Senior Labour Inspectors' European Inspection Campaign on Psychosocial Risks 2012 (www.av.se/SLIC2012).

be described as a smaller Member State and does not have the same predominance of micro-enterprises as Cyprus. In this case, the comparatively high level of respondents reporting a lack of technical support and guidance may reflect the relatively recent focus on work-related psychosocial risks and their management in the country — something that we discuss in greater detail in section 5.3.

Given the strong association between the management of OSH in general and psychosocial risk management (EU-OSHA, 2012c), a similar set and pattern of influential factors is clearly not only likely but inevitable. In fact, as psychosocial risk management seems to lag behind general OSH management (EU-OSHA, 2012c), it might be best considered as an 'advanced' subset of OSH management, which, as such, is arguably even more sensitive to the sorts of influences discussed in Chapter 3, namely regulatory context and character; perceived costs of OSH management implementation and legislative compliance; available support infrastructures; and wider economic and political conditions. We will not, therefore, discuss these again here. Instead, the following sections focus on the two issues that the national reports identify as being of particular relevance to psychosocial risks and their management: first, the economic factors and working conditions that are associated with increased exposure to psychosocial risks and, second, the extent of the tradition for their recognition — as the essential first step towards protection and prevention. Much of the material presented in these sections is drawn from the national reports for France, Spain, Sweden and the United Kingdom. As we argue in section 5.3, these countries have longstanding traditions of research into psychosocial risk management and, with the exception of France, are identified by ESENER as having particularly high levels of psychosocial risk management measures in place in the workplace both overall and among the smallest enterprises (see Figures 5.1 and 5.3).

5.2 Exposure to psychosocial risks: antecedents and consequences

In common with, and with some reference to, a large and growing body of international literature, a number of the national reports identify significant levels of workplace exposure to psychosocial risks. For example, the Bulgarian report suggests that 65.4% of workers report stress due to work overload and 40.5% report stress due to lack of time, while 23.4% are exposed to violence or the threat of violence in the workplace, and 22.8% are exposed to bullying or harassment at work. Similarly, the Swedish report notes that nearly half of workers questioned felt that they had 'way too much to do', with levels among women increasing from 48% in 1989 to 56% in 2009. In addition, figures from the fifth European Working Conditions Survey (Eurofound, 2010) showed that, in the United Kingdom in 2010, 5% of employees reported that they had been subject to discrimination at work, 15% to verbal abuse, 8% to threats or humiliating behaviour, 3% to violence and 5% to bullying or harassment, while levels of perceived work-related stress of approximately 20% have been reported (Smith et al., 2000).

Exposure to stress, violence and bullying have been strongly linked to ill health (Kearns, 1986; Jones et al., 1998; Peter et al., 1998, 1999). Again, this is borne out by the figures, which show high and, in some cases, increasing levels of both mental ill health and MSDs — the conditions most closely linked to psychosocial stressors. For example, in the United Kingdom, recent Labour Force Survey data suggest that during 2008/2009 the most commonly reported conditions that workers felt were caused or made worse by work were MSDs (1,770 per 100,000), and stress, depression or anxiety (1,370 per 100,000) (HSE, 2010). This was further reflected in figures showing that MSDs and mental ill health accounted for 54.7% and 30.0% of new work-related ill health diagnoses, respectively, in 2009 (HSE, 2009b) and that stress accounted for 40% of all work-related illnesses in the United Kingdom in 2011/12 (HSE, 2012a). This, of course, is costly both to employers and to society more widely. Recent studies have shown that at least half the annual total of days off work in the United Kingdom are the result of a stress-related illness (Dyer, 1998; James and Walters, 2005; James, 2006), with stress, depression or anxiety and MSDs accounting for the majority of days lost due to work-related ill health at 10.4 and 7.5 million days, respectively (HSE, 2012b). These kinds of conditions are consistently associated with increases in flexible or contingent work patterns, and consequent increases in insecurity and lack of control over work (see, for example, reviews by Quinlan et al., 2001; Quinlan and Bohle, 2008; Walters et al., 2011b).

There is a large body of research that has established a powerful link between psychosocial risks such as these and their physical and mental consequences on the one hand and changes in the structure and organisation of work on the other (see, for example, Smith et al., 2000; Stansfeld et al., 2000). In particular, these associations concern the changes to business and employment practices that have been increasing across the EU (and further afield) since the mid-1970s and which, in many cases, have increased sharply as a result of the recession and political and economic responses to it. The kinds of changes to the structure and organisation of work have included downsizing and restructuring of large enterprises in both the public and private sectors; changes to the way people are employed, in particular the growth of non-standard employment (i.e. fixed-term, casual, temporary, agency and other contingent employment); increasing use of outsourcing and subcontracting; growth in home- and other non-workplace-based forms of work; reductions in job security and tenure; changes to working hours and patterns (e.g. increases in irregular hours, split shifts, on-call work); poorer work–life balance; increases in work intensity combined with decreases in control over and support at work; and changes in the composition of the workforce (such as increasing numbers of older and female workers).

Evidence of the associations between changes such as these and increases in workers' OSH vulnerability has been well documented (see, for example, Quinlan et al., 2001; EU-OSHA, 2007b; Quinlan and Bohle, 2008; HIRES, 2009; Walters et al., 2011b). This is particularly significant given the extent of these kinds of changes

across the EU — as reflected in the national reports. For example, in France in the fourth quarter of 2011, 9.4% were unemployed overall, but this rate rose to 22.4% for those under 25 years; 5% were underemployed; and 6.8% held fixed-term or temporary contracts (INSEE, 2012). Similarly, recent United Kingdom figures show a recent sharp rise in underemployment (currently 1 in 10 workers, i.e. 3.05 million out of a total workforce of 29.41 million, an increase of 980,000 (a third) in the four years since the recession began in 2008 ([16]). As the French report argues, these changes reinforce feelings of insecurity and dissatisfaction, as is clear from the finding of a recent survey that over a quarter of employees (27%) felt vulnerable and had experienced deteriorating working conditions (Rouxel, 2009). This report also found associations between job insecurity and accidents at work, as well as lack of safety training (23% of those on fixed-term contracts had not received any safety training compared with 12% of those in stable employment), while another found associations between job insecurity and stress (Lerouge, 2009).

Overall, therefore, the national reports suggest that the structure of work, the way in which it is organised and the ways in which people are employed have changed substantially in all the Member States. They also make it clear that these changes have been rapid and are continuing at a significant pace. Research has established that changes of this nature are strongly linked to increased vulnerability for workers as a result of the challenges such changes create for effective OSH management, worker participation and regulatory inspection and enforcement on the one hand and the increased exposure to workplace risks, in particular psychosocial stressors on the other (see, for example, Quinlan and Bohle, 2008; Walters et al., 2011b; EU-OSHA, 2012d). There are, of course, variations in the extent to which particular changes have been felt in specific Member States. However, what is key in terms of the current study is the extent to which Member States have had the capacity to document these changes, research and understand their implications, and subsequently react in a coherent, coordinated and appropriate way.

5.3 Recognition of and reaction to psychosocial risks

Member States' capacity for recognising and responding to changes associated with workplace psychosocial risks is determined by their wider economic, political and social contexts. These, of course, are also always changing, but the national reports provide something of a 'snapshot' of the kinds of backdrops against which provision for the recognition of and reaction to psychosocial risks is made. In particular, what emerges from these snapshots is significant variation — effectively a number of European tiers. So for those countries currently facing more of a struggle to protect workers from traditional risks (such as Latvia), prioritising new and emerging risks, including psychosocial risks, is necessarily further over the horizon than for countries more advanced in these respects (such as Sweden). Furthermore, within the 'tier' of Member States where there is greater recognition, as evidenced by research into, and the provision of support and inspection for, psychosocial risk management measures, the national reports suggest two distinct levels. First, there are countries such as France and Spain, in which recognition has been comparatively recent; second, there are countries such as Sweden and the United Kingdom, where the recognition of psychosocial risks is longstanding. As Figure 5.1 shows, ESENER indicates that three of these four Member States (Sweden, the United Kingdom and Spain) have relatively high levels of psychosocial risk management measures in place, whereas in France the mean number of measures is somewhat lower.

Considering France and Spain first, both national reports make it clear that psychosocial risks have become a focus relatively recently. In France, risks such as stress, physical and verbal abuse, harassment and burnout have become major concerns nationally since the late 2000s. The report's author argues that research, in combination with media coverage of work-related suicides, has played a significant role in raising the profile of psychosocial risks among the social partners and more widely. This has led to significant efforts on the part of the social partners to improve workplace practice through the provision of information and support. In addition, the Agreement of 2 July 2008, which transposed the Framework Directive into French law, has also been seen as influential (Douillet and Mary-Cheray, 2008). Similarly, the Spanish report suggests that a focus on psychosocial risks has been prompted, at least in part, by national research in the area, much of which is now being used to inform policy and legislative development. For example, a 2006 report (Benavides, 2007) delivered by the Spanish Observatory of Occupational Health (which has since been integrated into the Center of Research in Occupational Health), part of an ongoing series (Durán López and Benavides, 2004) made recommendations, which included the identification of monotony and lack of control at work as one of the most prevalent occupational risks in Spain; the evaluation of the impact of employment policies on workers' health; and the surveillance of work-related conditions, including mental illness, and the development of preventive actions in this regard. This tradition of research is strongly linked to the trade unions in Spain, mostly to the confederations: CCOO and UGT CCOO was involved in the creation and maintenance of ISTAS (the Trade Union Institute of Work, Environment and Health), which aimed to promote and improve working conditions and OSH protection generally. ISTAS has been particularly influential in social dissemination and mobilisation around key issues including the importance of occupational exposure to psychosocial risks and the opportunities for their management (Moncada et al., 2011). UGT has also developed specific resources and tools in relation to surveillance and assessment of these occupational risks in Spain, namely the so-called *Observatory of Psychosocial Risks*.

Both France and Spain, therefore, have focused on psychosocial risks more recently (relative, for example, to Sweden and the United Kingdom) as a result of national-level research. In each case, the role of the social partners has also been significant in terms of supporting this work, but also, and importantly, in

([16]) www.bbc.co.uk/news/business-20509189

relation to facilitating its 'translation' into policy and workplace-level developments and improvements. Developments in both Member States' support services and regulatory provision have also been apparent. For example, Spanish prevention services are required to be accredited to offer services in a number of disciplines including psychosociology (though, as both Chapter 3 and the national report point out, there are some concerns about the quality of these services), and the labour inspectorate is currently in the process of increasing its capacity and scope in relation to psychosocial risks. To this end, it has recently published a guide to regulate activities of the inspectorate on psychosocial risks at work (Dirección General de la Inspección de Trabajo y Seguridad Social — Instituto Nacional de Seguridad e Higiene en el Trabajo, 2012) and has instigated a number of initiatives promoting control and promotion of safety culture in the companies (Instituto Nacional de Seguridad e Higiene en el Trabajo, 2008; Velázquez, 2009).

Nevertheless, ESENER suggests significant differences between France and Spain in terms of levels of workplace measures to tackle psychosocial risk (Figure 5.1). These in fact reflect the differences between the two countries in relation to general OSH management (see Figure 3.1), which is consistent with the close association between the management of both traditional and new and emerging risks. As we suggested in Chapter 3, this may be the result of the Member States' differing reactions to the Framework Directive: in Spain it was taken as an opportunity to comprehensively overhaul the OSH regulatory system, while in France it prompted significant and ongoing internal debate and struggle towards integration into the existing OSH infrastructures. This points to the importance of not only the style and character of the regulatory regime itself, but also both the ease with which it was adapted to the Framework Directive and its process-based approach and the extent to which the necessary changes to the regulatory, legislative and infrastructural support systems were made in a comprehensive and overall way.

Turning to Sweden and the United Kingdom, both countries also have clear traditions of recognition of the significance of psychosocial risks and the need to manage them, which are based on national research. In each case, these traditions have been ongoing for several more years than they have in France or Spain. For example, research in Sweden in the early 2000s into increases in levels of sickness absence and early retirement identified psychosocial risks as a major cause of these increasing demands on public funds (Ds, 2001; SOU, 2002; Marklund et al., 2005). This led to political initiatives, which included requiring the inspectorate to increase its focus on psychosocial risks and (at that time at least) increasing its resources to enable this additional emphasis. This has clearly had an impact, as recent inspectorate figures show that the proportion of visits focused on psychosocial risk and ergonomics has been between 16% and 21% for the last five years (AV, 2012). However, the recent change of political direction identified in the national report, focusing more on return to work than on the psychosocial roots of high levels of sickness absence, with the ultimate aim of reducing costs, may be beginning to impact on this positive development.

As in Spain and France, and as might be expected from the country's wider traditions of social dialogue (see Chapter 1), the social partners have also been influential in Sweden. Both workers' and employers' organisations acknowledge the seriousness of the problems of high levels of sickness absence and the contribution of psychosocial risks, and both provide significant support for workplaces, including training, information, advice, written materials and websites. The difference between the social partners is principally the extent to which they would like to see legislation, as opposed to voluntary agreements, in relation to psychosocial risk management. In particular, the unions would like to see psychosocial risks specified within the country's SWEM provisions, whereas the employers would not. To date, the view of the employers has prevailed, which the report's author suggests is at least in part related to the failure to translate the EU social partners' Agreement on Work-Related Stress into collective agreements (Frick, 2010).

ESENER indicates (Figures 5.1 and 5.3) that, in terms of psychosocial risk management measures, Sweden is functioning at a higher level than other Member States, and, further, that this extends to even the smallest enterprises. However, the Swedish national report questions the extent to which this reflects the quality and effectiveness of workplace practice. For example, the SWEM provisions require employers to ensure that they have adequate competence in all areas of the work environment, including psychosocial risks. This can be provided by an external service if necessary, but, as the national report's author points out, this is rarely enforced as inspectors frequently feel that these services do not have the necessary competence in areas such as psychosocial problems (Frick, 2011). He goes on to suggest that psychosocial risk management is an area that the inspectorate (in common with most others across Europe) finds difficult to inspect and regulate; something which may be exacerbated by recent cuts to its budget, which have shortened inspection time. Furthermore, although there is an agreement between the social partners on cooperation and the work environment (FAS, 2005), the national report cites recent work suggesting that its central guidance and support is more effective in promoting local work-group dialogues than SWEM to reduce health risks (Frick and Forsberg, 2010). The Swedish report concludes that 'widespread stress and MSD risks indicate that many employers may have implemented the SWEM routines but they have only partly integrated these into their management systems'.

Like Sweden, the United Kingdom has a relatively long tradition of research into work-related psychosocial risks stretching back at least to the late 1990s (see, for example, Kearns, 1986; Jones et al., 1998; Peter et al., 1998, 1999; Smith et al., 2000; Stansfeld et al., 2000). In addition, the United Kingdom national report notes a trend towards increasing recognition of the link between work and health, which, in combination with concern about economic loss as the result of absence from work, it suggests has raised the profile of psychosocial risk both within the regulatory bodies, and hence in the support and guidance they provide to organisations, and among employers, trade unions and society more widely. This recognition is apparent, for example, in the inspectorate's Field

Operations Directorate (FOD) inspection strategy, which, in 2003, was embraced within a programme called FiT 3 ([17]). FiT 3 identified new and emerging risks resulting in stress and ergonomic issues concerning manual handling as areas in which FOD should increase its efforts. Similarly, the inspectorate has developed the Management Standards (see Cousins et al., 2004; MacKay et al., 2004) — an employer's guide for managing workplace stress, which has also been widely used outside the United Kingdom. As in Sweden, recent political changes and resulting inspectorate budget cuts threaten to undermine this inspectorate focus on psychosocial risk management. In fact, it has long been widely accepted that, given the imbalance between the resources available for inspection and the number of workplaces, employers and workers potentially subject to inspection, there is generally very little possibility in practice that face-to-face contact with labour inspectors will take place in more than a small minority of cases. Inspectorate budget cuts, particularly when coupled with political changes of the kind seen recently in Member States such as the United Kingdom and Sweden, serve to exacerbate this imbalance, further lengthening the odds of workplace inspection. This is of particular concern in relation to psychosocial risk given that one of the increasingly common ways in which inspectorates deal with the imbalance between their resources and the numbers of workplaces, employers and workers is by taking risk-based approaches to inspection and enforcement (i.e. targeting their interventions by focusing on workplaces and sectors creating the most health and safety risks at work (see Fookes et al., 2007: 37–41 for an overview of approaches to targeting)). Psychosocial risk is, of course, a possibility in any workplace, but recent research suggests that those in particular occupations may be more likely to experience, for example, above-average levels of stress. These include, for instance, teaching (Travers and Cooper, 1993; Johnson et al., 2005), social services and call centre customer services (Johnson et al., 2005) — sectors and workplaces that are particularly unlikely to be targeted for inspection by risk-based approaches, as these are most frequently based on rates of injury, illness, compliance or regulatory intelligence (Fookes et al., 2007) and so focus in particular on more traditional risks.

ESENER suggests that United Kingdom enterprises generally have relatively high levels of psychosocial risk management measures in place (Figure 5.1), albeit somewhat lower than those for Swedish organisations. However, the United Kingdom national report, like the Swedish report, also suggests that this headline figure may not represent effective workplace practice. For example, a recent survey (IES, 2006) showed that fewer than 5% of the enterprises studied cited psychosocial hazards as presenting health and safety risks, suggesting very little recognition of their significance at the workplace level. The United Kingdom, therefore, in common with many other Member States (and a number of other areas of OSH management), seems to have found it difficult to translate the knowledge and understanding available in the country as a result of research into effective workplace-level risk management in practice.

([17]) FiT 3 stands for 'fit for work, fit for life, fit for tomorrow', so very much reflects the policy lexicon used by the Department of Work and Pensions to address the health of the working-age population.

In addition to their relatively long traditions of research into psychosocial risks and both their causes and management, the Swedish and United Kingdom national reports each highlights an understanding of the 'business case' for workplace psychosocial risk prevention and management. Although both reports question the extent to which this has filtered down to the workplace, they suggest that it has been apparent at the national — that is, policy — level, with both countries funding research into the causes of sickness absence. However, recent political sea changes in the two Member States suggest that this focus is now rapidly shifting away from the psychosocial causes of sickness absence and towards returning people to work in order to minimise public and business costs. This is a further reflection of the shift of power from labour to capital to which we have referred elsewhere, and seems to threaten the steps these two countries, which appear to be the most advanced in terms of psychosocial risk management, have taken in this area.

5.4 Conclusions

The third lot of secondary analyses of ESENER suggested that psychosocial risk management is strongly linked to OSH management generally, with establishments with good management of general OSH risks also better at managing psychosocial risks (EU-OSHA, 2012c). In fact, the analysis also suggested that psychosocial risk management lags behind general OSH management and varies substantially from country to country (EU-OSHA, 2012c). These conclusions make it clear that psychosocial risk management is influenced by the same factors as OSH management more generally, which we have discussed in Chapter 3. Arguably, the influence of factors such as regulatory characteristics and context, perceived costs of implementation and compliance, support infrastructures and wider economic and political conditions may be even greater over psychosocial risk management since it is currently something of a 'fledgling' component of OSH management generally, so one that may be particularly susceptible to broader national environments, trends and pressures.

There is an increasingly large body of international literature, from Europe and from further afield, that shows clear and very strong links between changes in the way in which work is structured and organised and increases in work-related vulnerability, injury and ill health. The kinds of changes implicated in this relationship have become increasingly widespread in recent years across Europe and, as the national reports make clear, in all of the Member States that are the focus of this study. In particular, these changes have been associated with exposure to psychosocial stressors and their most common consequences: mental ill health and MSDs. Crucially, Member States' capacity to recognise and manage these risks varies substantially, and is determined by the wider economic, political and social contexts in which this recognition and response is situated.

From the national reports, three factors, all of which are interlinked, seem to be of particular significance in this respect. First, traditions of national-level research into OSH

both generally and in relation to psychosocial risks and their management specifically, are particularly important. These act as drivers, stimulating debate and development among policy-makers, society more widely and, perhaps most significantly, the social partners. This, of course, is a cyclical process, with a higher national profile prompting further research and so on. Second, the role of the social partners is of particular importance. In addition to further raising the issue in the public consciousness, the social partners play a key role in 'translating' research into practice. That is, they contribute to legislative and policy development; they provide support for employers, employees and their representatives, as well as workplaces more generally, in implementing psychosocial risk management measures; in addition, in some cases, they are significantly involved in the facilitation and support of the research activities themselves. Third, EU-level policy and legislation is identified as being of significance in some cases, perhaps particularly in Member States where research traditions are less well established. This, of course, implies potential for further influence and support for national efforts from this level (although some of the recent proposed changes referred to in Chapter 3, for example in relation to the perceived 'burden' of OSH management on business and the need to reduce it, suggest that this may be less likely to be forthcoming in the future).

These three influential factors were identified by national reports, most of which were on countries which ESENER identifies as having relatively high levels of workplace psychosocial risk management measures in place. However, it is important to bear two things in mind at this point. First, several of those reports suggest that, while enterprises might have risk management measures in place, they are not necessarily fully understood and effectively implemented. Second, the conditions which have allowed those countries to set up research and infrastructural supports, and mechanisms for their practical application and development at the workplace level, are being eroded by the same kinds of economic and political changes that are implicated in relation to a number of the changes in the organisation and structure of work that lead to increased psychosocial risk. This is of particular importance given that both of these factors are almost certain to apply to a greater or lesser extent in all Member States, including those which ESENER suggests do not yet manage psychosocial risk as well as they might.

In most enterprises in most countries, health and safety management systems focus predominantly on reducing the causes of injury rather than on dealing with the issues of work organisation that generate psychosocial risk and lead to health and safety consequences, particularly mental ill health and musculoskeletal problems, among workers. The management and prevention of these working conditions and their causes is also acknowledged to be in many respects harder for traditionally safety-orientated regulatory inspectorates to address, particularly if there are fewer resources at their disposal to do so. This need to respond to emergent trends, increasingly with very limited resources, is something we return to in the following chapter.

6. Conclusions

In the last three chapters we have indicated that survey evidence, especially that of ESENER, points to some degree of unevenness in OSH management practices in establishments in different EU Member States and that an explanation for this might be found in the national contexts and environments in which this OSH management occurs. That is, this evidence suggests that the application of national measures to transpose EU requirements in this respect is not entirely uniform, in terms of either their implementation or their operational outcomes. Referring to material from the country studies presented previously, this chapter outlines the most significant contextual influences apparent in the implementation of mandatory health and safety management in the countries we studied. The influences of the structural and procedural characteristics of the countries concerned are examined, with the focus especially on their political and economic backgrounds and the overarching moderators of the implementation and operation of supranational measures. Some of these factors lead to similar outcomes among Member States, whereas others promote differences. The chapter therefore discusses trends of convergence and divergence in these areas. Although evaluative research of this kind is quite underdeveloped, and this contribution is limited in several significant respects, we think it is nevertheless able to draw some useful conclusions concerning the impact of context and change, as well as point to some areas for future research on the role of the process of regulation as an effective means of improving health and safety outcomes in the range of advanced market economies within the EU.

6.1 Some theoretical reflections on OSH management regulation and its contexts

Public regulation of economic activity occurs in all Member States of the EU. From its development in the nineteenth century it has come to play a pervasive role in intervening in economic relationships and it now constitutes one means by which to manage the risks with which we live in advanced industrial societies.

Debate on the relationships between regulation and risk and between public and private regulation has burgeoned in recent decades. For example, Ayres and Braithewaite (1992), Gunningham and Johnstone (1999) and Hutter (1997, 1999) have discussed approaches to the development of regulation on OSH and the environment. Carson (1970), Hawkins (2004) and, more recently, Tombs and Whyte (2010) and Walters et al. (2011a) have discussed social, political and economic influences on the practice of enforcement of OSH regulation. More generally, Colebatch (1989), Bardach and Kagan (1982), Hancher and Moran (1989) and Selznick (1980), among many others, have presented a theoretical analysis of the role and meaning of regulation in advanced industrial societies. Social science approaches to risk in society since the 1990s have been particularly influenced by the work of Giddens (1990) and Beck (1992), while Jassanoff et al. (1995), Nelkin (1992) and Wynne (1994, 1996) have discussed the relationship between risk and science, and Hutter (2001: 2–23) has made a more specific attempt to relate the theoretical analyses of risk and regulation to OSH management. More recently, it has been acknowledged that studying compliance has become more complex, partly as a consequence of the growth of non-state regulatory authorities and standard-setting bodies, both national and international (Black, 2008), but also as a consequence of the wider efforts of states to roll back their regulatory position to facilitate the growth of business under the influence of neoliberal political and economic thinking and the pressures of globalisation (Gereffi et al., 2005; Estlund, 2010).

In current discussions concerning the limits of public regulation in these emergent scenarios, theorists have focused on the example of OSH in order to analyse the significance of new 'regulatory mixes' in which private regulation, and social and economic actors, as well as the interests of business, play a more prominent role (Lobel, 2005; Estlund, 2010). Here is not the place to digress at length on these developments in the theoretical literature. However, they are clearly relevant to achieving a deeper understanding of the role of context and environment in influencing differences in the operation of health and safety practices in workplaces in different Member States of the EU; practices which themselves are actions taken, at least in part, in order to meet regulatory standards imposed at supranational and national levels.

The constitutive and controlling functions of regulation are seldom questioned. We broadly accept the notion that it is a means by which to restrain competition either to make markets operate more efficiently or as is more the case in relation to OSH, to prevent undesirable outcomes for workers. As Hutter has elaborated, current OSH regulation is a form of control which does not prohibit risk, but rather attempts to manage it, and structures, routines and procedures are constituted 'which will be incorporated into organisational routines and also become part of everyday individual activity. Where this fails the law can intervene through more overt forms of control, notably external regulation and sanctions' (Hutter, 2001: 5). This process of incorporation is what has taken place in the shift from prescriptive to process regulation in OSH from the 1970s onwards. In the regulatory mixture now evident in the advanced industrial societies of the EU and elsewhere, this includes the widespread introduction of new sets of regulatory provisions in which employers are required to institute structures and procedures to manage the risks to the health and safety of their workers and the repeal of more prescriptive instruments that were emblematic during the 1990s. These provisions have a constitutive and structuring function for employers and they require them to focus on the organisational means with which they are equipped to assess and manage risks.

Essentially, then, at the level of the EU during the last 20 years there has been a major shift in regulatory policy in which the regulation of process has taken ascendancy over the traditional regulation of substance in protective legislation on health and safety. The shift, while present to a greater or lesser extent in a number of Directives dating from the period around the beginning of the 1990s, is especially seen in the Framework Directive. This is in part because of its generality, but more significantly it is because of its focus on processes in which requirements on employers to manage health and safety are made mandatory. Its prevention principles, requirements on risk assessment, provision of information and consultation with workers, as well as its requirements on competency in OSHM, are all process orientated and addressed primarily to employers. Thus, it is representative of an important paradigm shift in regulatory strategies in which a primary objective has become the means of influencing employer/management will and capacity to operationalise OSH management in order to manage risk and lead to improved OSH performance outcomes. Its non-specificity in relation to what kind of risks it covers also make it a suitable frame for requirements, regulatory or otherwise, concerning the management of psychosocial risks.

However, this is not a shift that originated at the level of the EU, but rather within some Member States, the influences of which were strongly felt during the 1980s when the groundwork for the Directive and its daughter Directives — which espouse similar principles — was being laid. It follows from this that a variation in the national contexts in which transposition of these instruments occurred subsequently could be anticipated. This is likely to be the case between those countries which were influential in constituting the EU requirements, those whose regulatory content, structures and processes had taken different directions in their development, and those whose systems were underdeveloped and less mature than either of the former. It is further reasonable to suppose that such contextual variation would continue to exert an influence on the practice of health and safety management in workplaces long after transposition of the regulatory requirements was complete. In the previous three chapters we have considered how national contextual differences help to explain different experiences of health and safety management practices identified by the ESENER findings. At the same time we have also shown how similar variation in contexts and environments exert an influence on the practice of worker representation and consultation in relation to health and safety management and how they also affect the management of psychosocial risks, which are widely regarded as among the most significant of emergent risks in modern European work scenarios.

We have further shown that factors which have facilitated or impeded the practice of OSH management according to the requirements of EU Directives are not restricted to health and safety systems in different Member States but are also driven by aspects of the wider national infrastructures for economic governance as well as (less tangibly but nevertheless importantly) by shifts in political ethos and culture. We have attempted to capture the broad nature of the infrastructural contexts in which managing health and safety is situated in Figure 6.1, which depicts its position in relation to these larger and overlapping spheres of influence.

Before embarking on a detailed discussion of these influences, however, we also need to remind ourselves that although the Framework Directive was adopted in the late 1980s as part of a wider EU strategy to provide a floor of rights and duties for workers' protection in health and safety, its transposition and the subsequent operation of OSH management within establishments has taken place in a very different political and economic environment to the one in which these measures were developed. As all of the national reports presented in the Annex make plain, the single most common environmental context that all the countries we studied share is that of change. Change has occurred across a spectrum of work restructuring and reorganisation and the restructuring and repositioning of the wider economic, regulatory, political and even cultural contexts in which it is embedded. This is, of course, not without consequence for the operation of health and safety management, the role of worker representation and consultation or the management of psychosocial risks. Indeed, in the case of the latter, its rise to prominence as a serious issue in terms of work-related ill health is itself a consequence of such change.

This chapter therefore returns to the same elements of the EU model of OSH management that have been the focus of analysis in the previous chapters on national influences on its practice. We start by revisiting our findings concerning OSH management practice, worker representation and the management of psychosocial risks and setting them against the main features of the environmental contexts in which they operate and which seem to influence how they operate. We have summarised these experiences in Table 6.1 and it is to a discussion of these that we now turn.

6.2 National contexts and environment

In Table 6.1 the main contextual and environmental determinants of OSH management practice generally and in relation to psychosocial risk specifically, as well as of the role of worker representation and consultation in both, have been grouped into five broad categories for the countries we studied:

- EU and supranational influences;
- national governance and regulation and the OSH system;
- labour relations, trade unions and employers' organisations and processes;
- economic restructuring; and
- other related systems, e.g. social welfare, health.

The effects of these determinants are summarised in the Table 6.1. Drawing on the material from the national reports in the Annex, the key elements of which are summarised in Table 6.1,

Table 6.1: **Determinants of workplace occupational safety and health practice: findings from the national reports**

Contexts and influences	Determinants	OSH management	Psychosocial risk management	Worker representation and consultation
EU and supranational influences	1. Framework Directive	Degree of required change to existing systems (all Member States):		
		Smaller (e.g. Sweden, United Kingdom); greater (but used as an opportunity for systematic overhaul (e.g. Spain) or prompting internal debate (e.g. France, Germany))		Varied with different national legal positions and combinations of works councils (e.g. Germany), joint safety committees (e.g. Cyprus, Bulgaria) and workplace representatives (e.g. Cyprus, United Kingdom)
	2. Wider political and policy influences	Reduced emphasis on OSH and portrayal of regulations as administratively and financially burdensome (especially for SMEs) (all Member States)		
			Lack of implementation of the EU social partners' Agreement on Work-related Stress	
	3. Accession	Europeanisation: OSH and wider rapidly made regulatory reforms (Bulgaria, Latvia)		
	4. Economic crisis	Economic, political and social impact (all Member States)		
National governance and regulation and the OSH system	1. Regulatory approach	Predates the Framework Directive (Sweden, United Kingdom)		
				Structures and provisions for various forms of participation and consultation, and their regulation and inspection
	2. Wider political and policy influences	Reduced emphasis on OSH and portrayal of regulations as administratively and financially burdensome (especially for SMEs) (United Kingdom); OSH deregulation (e.g. Latvia, United Kingdom); role of occupational health professionals (France, Spain)		
			Length and depth of focus on psychosocial risks: more recent (e.g. France, Spain); longstanding (e.g. Sweden, United Kingdom); yet to come (e.g. Bulgaria, Latvia)	
	3. Labour inspectorate	Reduced budget and resources (all Member States)		
		Provision of support: additional advisory role (France); tradition of information provision (e,g, Cyprus, Sweden, United Kingdom)		
		Change in emphasis (e.g. increased focus on undeclared work (e.g. France, Latvia))		
		Enforcement style: move away from sanctions (e.g. Latvia); traditional consensus approach (Sweden); move away from proactive visits (e.g. Sweden, United Kingdom)		
			Political pressure and resource provision to improve psychosocial risk coverage (Sweden)	
			Difficulties of psychosocial risk inspection (all Member States)	

Contexts and influences	Determinants	OSH management	Psychosocial risk management	Worker representation and consultation
Labour relations, trades unions and employers' organisations	1. Employee voice	Worker representation, management commitment and degree of recognition of workplace role: associated with more (traditional and psychosocial) risk management measures (all Member States)		Position and power of labour and unions and shift in relation to power of capital and employers (all Member States)
	2. Social dialogue	Traditions, influence of sectoral institutions and bi- or tripartite bodies, union density, and provision of support services by social partners (all Member States); maturity of labour relations systems (e.g. Bulgaria, Latvia compared with Sweden, United Kingdom)		
				Union support and provision of training for safety representatives (e.g. Sweden, United Kingdom)
Economic restructuring	1. Economic, workforce and labour market changes	Increases in SMEs, self-employment, non-standard (contingent) employment, unemployment (particularly youth), underemployment changes in workforce composition (age, gender, migration), move towards service-based economy (all Member States); undeclared work (e.g. Bulgaria, Cyprus, France, Latvia); deregulation of OSH and of labour markets (e.g. Latvia, Sweden, United Kingdom); transition from a planned economy (Bulgaria, Latvia)		
	2. Enterprise size	Fewer measures in smaller enterprises		
	3. Costs	Perceived costs of OSH compliance at the enterprise level: by employers — temporal and financial (all Member States); by employees — job retention (Bulgaria, Latvia)		
	4. Wider political and policy influences			Support for representation (all Member States); increased levels of direct consultation (United Kingdom)
Other related systems	1. Priority of and data on OSH	Enterprise-level understanding of OSH — conceptually and practically; lack of reliable data (all Member States)		
			Level of general OSH management measures (all Member States); traditions of research (e.g. France, Spain, Sweden, United Kingdom); requests from employees to deal with psychosocial risks (Sweden); lack of availability of technical support and guidance (Cyprus)	
	2. External services	Quality (e.g. Bulgaria, Spain, Sweden); independence (Spain); consequences for in-house expertise and enterprise-level marginalisation of OSH (e.g. Spain)		
	3. Insurance and other institutional agencies	Provision of support (e.g. France, Germany); coverage (e.g. uninsured employers — Bulgaria, Latvia); independence (Spain)		

we have attempted to schematically represent the relationships between the determinants of OSH management practice in Figure 6.1, which forms the basis for our analytical model. The innermost circle in the diagram represents the elements of the management processes for health and safety generally as well as those addressing psychosocial risks specifically and the role of worker representation and consultation within them both. These we have surrounded with a second circle, which represents the proximal elements of influence found in the national health and safety systems in the countries we have studied. They would include actors such as those representing the special health and safety interests of trade unions and employers, OSH interest groups, professional bodies and individual professionals in the OSH field, all of whom are part of the scientific/medical and legal system. We have identified the courts separately within this sphere, since they are not only part of the scientific/medical/legal nexus of influence, but also in their own right prominent features of the legal system and vary in terms of their structures, procedures and functions in relation to OSH management from country to country. The circle also represents the process of national discourse on health and safety management including the policies of the actors and the debates on the reform of OSH regulation within the various countries since the 1970s. It further embraces the processes through which problems and solutions are defined within the scientific/medical and legal system and how such

definition is brought to bear upon the formal actors in national decision making on OSH. Finally, it includes the compensation systems in place in different countries whose role in relation to the prevention discourse varies considerably and which helps to further define the national contexts of OSH management.

Our second circle is surrounded and overlapped by three further spheres that represent the wider contexts in which regulatory policy on OSH is set and which, we argue, has an important influence over its operation. These include one sphere of influence representing governance in general, in which such elements as its organisation and structure, its policies on acceptable levels of deviance and compliance and on regulation/deregulation impinge on the regulation of health and safety management and therefore on the practice of its three workplace elements in which we are interested. A second sphere of influence is found in the relations between capital and labour. It includes the structure and operation of the labour market and changes therein, employment law, unionisation, national industrial relations' systems and the degree of corporatism evident in national systems. The third circle reflects the significance of the national economic system as a supporting or limiting factor to change in OSH regulation. Here we have the state of the national economy, shifts in the profile of production (e.g. from goods to services in the countries we have studied) and the organisational restructuring that has been a major feature of economic development during the past 20 years.

The schematic representation as a whole is not intended to be static but subject to continuing change over time. We have indicated the longitudinal aspect of change with the horizontal bars representing time and change along the top and bottom of the analytical model. As we have already pointed out, in recent decades the pace of this change has been rapid and the determinants of OSH management practices have been influenced in all the countries we have studied.

The previous chapters make clear that, in each of the countries included in this project, policies and structures as well as the relationships between actors are subject to:

- changes brought about by globalisation and its attendant labour market restructuring, budgetary deficits and decline in unionisation; and
- changes in the political composition of governments and their ramifications amongst the policies of regulatory bodies, social, economic and (even) professional actors.

We will return to these issues in greater detail in the following section.

While the schematic representation is a way of looking at the national pictures, as we acknowledge in Table 6.1, in the countries we studied, such pictures are also subject to influence from the EU level, as well as to other supranational influences, both within OSH policy and in the relationship of such policy to more general EU economic and social policies. We have therefore further indicated these influences in Figure 6.1 and we will have cause to return to discuss their implications in subsequent sections — along with those of the changes referred to above. Finally, in relation to Figure 6.1, it is important to bear in mind that, like any schematic representation, it is something of an oversimplification of a complex reality; one further feature of the spheres of influence that needs to be emphasised is the fact that they overlap. That is, the contents of each impact not only on OSH management at the workplace directly, but also on each other, and it is the consequences of this, and their combined effects, which influence practices at the workplace level.

There were a number of examples of this kind of combined effect in the study. One example as an illustration will suffice here. It can be seen in the combined effects of the reduced resourcing available for inspection in many Member States and the even more ubiquitous restructuring of work in which fracturing, downsizing and outsourcing contribute to increasing the number of hard-to-reach duty-holders while adding operational complexity to managing OSH in situations in which, as a result of restructuring, multiple duty-holders may share the same worksites. As is reported in many of the countries in the present study, regardless of where they sit in the distribution of frequency of good practices found in the ESENER results, these effects have led to some reorientation of inspection practice in which 'hands-on' workplace inspections have given way to alternative approaches to extending the reach of messages concerning the good practice desired by inspectorates. As both the United Kingdom and Swedish reports point out, this is in part because the inspectorates concerned are exploring such ways to reach duty-holders that are hard to reach by more conventional approaches to inspection, but also because in situations in which resources for inspection are reducing, savings need to be made and cheaper alternative ways of delivering the prevention tasks of the inspectorate need to be found. This then becomes an additional influence to the promotion of advice and information strategies of the inspectorate in situations in which scarce resources might prevent inspection itself.

6.3 The effects of change

Generally, the effects of change were the single most common feature shared in all the reports and reflected in the previous three findings' chapters. We can summarise them under several headings.

6.3.1 Changes to labour markets and workforce composition

As the reports dealing with, for example, Sweden, the United Kingdom, France and Spain make clear, in recent decades there has been a growth in the proportion of the workforce engaged on a short-term or temporary basis (including that provided by temporary employment agencies) and those who are self-employed. Often repeated rounds of organisational

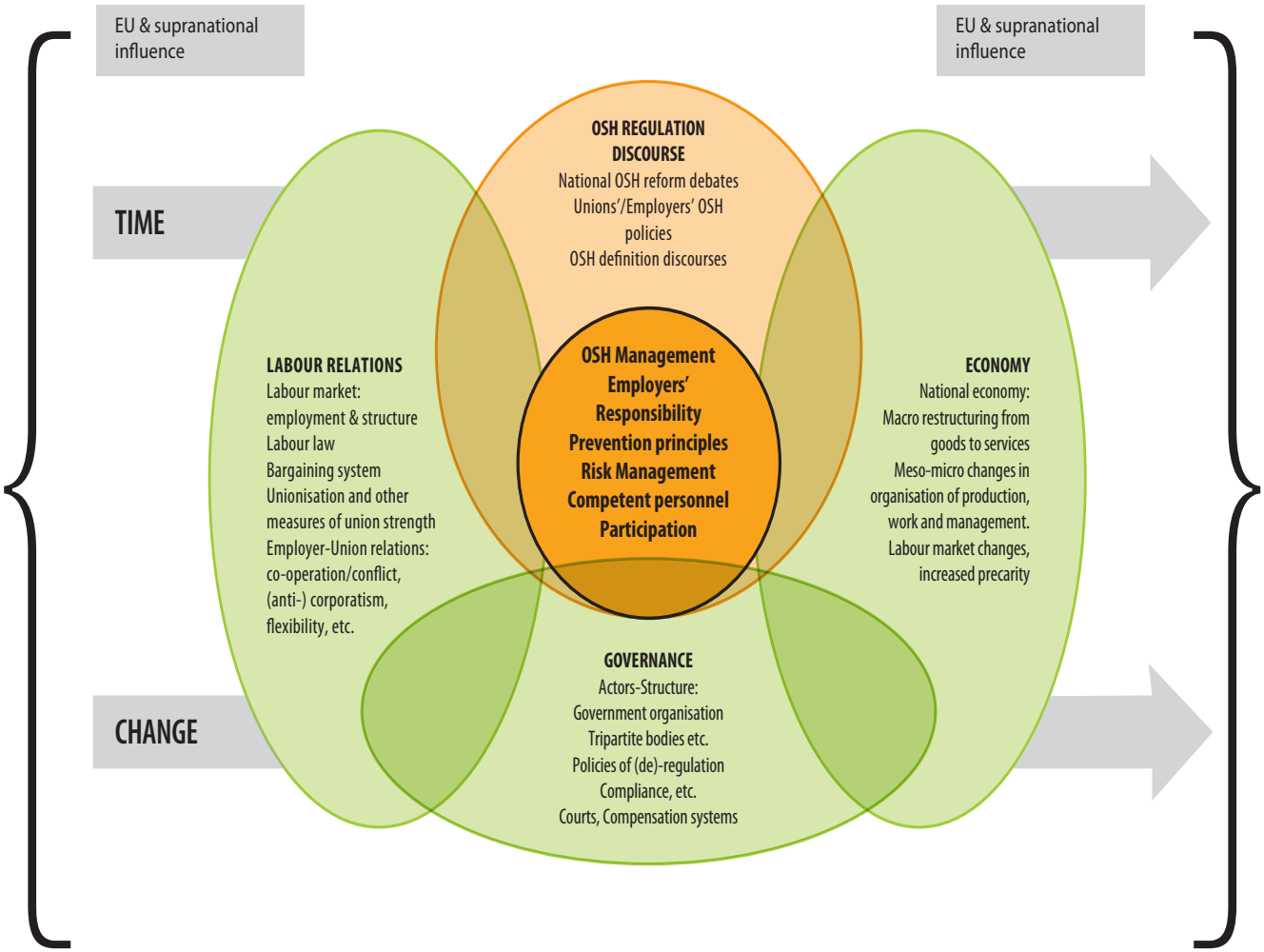
restructuring/downsizing, outsourcing and privatisation have increased job insecurity, even among those employees holding 'ongoing' contracts, while the growth of elaborate subcontracting networks has also shifted employment into smaller firms. A substantial body of international research, including research undertaken in the EU countries just mentioned, has linked job insecurity and the growth of precarious employment to poorer OSH outcomes as measured by an array of indices including injury rates, hazard exposures and self-reported health (as well as more subtle effects on knowledge transmission at work — see Cloutier et al., 2012).

There is also growing evidence that this shift weakens the effectiveness of regulatory oversight by labour inspectorates and can undermine OSH surveillance systems. Again, a number of the national reports for this project (see, for example, Spain) make reference to this as well as to the already substantial gaps in reporting (e.g. with regard to disease).

As the report on Latvia illustrates, the growth of more flexible work arrangements (such as temporary employment) is not restricted to western European economies, but also occurs in former Soviet Bloc countries too, although there it has to be viewed in a context in which employment in these countries was already characterised by poor working conditions, employee disempowerment, poor job security and limited regulatory protection.

Perhaps the most extreme form of 'flexible' work arrangement is undeclared work, or the so-called 'black economy' of unregulated businesses and cash-in-hand payments. Again, a number of the national reports make reference to undeclared work and this is consistent with data suggesting that undeclared work has grown substantially within the EU, being especially prominent in less prosperous Member States and those with a weak regulatory framework, and strongly reliant on seasonal industries (such as agriculture and tourism). However, it is also an issue of growing importance in countries such as France, Sweden and the United Kingdom. As undeclared work evades, as far as possible, all forms of regulatory oversight, it is often found in hazardous industries (such as construction and agriculture) and frequently employs

Figure 6.1: **Analytical model: the relationships between determinants of OSH management practice**



more vulnerable categories of workers (such as the very young, home-based workers and foreign-born workers, including illegal immigrants). The overall size and growth of the black economy poses a particular challenge to OSH and those tasked with enforcing regulatory standards.

Another change contributing to more flexible patterns of employment has been the increasing significance of migrant workers within the EU, both persons moving from one Member State to another (sometimes on a seasonal or short-term basis) and persons from outside the EU (including students and illegal immigrants). While such movements are not especially new, they have grown in scale over the past decade, in part as a consequence of EU enlargement. In fact, since the 1990s migration has been the most significant factor in the size of the EU population (Eurofound, 2012), with around 20 million non-EU nationals living in the EU-27, and a further 10 million EU nationals living in a Member State other than their own (European Commission, 2011). As the reports on Latvia and Bulgaria highlight, movements of labour from Eastern Europe to the West have become substantial (especially prior to the current economic crisis). In conjunction with other movements (such as illegal immigrants), this can create additional challenges for OSH inspectorates because these workers are often concentrated in temporary jobs, in industries that are hazardous (such as construction; see, for example, the Cyprus report) or already difficult to inspect (such as agricultural harvesting), and the workers themselves are unfamiliar with legislative protections (and/or are not fluent in the language) and are vulnerable to victimisation (especially in the context of transient employment). In short, as noted in a number of the national reports (such as that of France), the increased foreign component of the workforce represents an additional demand on the regulatory framework in terms of both resources and enforcement strategies.

As noted by the reports on Latvia and Bulgaria, emigration also affects the population and age profile of these societies — which may have consequences for health and social insurance infrastructure and training regimes. The report on Bulgaria noted a significant increase in the proportion of new workers without qualifications (from 45% to 53%) over the past five years. Whether increased labour shifts within the EU are having the effect of undermining training levels/regimes within specific countries — a shift with consequences for OSH, among other things — and whether this effect will be exacerbated by the current recession (see below) are questions warranting consideration.

Assessment of the OSH implications of the growth of less secure work arrangements needs to take into consideration other demographic changes in the EU workforce. For example, in the context of the long-term increase in female workforce participation, how will these arrangements affect the balancing of work and non-work activities in families where both parents are working or where children are being raised in single-parent households? Further, in the context of the ageing population profile found in most EU Member States, what are the implications of more volatile labour markets and short-term employment for older workers who are more likely to have to seek re-engagement, change jobs or accept intermittent employment? The ageing of the workforce in the EU, as the report on Spain points out, has more general implications for OSH prevention activities, especially in jobs where older workers could be seen to be at greater risk of suffering an injury or disease. Among researchers and policy-makers, increased attention is being given to the concept of 'work ability' with regard to older workers; but whether this is more about fitting workers to the job rather than vice versa is a moot point. It could also be asked that, barring a regulatory requirement, how many employers of short-term workers would really be interested in assessing or recognising the work ability of an older job applicant?

As indicated in Table 6.1, the labour market changes just described have implications for all three of the areas of OSH activity that are of central concern to this report. For example, the growth of elaborate subcontracting networks including a vast array of small businesses makes the effective implementation of risk assessment processes, as required by the Framework Directive, more challenging and difficult. A number of the national reports pointed to limitations in risk assessment with regard to small business (see, for example, Bulgaria). These changes, in combination with greater use of temporary workers/contractors, business volatility and the reduced role/influence of unions referred to in a number of the reports (such as those dealing with the United Kingdom and Sweden), also weaken the infrastructure for undertaking risk assessment and important feedback loops by which workers can raise and resolve OSH issues.

There are also important implications in relation to surveillance — a critical activity in terms of prevention measures and tracking the overall success of OSH interventions. Most of the national reports point to significant limitations of existing official datasets for the country they examined and some make reference to the increasingly problematic nature of data due to a variety of influences (including the recession and labour market change). Labour markets characterised by a higher level of temporary employment, job changes and self-employment make it hard to track injuries and hazard exposures, especially with regard to hazards (such as some chemicals) where there is a prolonged gestation period between exposure and the onset of health effects or where the worker has been exposed to different hazardous materials over a succession of jobs for a number of different employers. There is also evidence that especially vulnerable groups of workers (such as foreign workers and, in particular, those working 'illegally', seasonal workers or those who are self-employed) may be reluctant to report injuries or health issues for fear it may jeopardise their future employment prospects (or risk deportation in the case of those working 'illegally'). Not all reporting regimes described in the national reports include all industries or all types of employment (such as self-employment). Finally, but

certainly not least, the growth of undeclared work represents a particular challenge because, by its very nature, it evades regulatory detection (including the reporting of injury or disease) and is often found in hazardous industries (such as harvesting and construction).

All of these observations concerning change and its impact have been made in one way or another in the national reports. They are also, to some extent, previously discussed in the findings' chapters and, as noted already, they are the subject of a growing body of research. Therefore, the existence of their negative effects is not really in question. However, their effects on health and safety management practices and outcomes are difficult to discern from the results of European surveys such as ESENER. Indeed, the same limitations apply in the case of most national surveys of health and safety and working conditions, as well as to more routine means for collecting such data, for reasons such as those outlined in the preceding paragraph. This is an important consideration that needs to be borne in mind when discussing the limitations of current methods to gauge the state of health and safety at work.

6.3.2 The impact of recession in the EU

In writing a report concerned with national contexts and determinants of health and safety at work in which the importance of economic and labour market determinants has been clearly acknowledged, it would be a little odd if, at the present time, it did not give some consideration to the impact of economic recession. Indeed, in addition to the labour market changes just described, most of the national reports made reference to changes in the levels of employment/unemployment following the start of the financial crisis in 2008 (and subsequent events including stagnant/slow economic growth), and the particular effect this has on youth unemployment in countries such as Spain (but also the United Kingdom), as is reflected in Table 6.1. The national reports indicate that the impact of the recession has been especially severe on countries in Southern and Eastern Europe. Bulgaria, for example, has experienced a sharp decline in GDP growth and foreign investment along with an equally sharp increase in unemployment (which almost doubled between 2008 and 2010) and business bankruptcies. The report noted that wages have remained very low, as has the level of employer understanding of OSH, and that working conditions in SMEs have not simply failed to improve, but visibly degraded.

The national report on Latvia also paints a picture of the severe effects of the recession on a volatile economy that, like some others in Eastern Europe, was characterised by the export of workers to other Member States and the relocation of some industry seeking a lower cost operating environment. Between 2008 and 2010 unemployment in Latvia grew from 7% to well over 20% — similar to the unemployment rates experienced by Spain and Estonia (followed by Lithuania, Slovakia and Ireland) — with youth unemployment at almost 40% (exceeded only by Spain and Estonia). By the last quarter of 2011, real GDP in Latvia had fallen to 85% of what it had been four years earlier — a decline more substantial than that experienced in Ireland. As with Bulgaria, this decline must be viewed in the context that even prior to the recession the country had a very limited OSH infrastructure compared with other EU Member States such as Sweden, the United Kingdom, Germany and France. The recession sparked substantial cuts in government expenditure, including a 50% cut in the size of the already small labour inspectorate (and similar changes occurred in other Baltic States).

As the last point illustrates, the recession has not only stalled improvements in OSH in some Member States seeking to meet EU standards, but also induced a number of retrograde policy and regulatory measures. In Bulgaria, budget constraints have put pressure on government expenditure and led to discussions amongst the social partners on the issues of employment, working time and social insurance. At the same time, Bulgaria (like Latvia) is not part of the eurozone and the country has a relatively low level of public debt. If anything, as the report on Spain highlights, southern European countries which are members of the eurozone have faced even more intense pressure to wind back public expenditure and to introduce measures to 'free up' the labour market under the rationale that this will promote improvements in productivity and enhance employment levels. The recession has been used to bolster the need for essentially similar budget and labour market changes in other EU Member States examined in this report, notably those in north-west Europe (particularly the United Kingdom and Sweden). With the partial exception of Germany, these countries have also experienced low/stagnant economic growth and increased unemployment since the recession.

Irrespective of whether the budget austerity measures and labour market 'reforms' will actually have the effects used to justify them — and we remain unconvinced — there are good grounds for believing (on the basis of existing evidence, including that pertaining to many of the countries considered in this report) that cuts to regulatory agency resources/enforcement, downsizing of the public sector, further outsourcing/privatisation and an increased proportion of the workforce in flexible/insecure jobs will have adverse consequences for OSH. Again, current European surveys on health and safety management and the working environment do not generally depict these outcomes. But we would argue that this is a result of the limited sensitivity of such surveys rather than evidence of their absence.

Prolonged unemployment has long been associated with serious adverse effects on health. While this may not appear to have relevance to a consideration of OSH indices, several points should be made. First, the recession appears — not surprisingly — to have exacerbated labour market insecurity with its attendant health risks even to those retaining jobs or able to secure intermittent employment. In Spain, as the national report shows, unemployment reached 22% by 2011

(40% amongst the young) in a labour market where 24% of workers held temporary contracts and where those more likely to lose their jobs included those in temporary posts and foreign workers (there is considerable overlap between these two categories). Second, prolonged high levels of unemployment place an additional burden on social insurance and healthcare infrastructure, which in turn may affect the funding available for training, job creation programmes and programmes aiming to improve workplace health and safety. Poverty arising from unemployment can also have flow-on effects to dependent children in terms of background health/access to healthcare, education and career options. Again, as the report on Spain points out (citing García, 2010), without a strong social protection system the combination of a high level of unemployment and temporary employment will negatively effect the health and well-being of the working population and their families. While there is a presumption that the growing level of unemployment within many EU Member States will be relatively short-lived, there are historical precedents for prolonged periods of high unemployment.

6.3.3 Changes to the policy and regulatory context

Over the past decade (or more) there have also been important changes with regard to the legal and institutional arrangements regulating labour markets within EU Member States. One prominent change mentioned by the national reports on Sweden and the United Kingdom, and indeed most other countries, was a decline in union membership density. This has several implications for OSH, including representation of OSH issues (and other issues where there is an OSH component such as hours of work), providing logistical support for health and safety representatives and providing an environment where workers are willing and able to raise OSH issues without fear of victimisation. In Eastern European countries the national reports on Bulgaria and Latvia also pointed to limited union influence but for rather different reasons, namely that these countries have only relatively recently emerged from a prolonged period of totalitarian government where unions acted essentially as arms of the state rather than independent bodies representing workers. Unions (either reformed from earlier bodies or newly formed) remain relatively weak. In some countries the capacity of unions to be involved in OSH, or the scope of their capacity to collectively negotiate working conditions more generally, has been further weakened by changes to industrial relations/labour market legislation.

The last observation is relevant to another prominent area of change, namely the regulation of the labour market. As some country reports, such as those of Sweden and the United Kingdom, note, changes have been made to labour market regulation facilitating the growth of more flexible work arrangements. The extent of these changes has varied, as has the base point for such changes. For example, in Sweden the labour market was subject to a relatively high level of regulation/collective determination of working conditions throughout much of the post-war period, but the past decade has witnessed an abrupt shift that facilitated the greater use of supply chains and temporary workers. In a number of countries the recession has either initiated or reinforced changes to labour market regulation. In Spain, for example, the 'post eurozone crisis' austerity measures have included a number with regard to labour market regulation that weaken job security and remove restrictions on the role of temporary employment agencies in the private sector (even though Spain already had the highest level of temporary employment in the EU). In a number of countries changes to social security and workers' compensation regimes have also increased labour market vulnerability.

In most EU countries changes to regulation have not extended to directly weakening standards in OSH laws, though, as the United Kingdom report notes, more significant changes are now occurring. Further, rhetoric relating to the 'problem' of 'regulatory burden' has grown in policy circles. The European Commission (2010), for example, argued that, in the context of the recession, there was an urgent need to address 'unnecessary administrative burdens' on SMEs. The national report on Latvia indicates that the recession encouraged pressures for 'light touch' regulation, which has inhibited progress towards the adoption of EU Directives.

At the same time, beyond formal legislation there is also the question of regulatory infrastructure and, as the report on Latvia makes clear, the regulatory infrastructure governing labour markets and OSH is not comparable to that of other EU countries, such as Sweden. During the post-war period, when Keynesian full-employment policies prevailed and significant changes to labour market regulation, including improvements to OSH laws, were being made in Sweden, the United Kingdom and Germany, Latvia was subjected to a totalitarian socialist regime. Upon obtaining its independence (and subsequently joining the EU) it moved directly to embrace the now dominant neoliberal policy discourse, which was not sympathetic to the earlier wave of regulatory reforms that had occurred in north-west Europe (and elsewhere, such as in Canada and Australia). Even ignoring the question of historically contingent shifts in policy context as the report on Spain highlights, building an effective OSH regulatory infrastructure is not simply a matter of introducing new laws and an inspectorate but requires, among other matters, prolonged attention to building a participatory framework and adequately resourcing/training the inspectorate.

The United Kingdom provides a striking case of where this regulatory infrastructure has come under sustained attack under two periods of Conservative government beginning in the late 1970s and recommencing with the election of the coalition government in 2010. In other countries changes to infrastructure are more recent. In Sweden, Latvia and Germany reference was made to a significant reduction in resourcing of the inspectorate or the growing inadequacy of regulatory resources relative to the demands being placed on it in terms of implementing legislation. The national reports also provide

evidence of changes to enforcement practices. For example, following the recession the Latvian labour inspectorate shifted its enforcement activities to place greater emphasis on issuing warnings rather than imposing fines. While effective enforcement relies on using an array of remedies, not just one sanction, changes to the balance of enforcement actions taken can have significant consequences, as can changes to the nature of workplace inspections in terms of duration or what is examined (Walters et al., 2011b).

The recession has had other effects on regulatory activities with consequences for OSH. In a significant proportion of EU Member States, such as Spain and France, labour inspectorates are responsible for a number of labour standards, not simply OSH, but also wages, hours etc., whereas in other countries (such as Sweden and the United Kingdom) there is a specialist OSH inspectorate. A potential issue with the former arrangement, and one mentioned by several of the national reports, revolves around the division of time and resources to different areas of labour standards. One area for competing attention has been the growth of undeclared work, which has serious consequences for government revenues and service provision. As a result, for example, the report on Latvia noted that labour inspectorate resources were being diverted from enforcing OSH regulation to combating undeclared work. An earlier report of a study carried out for the European Commission found that this tension with regard to undeclared work was a significant issue for a number of EU Member States (Walters et al., 2011b). Finally, an International Labour Organization (ILO) report also pointed to labour inspection activities being diverted from OSH to other matters such as mass redundancies in the context of the economic crisis.

Taken as a whole, changes in regulatory infrastructure and enforcement activities can have effects at least as significant as formal changes in the legislation itself, especially when taken in combination with reduced trade union influence (see Table 6.1). This is another example of the combined effects illustrated in Figure 6.1. At the same time, it would be simplistic to view the OSH challenges associated with workplace change in terms of only labour market regulation and policy responses to this. At a fundamental level, regulation and policies have facilitated the very problems OSH regulators are now being asked to address. Changes to areas of law (such as business, trade and competition law) and policy (especially the dominance of neoliberal policy discourse) have facilitated business practices such as restructuring, outsourcing and the increased use of contingent work arrangements. In other words, laws and government policies have given rise to work arrangements whose problematic effects others (including regulators) must address (Johnstone et al., 2011).

Without addressing the 'disconnect' of contradictory and imbalanced policy settings, it is difficult to see how the problems posed by the changes to contexts can be remedied. It is, therefore, perhaps pertinent to turn last to the present role of the EU in providing a steer on these matters.

6.3.4 The role of the European Union as a determinant of health and safety management practice in times of change

We have argued that our findings' chapters and national reports make it clear that the effects of the EU on health and safety management practice have been felt in several different ways in different Member States. To recap, as we show in Table 6.1, there are several countries, such as Sweden and the United Kingdom, where process-based standards were already well developed, so they were not required to change their approach significantly in the transposition of the Framework Directive and its daughter Directives, whereas others with relatively mature but non-process-based systems required substantial changes to be made both in regulation and in the policy discourse informing it (e.g. Germany, France and Spain). A third set of countries, mainly smaller Southern European ones with substantially less mature systems, used the Directive as an opportunity to bring their systems in line with European requirements, while most of the accession countries adopted the provisions of the Directive as part-preparation for membership of the EU. The role of the EU as a force for change in the approach to health and safety management practice was, therefore, different according to the different situations of each of the Member States.

As Vogel and Walters (2009) have previously outlined, in the several decades of supranational regulation of OSH in the EU, for a relatively brief period, the character of Community regulatory policy was influenced by the vision of a 'social Europe' associated with Jacques Delors. The same period coincided with, and influenced the spread of, the process-based reflexive regulation that currently styles the approach to OSH regulation in Europe.

However, the European Community approach has changed fundamentally since that time. In a series of well-documented policy moves and treaties from the Maastricht Treaty of the early 1990s onwards, the regulatory policies of the EU and their administration through the Commission have increasingly reflected the wider influence of the free-market rhetoric and the interests behind it. Under the EU version of 'new governance' and in line with the supposed economic wisdom espoused by international bodies such as the Organisation for Economic Co-operation and Development (OECD), the interests of capital are increasingly pervasive, undermining the concepts of social protection under which the OSH management arrangements that have been the focus of this report were previously conceived. The approach is consistent with the notion that public regulation of any kind is a burden on business growth, and therefore its legitimacy must be measured by economic impact assessments, cost–benefit analyses and the like, and which have the effect of slowing down regulatory interventions, if not stopping them altogether (see, for example, Verheugen, 2008; van den Abeele, 2009; Vogel and van den Abeele, 2010).

This approach is, of course, not restricted to regulating OSH; indeed, it is arguably not primarily aimed in this direction, but part of change in the orientation of the wider policy agenda pursued by the Commission (European Commission, 2009). However, preventive measures for OSH are especially vulnerable. For example, one of the positions adopted by the Commission, which we have already noted, is that culling legal requirements on employers to provide information can reduce administrative burdens on business. As Vogel (2009) has argued, such requirements are fundamental to the operation of the model of health and safety management embraced by the Framework Directive. The sustained effort to dilute requirements on employers in relation to workplace risk assessment, information on injuries, incidents and work-related ill health required by public authorities and on working time, as well as the ongoing sophistry (well illustrated in the current European Commission Better Regulation agenda) that small and medium-sized firms must be protected from 'excessive regulation', have been a continued feature of Commission policy positions over the past decade (European Commission, 2009). As Vogel (2009) has shown, they act to undermine the effectiveness of the participatory approaches to OSH management required by the Directive.

As a result of the shift in policy orientation there is now a well-established brake placed on the introduction of new Directives on health and safety and there have been successive attempts to remove or water down the requirements of existing Directives through the advice and actions of various groups at Community level, such as those of the so-called 'High level Group of Independent Stakeholders on Administrative Burdens' (European Commission, 2007).

These changes are further reflected in the shift that has occurred in the tone and content of successive Community Health and Safety at Work Strategies since the 1980s when the last of the Delors' vision of a Social Europe led to the adoption of the Framework Directive 89/391 and its daughter Directives. With each successive strategy, greater emphasis has been placed on the business case for health and safety, and the role of softer options for its implementation. There has been increasing emphasis not on the need to protect European workers, but on the notion that a healthy and safe workforce is likely to be more profitable. Indeed, the position has moved so far that the major element of the debate around the creation of a new Community Health and Safety at Work Strategy for 2012 onwards concerned not the content of the strategy but whether it is necessary to have a strategy at all (see, for example, SLIC, 2012).

At the same time, alternatives to regulation have been sought and initiatives involving 'soft law' have replaced regulatory actions on a variety of subjects. The EU Framework Agreement on Workplace Stress is a case in point. The argument has been advanced that in some cases they serve to achieve more workable solutions to problems of industrial relations and labour regulation that have proved intractable to regulation (Bercusson, 2008). However, as Bercusson also pointed out, there are considerable uncertainties as to whose interests are actually best served by many of these alternatives and the administrative means chosen to facilitate them. Here, again, the one thing that stands out in this lexicon of 'new governance' in Europe is the primacy of the aim of states, the Community and the Commission to achieve an enhanced business environment for employers — which takes precedent over concerns for the health and safety of workers. Under such conditions, expecting a regulatory steer from the EU or its Commission on future approaches to managing OSH in countries that are at the lower end of the operational spectrum, as suggested by the findings from ESENER, is perhaps a little unlikely.

6.4 Limitations and some implications for further research

This report offers an attempt to explain differences observed in the indicators of practice in managing health and safety risks in European workplaces by considering the features of the national contexts in which such practices take place. It was prompted by secondary analysis of data from ESENER, which suggested there may be some 'national effects' that could not be explained by other variables such as workplace size. Using a variety of sources, we have sought explanations by examining traditions of regulation, industrial relations and social protection, and their various styles and characters in different Member States, as well as by giving some consideration to other significant contextual factors, such as OSH support infrastructures, the economic climate and changes in the structure and organisation of work and labour markets.

We have demonstrated the substantial influence of these contexts upon the way in which health and safety management is practised in different Member States of the EU, as well as showed the continuing influence of supranational determinants of practice, such as that of the changing policies and Directives of the EU itself. However, in undertaking a study of this kind, we are well aware of its limitations and we need to be clear that the methods, time and data we have had at our disposal all limit the extent to which our findings can be said to be definitive.

First, as a policy-orientated project with a limited time frame and budget, this work has been carried out as an exercise in scoping expert perspectives on OSH management policy and determinants. Rather than being the result of a specific analytical technique, therefore, this report presents a composite of those expert views, and as such must be taken as an expert perspective grounded on a number of evidential sources rather than a strictly evidence-based analysis. Also, our selection of countries for study, while justified by the arguments presented in their support in Chapter 1, nevertheless represents no more than a selection of Member States. Each of them, while sharing some of the features of the wider groups they were selected

to represent, also has its own idiosyncrasies and in this sense is not entirely 'typical' of any group.

Second, the quantitative data the project draws on have their own shortcomings. As is acknowledged elsewhere, the ESENER data are in general drawn from enterprises that are operating 'at the best end of the spectrum of OSH management'; they do not include direct measures of OSH performance and they cannot determine the quality or effectiveness of OSH management measures in place in an enterprise. Other data on health and safety experience drawn on in this report are subject to similar limitations and, as they are from a variety of sources, are not directly comparable and at best offer only a partial perspective. We have not, for example, been able to take full account of the effects of outsourcing on arrangements for health and safety management or their outcomes, although we know from the research literature that its effects are significant. Moreover, in our focus on offering national contextual explanations for features of the ESENER findings, we are aware that we cannot provide an entirely consistent explanation. Just to give one example, the relatively high position of Bulgaria on positive indicators of health and safety management would not be anticipated either from the general contextual explanations we have offered or indeed from the more detailed account of the Bulgarian national context and environment presented in the national report in the Annex. Equally, the variation in the order of countries that appear to occupy the middle ground in some of the figures in Chapter 3 (and to some extent in Chapters 4 and 5) suggests further limitations. Nevertheless, our findings are consistent with those from a number of other sources and are supported by European injury data, which suggest that those countries that our research points to as operating at the better end of the spectrum, namely the Nordic countries and Ireland and United Kingdom, do in fact have lower injury rates (HSE, 2011). We therefore think that our findings are legitimate and robust and, further, that there is a strong case for using them as the basis for the further qualitative investigation of the determinants of workplace OSH practice and the relationships between them that we have identified in our analytical model as being influential within the dynamic and fast-moving environments in which such management takes place.

As we have elaborated in previous chapters, there are five broad categories of determinants on which we have focused, which operate at a number of levels and produce varying results in different circumstances. However, the single most common environmental context that all the countries we studied share is the process of change. It is found across the spectrum of work restructuring and reorganisation and the restructuring and repositioning of the wider economic, regulatory, political and cultural contexts in which it is embedded — with consequences for the operation of general health and safety and psychosocial risk management, as well as the role of worker representation, and consequently also for the safety, health and well-being of workers. This means that determinants of OSH management practice operate within a dynamic environment. OSH management processes are embedded within the influences found in national health and safety systems. They and the systems in which they are embedded are influenced by national governance, relations between capital and labour, and by the national economic system, none of which is static, but subject to continuing change over time, which, in recent decades, has been rapid and, as we have argued, has profoundly influenced the determinants of OSH management practices in all the countries we have studied. Such changes have included those brought about by globalisation and its attendant labour market restructuring, budgetary deficits and decline in unionisation and in the political composition of governments and their ramifications amongst the policies of regulatory bodies and social, economic and professional actors.

All of this is subject to influence from the EU level, as well as to other supranational influences. As such, there are important messages for policy-makers at this level that emerge from our analysis. In particular, they are twofold. First, our work demonstrates that many of the determinants of good practice we have identified are changing in ways that point to them being less significant in the future as positive effects on OSH. Current and future OSH strategy at the EU level needs to take some account of this. Second, it is clear that the impact upon Member States of steers from the EU, whether they are regulatory, economic or political, varies enormously according to existing national infrastructures and processes already in place. From the perspective of improving good practice and reducing the harm caused by negative work exposures, this suggests that EU policy-makers need to be extremely sensitive to these issues when contemplating supranational strategies. It further implies that it is mistaken to assume that a 'common position' has been achieved with regard to the determinants of good practice across all Member States within the EU. In terms of improving the prevention of harm and the quality of the experience of work for millions of European citizens, therefore, our findings indicate strongly that there is no lessening of the need for a robust prevention strategy on health and safety at work on the part of the EU in order to provide a significant and sensitive steer for the continuation of national efforts in this respect in the future.

7. References

van den Abeele, E., 'The Better Regulation agenda: a new deal in the building of Europe?', ETUI Policy Brief, European Social Policy, Issue 1, ETUI, Brussels, 2009.

Aidukaite, J., 'Welfare reforms and socio-economic trends in the ten new EU Member States of Central and Eastern Europe', Journal of Communist and Post-Communist Studies, Vol. 44, No 3, 2011, pp. 211–219.

Almodovar, A. and Pinilla, F. J., Encuesta Nacional de Gestión de la Seguridad y Salud en las Empresas, Instituto Nacional de Seguridad e Higiene en el Trabajo, Madrid, 2009.

AV — Arbetsmiljöverket, Arbetsmiljön 2009 — Arbetsmiljöstatistik rapport 2010:3, Arbetsmiljöverket, Stockholm, 2010a.

AV — Arbetsmiljöverket, Arbetssorsakade besvär 2010 — Arbetsmiljöstatistik rapport 2010:4, Arbetsmiljöverket, Stockholm, 2010b.

AV — Arbetsmiljöverket, Tillsynsstatistik 2007–2011, Arbetsmiljöverket, Stockholm, 2012. Available at: www.av.se/inspektion/inspektionsstatistik.aspx

Ayres, I. and Braithwaite, J., Responsive Regulation: Transcending the Deregulation Debate, Oxford University Press, New York, 1992.

Bardach, E. and Kagan, R., Going by the Book: The Problem of Regulatory Unreasonableness, Transaction, Philadelphia, 1982.

Barnard, C., EC Employment Law, Oxford University Press, Oxford, 2000.

Beck, U., Risk Society: Towards a New Modernity, SAGE, London, 1992.

Benavides, F. G., Informe de Salud Laboral. España, 2006, Observatorio de Salud Laboral, Barcelona, 2007.

Benavides, F. G., Velarde, J. M., López-Ruiz, M. and Rodrigo, F., 'Una década de éxito en la prevención de las lesiones por accidentes de trabajo en España', Seguridad y Salud en el Trabajo, Vol. 62, 2011, pp. 22–27.

Bercusson, B., 'A changing institutional architecture of the European social model', in B. Bercusson and C. Estlund (eds), Regulating Labour in the Wake of Globalisation: New Challenges, New Institutions, Hart Publishing, Oxford, 2008.

Black, J., 'Constructing and contesting legitimacy and accountability in polycentric regulatiory regimes', Regulation and Governance, Vol. 2, 2008, pp. 137–164.

Carson, W. G., 'Some sociological aspects of strict liability and the enforcement of factory legislation', Modern Law Review, Vol. 33, 1970, pp. 396–412.

CEC — Commission of the European Communities, Communication from the Commission to the Council and the European Parliament. Action Programme for Reducing Administrative Burdens in the EU Sectoral Reduction Plans and 2009 Actions, COM (2009) 544 final, Brussels, 22 October 2009. Available at: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0544:FIN:EN:PDF

Cloutier, E., Ledoux, E. and Fournier, P., 'Knowledge transmission in light of recent transformations in the workplace', Relations Industrielles, Vol. 67, No 2, 2012, pp. 304–324.

Colebatch, H. K., 'The concept of regulation in the analysis of an organised world', Law and Policy, 11, 1989, pp. 71–88.

Cousins, R., MacKay, C. J., Kelly, P. J., Lee, S. and McCaig, R. H., 'Management standards and work-related stress in the UK: practical development', Work and Stress, Vol. 18, No 2, 2004, pp. 113–136.

Dennis, I. and Guio, A.- C., 'Monetary poverty in the new Member States and candidate countries', Statistics in Focus, Population and Social Conditions, Eurostat, Luxembourg, 2004. Available at: www.eds-destatis.de/en/downloads/sif/nk_03_21.pdf

DG Employment, Social Affairs and Inclusion, Evaluation of the European Strategy on Safety and Health at Work 2007–2012, Interim Report, 2012.

Dirección General de la Inspección de Trabajo y Seguridad Social — Instituto Nacional de Seguridad e Higiene en el Trabajo, Guía de actuaciones de la Inspeccion de Trabajo y Seguridad Social sobre Riesgos Psicosociales, Ministerio de Empleo y Seguridad Social, Madrid, 2012.

Douillet, P. and Mary-Cheray, I., 'Agir sur le stress et les risques, travail et changement', No 318, March–April, 2008, pp. 1–14.

Ds — Departementsserien, Långsiktig verksamhetsutveckling ur ett arbetsmiljöperspektiv: En handlingsplan för att förnya arbetsmiljöarbetet, Departementsserien 2001: 28, Näringsdepartementet, Stockholm, 2001.

Durán López, F. and Benavides, F. G., Informe de Salud Laboral. Los Riesgos Laborales y su Prevención. España 2004, Atelier, Barcelona, 2004.

Dyer, C., 'Sick of work? SW195', Health and Safety Bulletin, Vol. 270, 1998, pp. 9–16.

Estlund, C., Regoverning the Workplace, New Haven, Yale University Press, 2010.

EU-OSHA — European Agency for Safety and Health at Work, Literature Study on Migrant Workers, European Risk Observatory Report, 2007a. Available at: https://osha.europa.eu/en/publications/literature_reviews/migrant_workers

EU-OSHA — European Agency for Safety and Health at Work, Bringing Safety and Health Closer to European Workers, Annual Report, Office for Official Publications of the European Communities, Luxembourg, 2007b. Available at: http://osha.europa.eu/en/publications/annual_report/2007full/view

EU-OSHA — European Agency for Safety and Health at Work, European Survey of Enterprises on New and Emerging Risks — Managing Safety and Health at Work, European Risk Observatory Report, 2010a. Available at: https://osha.europa.eu/en/publications/reports/esener1_osh_management

EU-OSHA — European Agency for Safety and Health at Work, A Review of Methods used across Europe to Estimate Work-related Accidents and Illnesses among the Self-employed, European Risk Observatory Report, 2010b. Available at: https://osha.europa.eu/en/publications/literature_reviews/self-employed

EU-OSHA — European Agency for Safety and Health at Work, Drivers and Barriers for Psychosocial Risk Management: An Analysis of the Findings of the European Survey of Enterprises on New and Emerging Risks (ESENER), 2012a. Available at: https://osha.europa.eu/en/publications/reports/drivers-barriers-psychosocial-risk-management-esener

EU-OSHA — European Agency for Safety and Health at Work, Management of Occupational Safety And Health: An Analysis of the Findings of the European Survey of Enterprises on New and Emerging Risks (ESENER), 2012b. Available at: https://osha.europa.eu/en/publications/reports/management-of-occupational-safety-and-health-analysis-of-data-from-the-esener

EU-OSHA — European Agency for Safety and Health at Work, Management of Psychosocial Risks at Work: An Analysis of the Findings of the European Survey of Enterprises on New and Emerging Risks (ESENER), 2012c. Available at: https://osha.europa.eu/en/publications/reports/management-psychosocial-risks-esener

EU-OSHA — European Agency for Safety and Health at Work, Worker Representation and Consultation on Health and Safety. An Analysis of the Findings of the European Survey of Enterprises on New and Emerging Risks (ESENER), 2012d. Available at: https://osha.europa.eu/en/publications/reports/esener_workers-involvement

EU-OSHA — European Agency for Safety and Health at Work, Understanding Workplace Management of Safety and Health, Psychosocial Risks and Worker Participation through ESENER: A Summary of Four Secondary Analysis Reports, 2012e. Available at: http://osha.europa.eu/en/publications/reports/esener-summary

EU-OSHA — European Agency for Safety and Health at Work, Worker Participation Practices: A Review of EU-OSHA Case Studies. Literature Review, 2012f. Available at: https://osha.europa.eu/en/publications/literature_reviews/worker-participation-practices-a-review-of-eu-osha-case-studies/view

EurLIFE database, Life expectancy at birth, European Foundation for the Improvement of Living and Working Conditions, Eurofound, Dublin, 2005. Available at: www.eurofound.europa.eu/areas/qualityoflife/eurlife/index.php?template=3&radioindic=1&idDomain=1

Eurofound — European Foundation for Improvement of Living and Working Conditions, Latvia — Legislation Strengthens Institutional Basis for Health and Safety, Eurofound, Dublin, 2003. Available at: www.eurofound.europa.eu/eiro/2003/08/inbrief/lv0308101n.htm

Eurofound — European Foundation for Improvement of Living and Working Conditions, Fifth European Survey of the Working Environment, Eurofound, Dublin, 2010. Available at: www.eurofound.europa.eu/surveys/ewcs/2010/index.htm

Eurofound — European Foundation for Improvement of Living and Working Conditions, Latvia Country Report, Health and Well-being of Workers, Eurofound, Dublin, 2011. Available at: www.eurofound.europa.eu/comparative/tn1105040s/lv1105049q.htm

Eurofound — European Foundation for Improvement of Living and Working Conditions, Living Longer, Working Better — Demographic Change, Eurofound, Dublin, 2012.

European Commission, Commission Decision of 31 August 2007 setting up the High Level Group of Independent Stakeholders on Administrative Burdens, European Commission, Brussels, 2007.

European Commission, Reducing Administrative Burdens in the European Union, Annex to the 3rd Strategic Review on Better Regulation, 28.1.2009 COM (2009) 16 final, European Commission, Brussels, 2009.

European Commission, Action Programme for Reducing Administrative Burdens in the EU: Delivering on Promises, Office for Official Publications of the European Communities, Luxembourg, 2010.

European Commission, Demography report 2010: Older, More Numerous and Diverse Europeans, European Commission, Brussels, 2011.

Eurostat, '23% of EU citizens were at risk of poverty or social exclusion in 2010', Statistics in Focus, 9/2012, 8 February 2012. Available at: http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-12-009/EN/KS-SF-12-009-EN.PDF

FAS, För bättre samverkan och arbetsmiljö i Leksand, Dalarnas Forskningsråd, Falun, 2005.

Fookes, G., Bergman, D. and Rigby, B., International Comparison of (a) Techniques used by State Bodies to Obtain Compliance with Health and Safety Law and Accountability for Administrative and Criminal Offences and (b) Sentences for Criminal Offences, RR607, Health and Safety Executive, HSE Books, Sudbury, 2007.

Frick, K., 'The semi-mandatory implementation of EU's Work Related Stress Agreement (WRS) in Sweden. National report to the EU-study on the implementation of the European Social Partners' agreement on work related stress', Mälardalen University, Västerås, 2010.

Frick, K., 'Implementing Systematic Work Environment Management in Sweden — interpretation by SWEA and supervision by its labour inspectors', in D. Walters, R. Johnstone, K. Frick, M. Quinlan, G. Baril-Gingras and A. Thebaud-Mony (eds), Regulating Workplace Risk — A Comparative Study of Inspection Regimes in Times of Change, Edward Elgar, Cheltenham, 2011.

Frick, K. and Forsberg, A., Hälsosam-projektet — Framgångar och svårigheter i att genomföra FAS 05 för bätter samverkan och arbetsmiljö I Leksand, Dalarnas Forkiningsråd, Falun, 2010.

Frick, K. and Walters, D., 'Worker representation on health and safety in small enterprises: Lessons from a Swedish approach', International Labour Review, Vol. 137, No 3, 1998, pp. 367–389.

Frick, K., Jensen, P. L., Quinlan, M. and Wilthagen, T. (eds), Systematic Occupational Health and Safety Management — Perspectives on an International Development, Pergamon, Oxford, 2000.

García, A. M., 'Mercado laboral y salud. Informe SESPAS 2010', Gaceta Sanitaria, Vol. 24, No 1, 2010, pp. 62–67.

García, A. M., Gadea, R. and López, V., 'Estimación de la mortalidad atribuible a enfermedades laborales en España, 2004', Revista Española de Salud Pública, Vol. 81, 2007, pp. 261–270.

Gereffi, G., Humphrey, J. and Sturgeon, T., 'The governance of global value chains', Review of International Political Economy, Vol. 12, 2005, pp. 461–487.

Giddens, A., The Consequences of Modernity, Polity Press, Cambridge, 1990.

Gil, J., Boix, P. and López-Ruiz, M., 'Evaluación del impacto de las políticas intensivas de intervención frente a los accidentes de trabajo en empresas de la Comunidad Valenciana', Archivos de Prevención y Riesgos Laborales, Vol. 13, 2010, pp. 128–134.

Gunningham, N. and Johnstone, R., Regulating Workplace Safety: Systems and Sanctions, Oxford University Press, Oxford, 1999.

Gustavsen, B. and Hunnius, G., New Patterns of Work Reform: the Case of Norway, University Press, Oslo, 1981.

Hancher, L. and Moran, M., Capitalism, Culture and Regulation, Clarendon Press, Oxford, 1989.

Hawkins, K., Law as a Last Resort: Prosecution Decision Making in a Regulatory Authority, Oxford University Press, Oxford, 2004.

Hinde, A. and Ager, R., Benchmarking the Competent Person in Manufacturing and Engineering Sectors, Research Report 121, Health and Safety Executive, HSE Books, Sudbury, 2003.

HIRES, Health in Restructuring: Innovative Approaches and Policy Recommendations, Rainer Hampp Verlag, Munich, 2009.

HSE – Health and Safety Executive, Phase 1 Report: Underlying causes of construction fatal accidents — a comprehensive review of recent work to consolidate and summarise existing knowledge, Health and Safety Executive, Construction Division, 2009a. Available at: www.hse.gov.uk/construction/resources/phase1.pdf

HSE — Health and Safety Executive, Health and Safety Statistics 2008/09 [online], 2009b. Available at: www.hse.gov.uk/statistics/overall/hssh0809.pdf

HSE — Health and Safety Executive, Self-reported Work-related Illness and Workplace Injuries in 2008–09: Results from the Labour Force Survey, 2010. Available at: www.hse.gov.uk/statistics/lfs/lfs0809.pdf

HSE — Health and Safety Executive, Health and Safety Statistics 2010/11, HSE Books, Sudbury, 2011. Available at: www.hse.gov.uk/statistics/european/index.htm

HSE — Health and Safety Executive, Stress-related and Psychological Disorders in Great Britain, 2012a. Available at: www.hse.gov.uk/statistics/causdis/stress/index.htm

HSE — Health and Safety Executive, Self-reported Work-related Illness and Workplace Injuries in 2011–12: Results from the Labour Force Survey [online], 2012b. Available at: www.hse.gov.uk/statistics/lfs/index.htm

Hutter, B. M., Compliance: Regulation and Environment, Clarendon Press, Oxford, 1997.

Hutter, B. M., A Reader in Environmental Law, Clarendon Press, Oxford, 1999.

Hutter, B. M., Regulation and Risk: Occupational Health and Safety on the Railways, Oxford University Press, Oxford, 2001.

IES — Institute for Employment Studies, An Evaluation of the Five Steps to Risk Assessment, Research Report 476, Health and Safety Executive, HSE Books, Sudbury, 2006.

Index of Decent Work, DGB-Index Gute Arbeit GmbH, 2008. Available at: www.dgb-index-gute-arbeit.de/

INSEE, INSEE conjoncture, Informations rapides, 1 March 2012. Available at: www.insee.fr/fr/themes/info-rapide.asp?id=14

Instituto Nacional de Seguridad e Higiene en el Trabajo, Guía Técnica para la Integración de la Prevención de Riesgos Laborales en el Sistema General de Gestión de la Empresa, Madrid, INSHT, 2008.

James, P., The Reshaping of Workplace Risks in Institutions, Production and Working Life, Oxford University Press, Oxford, 2006.

James, P. and Walters, D., Regulating Health and Safety at Work: An Agenda for Change?, Institute of Employment Rights, London, 2005.

Jasanoff, S., Markle, G. E. and Pinch, T. (eds), Handbook of Science and Technology Studies, SAGE, London, 1995.

Johansson, B., Tillväxt och Klassamarbete — en Studie av den Svenska Modellens Uppkomst, Tiden, Stockholm, 1989.

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P. and Millet, C., 'The experience of work-related stress across occupations', Journal of Managerial Psychology, Vol. 20, No 2, 2005, pp. 178–187.

Johnstone, R., Quinlan, M. and McNamara, M., 'OHS inspectors and psychosocial risk factors: evidence from Australia', Safety Science, Vol. 48, 2011, pp. 547–557.

Jones, J., Hodgson, J. T., Clegg, T. and Elliott, R., Self-reported Work-related Illness in 1995: Results of a Household Survey, HSE Books, Sudbury, 1998.

Kearns, J., Stress at Work: The Challenge of Change, BUPA, 1986.

Korostoff, J. E., Zimmerman, L. M. and Ryan, C. E., 'Rethinking the OSHA approach to workplace safety: a look at worker participation in the enforcement of safety regulations in Sweden, France and Great Britain', Comparative Law Journal, Vol. 13, 1991, p. 45.

Lerouge, L., 'Les effets de la précarité du travail sur la santé: le droit du travail peut-il s'en saisir?', Pistes, Vol. 11, No 1, May 2009. Available at: www.pistes.uqam.ca/v11n1/articles/v11n1a8.htm

Lobel, O., 'Interlocking regulatory and industrial relations: the governance of workplace safety', Administrative Law Review, Vol. 57, 2005, pp. 1071–1152.

Löftstedt, R., Reclaiming Health and Safety for All: An Independent Review of Health and Safety Legislation, Department of Work and Pensions, London, 2011. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/66790/lofstedt-report.pdf

Lulle, A., 'Labour emigration: government and social partner policies in Latvia', in B. Galgóczi, J. Leschke and A. Watt (eds), EU Labour Migration since Enlargement: Trends, Impacts and Policies, Ashgate, Farnham, 2009.

Lunt, J., Bates, S., Bennet, V. and Hopkinson, J., Behaviour Change and Worker Engagement Practices within the Construction Sector, Research Report 660, Health and Safety Executive, HSE Books, Sudbury, 2008.

MacKay, C. J., Cousins, R., Kelly, P. J., Lee, S. and McCaig, R. H., '"Management Standards" and work-related stress in the UK: policy background and science,' Health and Organisations, Vol. 18, No 2, 2004, pp. 91–112.

Marklund, S., Bjurvald, M., Hogstedt, C., Palmer, E. and Theorell, T., Den Höga Sjukfrånvaron — Problem och Lösningar, Arbetslivsinstutet and Försäkringskassan, Stockholm, 2005.

Moncada, S., Llorens, C., Moreno, N., Rodrigo, F. and Landsbergis, P., 'CCOO ("Comisiones Obreras") — ISTAS (Union Institute of Work, Environment and Health) participatory action plan for a healthier work organisation: a case study', Safety Science, Vol. 49, 2011, pp. 591–598.

Nelkin, D. (ed.), Controversy: Politics of Technical Divisions, 3rd edn, SAGE, London, 1992.

Nichols, T., The Sociology of Industrial Injury, Mansell, London, 1997.

Nichols, T. and Walters, D., 'Worker representation on health and safety in the UK: problems with the preferred model and beyond', in D. Walters and T. Nichols (eds), Workplace Health and Safety: International Perspectives on Worker Representation, Palgrave Macmillan, Basingstoke, 2009.

Nichols, T., Dennis, A. and Guy, W., 'Size of employment unit and industrial injury rates in British manufacturing industry: a secondary analysis of WIRS 1990 data', Industrial Relations Journal, Vol. 26, 1995, pp. 45–56.

ONS — Office for National Statistics, Opinions and Lifestyle Survey (formerly the ONS Opinions Survey and ONS Omnibus Survey), 2010. Available at: www.esds.ac.uk/government/omnibus/

Pabriks, A. and Purs, A., 'Latvia: the challenge of change', in D.J. Smith, A. Pabriks, A. Purs and T. Lane (eds), The Baltic States: Estonia, Latvia and Lithuania, London, Routledge, 2002.

Peter, R., Geissler, H. and Siegrist, J., 'Associations of effort–reward imbalance at work and reported symptoms in different groups of male and female public transport workers', Stress Medicine, Vol. 14, 1998, pp. 175–182.

Peter, R., Alfredsson, L., Knutsson, A., Siegrist, J. and Westerholm, P., 'Does a stressful psychosocial work environment mediate the effects of shift work on cardiovascular risk factors?', Scandinavian Journal of Work, Environment and Health, Vol. 25, 1999, pp. 376–381.

Quinlan, M. and Bohle, P., 'Under pressure, out of control or home alone? Reviewing research and policy debates on the OHS effects of outsourcing and home-based work', International Journal of Health Services, Vol. 38, No 3, 2008, pp. 489–525.

Quinlan, M., Mayhew, C. and Bohle, P., 'The global expansion of precarious employment, work disorganisation, and consequences for occupational health: a review of recent research', International Journal of Health Services, Vol. 31, No 2, 2001, pp. 335–414.

Raulier, A. and Walters, D., Trade Union Training in Health and Safety: A Survey of European Practice in Training for Worker Representatives, Trade Union Technical Bureau, Brussels, 1995.

Robens Report, Committee on Safety and Health at Work (Cmnd. 5034), HMSO, London, 1972.

Rodrigo, F., 'Las Mutuas, esas grandes desconocidas', Archivos de Prevención de Riesgos Laborales, Vol. 10, No 4, 2007, pp. 192–194.

Rouxel, C., 'Conditions de travail et précarité de l'emploi', Premières Synthèses, No 28.2, July 2009.

Safety and Health Practitioner, 'PM's approach to H&S not helpful says Prof Löftstedt', Safety and Health Practitioner, April 2012.

Selznick, P., Law, Society and Industrial Justice, Transaction Books, New Brunswick, NJ, 1980.

SLIC — Senior Labour Inspectors' Committee, Evaluation of the Swedish Labour Inspection System, Senior Labour Inspectors' Committee, 2008.

SLIC — Senior Labour Inspectors' Committee, EU Strategic Priorities 2013–2020. A submission from SLIC, European Commission, DGV, Luxembourg, 2012.

Smith, A., Johal, S., Wadsworth, E. J. K., Davey Smith, G. and Peters, T., The Scale of Occupational Stress: The Bristol Stress and Health at Work Study, Research report 265/2000, Health & Safety Executive, HSE Books, Sudbury, 2000.

SOU Handlingsplan för ökad hälsa i arbetslivet. SOU 2002: 5. Fritzes, Stockholm.

Stansfeld, S., Head, J. and Marmot, M., Work-related Factors and Ill-health: The Whitehall II Study, CRR266, HSE Books, Sudbury, 2000.

Sund, B., 'The safety movement and the Swedish model', Scandinavian Journal of History, Vol. 19, 1994, pp. 41–62.

The Baltic Course, '52% of Latvian residents would not mind working under the table', 1 June 2009. Available at: www.baltic-course.com/eng/analytics/?doc=14390

Tombs, S. and Whyte, D., 'A deadly consensus: worker safety and regulatory degradation under New Labour', British Journal of Criminology, Vol. 50, 2010, pp. 46–65.

Toren, K. (2010) 'Arbetsskadeförsäkringen — en historia om sambandet mellan arbete och sjukdom', Arbete & Hälsa, Vol. 44, 2010, p. 1.

Travers, C. and Cooper, C., 'Mental health, job satisfaction and occupational stress among UK teachers', Work and Stress, Vol. 7, No 3, 1993, pp. 203–219.

Uberti-Bona, V. and Rodrigo Cencillo, F., 'Sobre sistemas de inspección y sistemas de prevención', Archivos de Prevención de Riesgos Laborales, Vol. 9, No 3, 2006, pp. 117–120.

Vanadzins, I. and Matisane, L., 'Small and medium-sized enterprises in Latvia — main challenge for the occupational health and safety system', Barents Newsletter on Occupational Health and Safety, Vol. 14, No 1, 2011, pp. 6–8.

Velázquez, M., 'La integración de la prevención de riesgos laborales en la empresa', Archivos de Prevención de Riesgos Laborales, Vol. 12, 2009, pp. 165–169.

Verheugen, G., 'Reducing red tape for Europe', speech at 'Cutting Red Tape for Europe' EU conference, European Parliament, Brussels, 20 June 2008.

Vogel, L., 'Special report: Better Regulation', HESA — Newsletter of the Health and Safety Department of the European Trade Union Institute, Vol. 35, 2009, pp. 3–15.

Vogel, L. and van den Abeele, E., Better Regulation: A Critical Assessment, Report 113, ETUI, Brussels, 2010.

Vogel, L. and Walters, D., 'An afterword on European Union policy and practice', in D. Walters and T. Nichols (eds), Workplace Health and Safety: International Perspectives on Worker Representation, Palgrave Macmillan, Basingstoke, 2009.

Walters, D. (ed.), Occupational Health and Safety Strategies in Europe, Vol. 1 The National Situations European Foundation for the Improvement of Living and Working Conditions 1996, Office for Official Publications of the European Communities, Luxembourg, 1996a.

Walters, D., 'Health and safety strategies in Europe', Journal of Loss Prevention in the Process Industries, Vol. 9, No 5, 1996b, pp. 297–308.

Walters, D., 'Trade unions and the effectiveness of worker representation in health and safety in Britain', International Journal of Health Services, Vol. 26, No 4, 1996c, pp. 625–641.

Walters, D., 'Trade unions and the training of health and safety representatives in Europe', Employee Relations, Vol. 18, No 6, 1996d, pp. 50–68.

Walters, D., 'Health and safety strategies in a changing Europe', International Journal of Health Services, Vol. 28, No 2, 1998, pp. 305–331.

Walters, D., Health and Safety in Small Enterprises: European Strategies for Managing Improvement, Peter Lang, Brussels, 2001.

Walters, D. (ed.), Regulating Health and Safety Management in the European Union, Peter Lang, Brussels, 2002.

Walters, D., An International Comparison of Occupational Disease and Injury Compensation Systems: a research report prepared for the Industrial Injuries Advisory Council (IIAC), March 2007. Available at: http://iiac.independent.gov.uk/pdf/reports/InternationalComparisonsReport.pdf

Walters, D., Within Reach? Managing Chemical Risks in Small Enterprises, Baywood, Amityville, New York, 2008.

Walters, D. and Freeman, R.J., A Comparative Study of the Implementation and Operation of Provisions for Employee Representation and Involvement in Health and Safety at the Workplace in Five European Countries, Commission of the European Communities, EUR Report No. 13509 EN, 1992.

Walters, D. and Frick, K., 'Worker participation and the management of occupational health and safety: reinforcing or conflicting strategies?', in K. Frick, P. L. Jensen, M. Quinlan and T. Wilthagen (eds), Systematic Occupational Health and Safety Management — Perspectives on an International Development, Pergamon, Oxford, 2000.

Walters, D. and Jensen, P. L., 'The discourses and purposes behind the development of the EU framework directive 89/391', in K. Frick, P. L. Jensen, M. Quinlan, and T. Wilthagen (eds), Systematic Occupational Health and Safety Management — Perspectives on an International Development, Pergamon, Oxford, 2000.

Walters, D. and Kirby, P., Training and Action in Health and Safety, TUC, London, 2002.

Walters, D. and Nichols, T., Worker Representation and Workplace Health and Safety, Palgrave Macmillan, Basingstoke, 2007.

Walters, D., Dalton, A. J. P. and Gee, D., Worker and Trade Union Representation on Health and Safety in Europe: The Theory, the Practice and the Potential, Trade Union Technical Bureau, Brussels, 1993.

Walters, D., Johnstone, R., Frick, K., Quinlan, M., Baril-Gingras, G. and Thebaud-Mony, A., Regulating Workplace Risks: A Comparative Study of Inspection Regimes in Times of Change, Edward Elgar, Cheltenham, 2011a.

Walters, D., Wadsworth, E. J. K. et al., The NERCLIS Project: Contract to assess the potential impact of emerging trends and risks on labour inspection methodologies in the domain of occupational health and safety, European Commission, 2011b. Available at: http://cf.ac.uk/cwerc/reports/NERCLIS%20Vol%201%20FINAL.pdf (Vol. 1); http://cf.ac.uk/cwerc/reports/NERCLIS%20Vol%202%20FINAL.pdf (Vol. 2); http://cf.ac.uk/cwerc/reports/NERCLIS%20Vol%203%20FINAL.pdf (Vol. 3).

Westerholm, P. and Walters, D. (eds), Supporting Health at Work: International Perspectives on Occupational Health Services, IOSH, Leicester, 2007.

Woolfson, C., 'Labour standards and migration in the New Europe: post-Communist legacies and perspectives', European Journal of Industrial Relations, Vol. 13, No 2, 2007, pp. 199–218.

Wynne, B., 'Public understanding of science', in S. Jasanoff, G. E. Markle and T. Pinch (eds), Handbook of Science and Technology Studies, SAGE, London, 1994.

Wynne, B., 'May the sheep safely graze: a reflexive view of the expert-knowledge divide', in S. Lash, B. Szerszybski and B. Wynne (eds), Risk, Environment and Modernity, SAGE, London, 1996.

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