Introductory report

The TUTB Observatory on the application of the European Directives: a preliminary assessment

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This report is based on several years' research organized by the TUTB into the transposition of Community Directives. We initially looked at the different preventive systems to determine the likely impact of the Framework Directive on each. We then monitored the transposition of the Framework Directive in each country, which proved a far more tortuous process than might have been expected in 1989 when the Council adopted the Directive by unanimous vote. We are now refining our analysis of the problems stemming from transposition in the light of what happened with selected other Directives. We chose five Directives for their practical importance, innovative nature or ambivalent provisions which stood in need of interpretation[1]. This paper is no more than an interim and necessarily brief presentation of selected aspects of our research. In 1999, the TUTB will publish an overall general report expanding in greater detail on the issues addressed here.

In the first part of this paper, I describe the established body of Community laws and regulations constituted by the Directives adopted under article 118A. The second part contains a summary appraisal of the conclusions that can be drawn from national transpositions. In the third part, I argue that the way the Directives have been applied to national realities has largely eviscerated their essential purpose. I also suggest how the Directives might be better applied to actual workplace practice.

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[1] We chose the Directives on: work with display screen equipment; manual handling of loads; health and safety of pregnant and breast-feeding workers, use of work equipment and mobile and temporary construction sites. Reports on the first three Directives have been published in the *TUTB Newsletter*. Our thanks to the fifty-odd national correspondents who took the trouble to answer the questionnaires sent out to them.

The gains secured by the Community health at work Directives

A spate of law-making

The introduction of article 118A into the Community Treaty by the Single Act created a legal basis for the enacting of an unprecedented body of new social legislation. There are at least four reasons for this rapid spate of Community law-making on the working environment[2] :

- occupational health is an area in which even most free-marketeers have traditionally accepted the need for legislation;
- the need to harmonize the law to remove obstacles to the free movement of goods and services;
- the Community institutions had to give the unions a *quid pro quo* for the establishment of the single market;
- the European trade union movement proved able to put forward its own body of coherent common proposals. This self-empowerment stemmed from a decade of widespread strife over working conditions which led to a complete overhaul of union thinking on the matter. The framing of ILO Conventions 155 and 161 was a key precedent which allowed the trade union movement to frame common strategies, and translate them into proposals for legislative reforms.

Undeniable gains

The Directives adopted between 1989 and 1992 are an undeniable gain with potential for promoting the upward harmonization of working conditions.

The positive points of the Framework Directive include:

- extending the traditional scope of prevention policies to all occupational health-related factors;
- fostering worker participation;
- making the establishment of multidisciplinary preventive services an objective;
- placing a strict safety obligation on employers (apart from the few exceptions in article 5.4), thus doing away with the "reasonably practicable" clause used in previous legislation (1980 Framework Directive);
- setting a wider scope than many national laws could - among other things - help unify or at least close the gap between the rules for the civil service and the private sector.

Most of the individual Directives adopted under the Framework Directive also contain rules which can strengthen national legislation. In some cases (work with display screen equipment, manual handling of loads) they make new or better provisions which can improve preventive practice by widening the focus from employment injuries and compensation for prescribed occupational diseases. In others, they address risks of such severity that only more systematic intervention will do (the Carcinogens, Biological Agents, Mobile and Temporary Construction Sites Directives, in particular). Other Directives are intended to cover a vast range of work situations affecting large numbers of working men and women (the Work Equipment, Requirements for the Workplace, and Chemical Agents Directives in particular).

[2] Taken by date of adoption of the Directives, the relevant period stretches from 1989 to 1992. The increasingly unfavourable political context of the post- Maastricht period produced a rapid decline in law-making. If drafting time is included, the period can be said to have begun in 1987, with the debates on the Commission programme in the field of safety, hygiene and health at work.

Gains at risk

The gains made from 1989-1992 are under threat, however. Since Maastricht (1992), the pressure from employers and many Member States for deregulation has had serious consequences:

Legislative activity has been all-but halted

■ Most of the Directives adopted since 1992 have done little to further harmonization while maintaining the improvements made. They are poor and often inferior to existing legislation in many Member States.

This is certainly true of the Working Time Directive, which represents a serious threat to the structure of labour law rules in most of the Member States. Not only does it permit an inordinately long list of derogations through collective bargaining, but article 18 provides that the Member States shall have the option not to apply Article 6 (maximum weekly working time of forty eight hours) provided, among other things, that the measures taken require the worker's consent to work more than the maximum 48 hours and that up-to-date records of all workers who carry out such work are kept and placed at the disposal of the competent authorities. In so doing, the Directive harks back to the fiction of individual freedom of contract in order to hobble provisions which most Member States had always considered as matters of public policy. Not only that, but it throws the coherence of the Framework Directive open to question by excluding many sectors which would doubtless have benefited most from its provisions.

Similar criticisms may be levelled at the Protection of Young People At Work and Pregnant Workers Directives. The latter makes no provision for maintenance of pay during maternity leave and periods of leave on health grounds, so that the workers concerned face the dilemma of taking what may be a substantial pay cut to stay healthy, or putting their health at risk so as not to lose money. The inclusion of non-reducing clauses makes not a whit of difference, because the way they are drafted vitiates their legal effectiveness. They merely reflect the legislature's failure to comply with the requirement of harmonization while maintaining the improvements made.

■ The Chemical Agents Directive remained deadlocked for several years before finally being adopted by a Common Position in 1997. Other proposals for Directives remain deadlocked in the Council of Ministers, and seem unlikely to be adopted in the near future (Directives on physical agents, safe transport for workers with reduced mobility). Other directives heralded on different occasions have never even made it as far as official proposals by the Commission (protection for workers in agriculture, health and safety information and training for workers, notably). The only Directive that seems to have a chance of being adopted in the relatively near future is that on scaffolding and work at heights.

■ The Commission has put forward no formal proposals for revisions of Directives which are expressly required (1986 Noise Directive, 1992 Pregnant Workers Directive) or made necessary by changing circumstances (the Asbestos Directive still prescribes controlled use, whereas most Member States have banned it outright).

The philosophy behind further legislation has been radically thrown into question. Attempts of differing types, origins and promoters[3] have been made with the same end of making harmonized improvements in the working environment secondary to other considerations. This was the gist of the Anglo-German group for deregulation (set up in April 1994 by employers' representatives with German and British government support), the Molitor Group (a Commission initiative, whose report was published in 1995), UNICE (especially its June 1995 report on deregulation). The United Kingdom's appeal against the Working Time Directive had the same aim in view and challenged the very bases of article 118A. Not all these pressures were necessarily successful (the Court of Justice ruling confirmed our interpretation of article 118) but they did effectively combine to encourage a political climate unfavourable to improvements in the working environment. The recent organization, in the Netherlands, of a conference on "cost-benefit" analysis in the framing of prevention policies clearly reflects the growing pressure to make workers' life and health secondary to business profits[4] . A similar development can be seen in the Community institutions between the Edinburgh Summit and the recent Amsterdam Intergovernmental Conference. Chiefly, it attempts to make new occupational health legislation contingent on criteria which are extrinsic to the aims of the legislation, couched in the vaguest of terms (competitiveness, employment, creation of small and medium-sized firms), and based on unverifiable assumptions about the causal relationships between the legislative framework and social and economic realities. So, the Commission's proposed outline for Member States' written reports on the application of the health at work Directives includes questions on their impact on productivity, employment and competitiveness. The Commission departments have not, however, supplied the necessary crystal ball. Generally, we are witnessing an attempt to water down public political responsibility for workers' lives and health. This is one strand of a dominant trend to challenge every area in which the labour movement has managed to "de-commoditize" labour by removing it from the ambit of pure economic dictates.

The Commission has all-but given up

The Commission's new action programme - adopted three years late[5] - centres on non-legislative measures, none of them particularly innovative. The programme as a whole falls short of the joint proposals put forward by the employers and unions in 1992. Significantly, Directorate General V (Social Affairs) has been reorganized, losing many of its occupational health staff at a time when the follow-up on Member States's implementation of Directives requires more effort than ever. The Bilbao-based European Agency for Health and Safety was finally established long after it should have been. It was originally planned for 1992 to coincide with the 1992 European Year for Health and Safety, but was only established at a share-out of the headquarters of different institutions between the Member States, and did not become properly operational until 1997. The SAFE programme - presented as the Community's kingpin initiative for the period 1996-2000 - remains deadlocked in Council. But even outside the occupational health field proper, there are growing difficulties in mainstreaming occupational health concerns into other Community policies.

- The Community could have used its new public health powers to gain recognition for the key role of working conditions in any public health policy, based on the core objective of reducing health inequalities. It has not done. The recently-published report on women's health in the Community looks only at lifestyle determinants of women's health (smoking, drinking, diet, lack of exercise), but pays no attention to their extended working day in and out of home, nor the characteristics of women's paid work.

- Likewise, transport policy has signally failed to harmonize working conditions. In a sector where Community policy seeks to stimulate competition between firms in different countries, it is an omission which can only force working conditions downwards, as the lorry-drivers' strikes in France showed in 1996 and 1997.

[3] Britain's last conservative government made low-key attempts to orchestrate a deregulationist lobby. Reliable sources reported intensive canvassing of Commission officials, MEPs and Member States' governments by Chancellor of the Duchy of Lancaster, Roger Freeman. In an internal memorandum circulated in early 1996, the United Kingdom government estimated it could count on the support of the German, Dutch, Italian and Finnish governments (in the two latter cases, subsequent changes in majority led to a change in official attitudes).

[4] See O. Tudor, 1997.

[5] See Communication from the Commission on a Community programme concerning safety, hygiene and health at work (1996-2000), COM (95) 282 final, of 12 July 1995.

■ But the most serious threat comes from the Community employment guidelines, which stress the need for increased flexibility and more concessions to employers ("promoting private enterprise"). While it is questionable whether such policies can reduce mass unemployment, they certainly create job insecurity and worsen working conditions, both of which seriously impair health and safety.

Gains undermined by their own limitations

Recognizing the threat to these gains is not to hold them up as perfect. As well as defending the established legislative framework, there must be a critical discussion of the limitations on its effectiveness. Four elements are key here.

The legislation contains vague and ambivalent provisions designed chiefly to achieve a political compromise which has in practice led to their subsequent renegotiation. I shall cite just a few examples.

■ The Framework Directive does not spell out the connection between preventive services and medical surveillance, and leaves it to Member States to define the capabilities and aptitudes of preventive services. The reason for this uncertainty is connected to the failure to reach a political settlement of the French government's demand that existing occupational health services should be accepted as providing all the preventive services prescribed by the Framework Directive. The clear result of this is that neither practitioner independence nor worker consultation on preventive activities carried out by other operators are guaranteed. The Commission may now be having second thoughts about the political compromise of 1987-88 and be considering irregularity proceedings against France for failure to transpose article 7 of the Framework Directive. If so, it will mean that at least ten years have been lost because of the ambiguous wording of the Framework Directive. The problem is much less one of poor drafting technique than deliberate obfuscation as part of a power game very low on transparency.

■ The Framework Directive and many individual Directives often leave the substantive content of rules to be filled out in accordance with national legislation and practices. There would be nothing wrong as such with this reference back if minimum criteria were set and the objectives to be met were clearly defined. In some cases, the provisions are so vague that the national transposing legislation actually works against the original objectives: the legislation by which Italy first transposed the Directive on work with display screen equipment actually excluded most of the workers affected!

Some Directives are not in line with the general approach of the Framework Directive. The practical prevention objectives laid down by the Manual Handling of Loads Directive, for instance, do little to address the immense problem of musculoskeletal disorders due to increased throughput and the faster pace of work. Likewise, the Work with Display Screen Equipment Directive is more concerned with preventing eyestrain than with workstation design ergonomics, job content or software design.

Most of the legislation reflects a narrow view of how preventive systems work. Employers tend to be given obligations towards "their" workers, ignoring the other levels of preventive systems. This disparate, individual workplace-centred view of prevention is relatively inefficient unless supplemented by objectives on control/enforcement, socialization of problems and experiences, training and information for society, etc.. I shall return to this question later.

A first assessment of transpositions

Community occupational health legislation does not address the links between occupational health and the gender perspective in the workplace. This is a glaring inconsistency. While the Framework Directive accepts the relevance of the social aspects of work, the individual Directives consistently take what may be described as a "gender-blind" approach. In so doing, they voluntarily relinquish the ability to act on occupational health problems stemming from a differentiated and discriminatory sex structure of sectors, activities, levels of responsibility, and employment status. That is one of the failings of the Manual Handling of Loads Directive (which is more relevant to men than women inasmuch as it does not deal with repetitive strain injuries as such). A similar criticism can be made of the Working Time Directive, which works on the assumption that all unworked time in the firm is resting time, and "overlooks" the mutual effects that unpaid housework and waged employment have on one another. Likewise, it sets no requirements as regards part-time work, which is predominantly done by women and can be a source of major problems when it is organized flexibly according to the company's needs or fragmented with wide band-times in flexitime systems. Significantly, the only Directive to refer specifically to women workers deals with reproductive hazards connected with pregnancy and breast-feeding of newborns, which remains a very traditional approach. In the Scandinavian countries, by contrast, pregnancy- and maternity-related risks form part of a much wider general framework encompassing all reproductive hazards. That has two advantages: as the rules apply equally to men and women, no new pretexts for discrimination are created; protection is not confined to a limited period in human life (pregnancy and a usually short time after childbirth). This is particularly important because, generally-speaking, what is bad for reproductive health is also bad for general health.

Complex transposing legislation

What impact have the Directives had in the different Member States? Two stages must be distinguished: the first is when they are transposed into national law, the second when they are implemented in the workplace. However, analysis of what has happened nationally shows that these two stages overlap in time. The transposition process is not confined to enacting legislation or regulations to introduce the Directives' minimum requirements into national legislation. In most cases, a series of instruments are passed, starting with an outline statute (the transposing instrument), filled out by a raft of implementing legislation of widely varying kinds without which the minimum requirements cannot be met. Two textbook examples illustrate this conclusion. Portugal was the first country to transpose the Framework Directive. But the regulations on worker participation have still not been enacted more than five years after the entry into force of the transposing legislative decree. Consequently, key provisions of the Framework Directive remain on hold. In Italy, the transposing legislative decree extends the scope to the civil service, but subsequent budgets have failed to fund prevention provision in that sector. This is a key aspect: control of transposition which simply checks whether the Directives' provisions have been formally embodied in national legislation without investigating whether the objectives set have actually been delivered would be insufficient. I shall return to this later.

In any assessment of transpositions, objective factors derived from the characteristics of national preventive systems must be distinguished from the socio-political factors which conditioned the transposition.

The Community Directives map out a sort of model preventive system. But it is both an implicit model, and an imperfect one which does not include all the functions that a preventive system should. Nor is it entirely coherent, because the Directives borrow from different national models[6]. That in itself should not present a problem. Given that the Community Directives lay down only minimum requirements, each national system should be able to maintain its own higher standards or improve on the Directives' rules.

These three factors which seem to me objectively determined by the essential principles of the Community harmonization process[7] are compounded by the ambiguous wording of certain provisions, as I mentioned earlier.

6 The French occupational health system predominates in the earliest Community legislation, superseded by the British-inspired industrial hygiene model, which held sway up to the mid-Eighties. After the Single Act (1986), the Scandinavian model of an integrated approach to the "working environment" became the benchmark, without entirely eradicating the previous underlaying "layers".

7 Community occupational health legislation falls between two stools: full harmonization (design of work equipment, rules on the movement of chemical substances) and no harmonization at all (employer's civil and criminal liability, operation of the labour inspectorate, linkages between public health and occupational health, etc.).

National disparities

All Member States are equal in finding new elements in the Directives, but some are less equal than others in where they stand in relation to the objectives set. There are significant differences between national preventive systems in Europe. Be it predominantly scientific and technical cultures (occupational health in the Mediterranean countries, industrial hygiene in Britain, technical standards for equipment safety in Germany), the forms of worker participation (themselves closely linked to the industrial relations context), or the role of the public players (different types of labour inspectorate system, effective or non existent linkage between public health and occupational health, etc.), the diverse realities of national preventive systems complicates any attempt at harmonization. The changes needed to bring national systems in line with the implicit Community model may be relatively minor in some countries (the Scandinavian countries which already meet most minimum requirements) or huge in others (Spain and Germany, for example). It would be wrong to denigrate this diversity as a matter of national backwardness. While the preventive systems in some countries are obviously less efficient than in others, that is not the main problem. Every preventive system has its own history and a broader[8] context which it would be absurd to dismiss. Every country has situations in which prevention is effective and others in which it is not. The challenge is less to bring all national situations into line with an abstract European ideal than to attain the substantive minimum objectives set by the Directives while preserving the best of each national system which is best adapted to its own general conditions.

Adverse political conditions may exacerbate this objective difficulty of transposition. All that partly explains the significant disparities in national transpositions. In some countries, the Directives have had little material effect because their restricted and qualified transposition is designed solely to prove formal compliance rather than achieve the essential purpose. That, broadly, is the case with Germany, Britain and France. Other countries (the Scandinavian countries) have made few changes because their existing legislation largely meets the Directives' requirements. Elsewhere - like Austria, Spain and Italy - real legislative changes have been made which could produce radical transformations.

Political challenges

It is clear that various principles on which the Member States had agreed are now being thrown into question. The most evident - but far from the most serious - expression of this is the failure of many States to meet the transposition deadline. Most States initially underestimated the real impact the Directives would have on their preventive systems and thought they could get away with tinkering at the edges. This belief was encouraged by the lack of systematic European-scale consultations between States, the Commission and the trade unions and employers' organizations on the material objectives of the Directives. Some countries, too, had a clear political agenda for a restricted and qualified transposition (the United Kingdom's express intention). Later, it dawned on the Member States that radical changes might be needed, and they began to fear that the delays were too short or the putative costs of measures they had themselves approved were too high. The debates in this later stage clearly showed that the existing rules had been poorly applied, such that implementation of the Directives could not be seen in terms of the existing law alone (on which the innovative aspects of the Directives were not necessarily a radical improvement) but had also to be seen by reference to employers' and government attempts to "level down" those rules.

The employers' virulent campaign against the alleged costs of the Directives showed how unsafe it was to assume that health and safety had ceased to be an apple of discord between management and labour. Depending on the country, the estimated costs could be multiplied ten- or a hundred-fold with no objective differences to explain the discrepancies[9].

Member States have come up with different stalling tactics pending possible action by the Commission. So, the United Kingdom made no improvements to

[8] There is a wide culture gap between Catholic and Protestant countries as regards medical surveillance, for instance, which it would be absurd to deny as a factor. Likewise, the role of occupational health differs significantly in a national health system to one which is private practice-based.

[9] In Italy, it was claimed that the "package" of Directives transposed in September 1994 would cost over ten billion ECU to craft firms alone (*Il Sole 24 Ore*, 15 December 1995) and around 60 billion ECU in the civil service (*Il Sole-24 Ore*, 21 December 1996). In France, it was alleged that the Use of Work Equipment Directive would add FF 30 billion to metalworking industry costs alone. Spanish employers calculated the putative costs of the bill to transpose the Framework Directive with astonishing precision. The worker participation provisions alone would cost 294 billion pesetas according to the employers' confederation - which impressively calculated the number of elected prevention delegates needed to the very last one (996,025) - compared to the Government's figure of 52 billion pta.

the system of employee representation, which remained an employer's prerogative[10], but applied itself to getting around the contradiction between the reasonably practicable clause in its own legislation and the absence of such a clause in the Framework Directive's safety obligations. France "omitted" to transpose the Directive's article 7 - preventive services - and deferred transposition of the Directives in the civil service.

These "trimmed down" transpositions have resulted in much tinkering, revisions and occasionally regressions which have done little to promote substantive consistency or transparent application. In the United Kingdom, for instance, new regulations on worker participation had to be enacted in 1996, but the "reasonably practicable" issue remains unresolved. France amended the entire body of rules applicable to the civil service in 1995, but regulations on preventive services other than occupational health services remain deadlocked. Italy has enacted three transposing legislative decrees in little more than two years. Each decree amends its predecessors, but has the unfortunate side-effect of further delaying the actual application of the rules.

Coherence and objectives

All the national transposing legislation poses a problem of coherence both as regards the national preventive system and the Community objectives. Because the Community is not (reasonably, in my view) proposing total harmonization, whatever new provision is made must ensure that the various functions of the national preventive system are adapted to the stipulated objectives. In other words, Community harmonization acts only on one segment of activities (usually, workplace labour relations) without addressing what needs to be done elsewhere.

To simplify, two opposing philosophies of transposition can be identified. One is to "cut and paste" the strict minimum. This wins the State some time, since the Commission[11] is not a very proactive enforcer, and tends to satisfy itself with formal checks that each article has been "transliterated" somewhere in national legislation. This approach, were it to become the norm, would be the final nail in the coffin of harmonization while maintaining the improvements made.

The other approach is to act holistically on all components of the national preventive system, whether or not expressly referred to by the Directive. Only this can bring real improvements from the "grafting" of Community law onto national law. It is obviously more technically complex, since it entails looking at all the interactions between a Community Directive and national regulations. But it is also far more productive, because the transposition of a Directive can be an opportunity to revamp what may be inadequate national regulations. In this case, transposition offers a way to resolve national deadlocks.

The transposition of the Use of Work Equipment Directive in France shows the tension that can exist between the strict obligation to transpose and the material objective of a Directive. The French transposing legislation addressed the objective by requiring employers to draw up compliance plans which the labour inspectorate could use to check whether there was a policy for putting existing equipment into conformity with Directive's requirements. This was not an explicit requirement of the Directive, but was

10 The 1977 regulations restrict the appointment of employees' safety representatives to firms in which the employer has recognized a trade union for the purpose. He may derecognize the union at any time. The Court of Justice of the European Communities condemned a similar system for collective redundancies. The British government introduced new regulations in 1996 which coexist with the 1977 regulations. That means employers may now choose between the previous system and new, vaguely-defined forms of worker consultation by-passing the unions. Employers may even freely choose to move between union recognition - and hence application of the 1977 regulations - and derecognition - allowing them to apply other, largely discretionary consultation arrangements (see James and Walters, 1997).

11 The Federal Republic of Germany has been most inventive in its delaying tactics. While it only began to transpose the Directives in summer 1996, it swamped the Commission with reference to previous - sometimes very old - legislation the scope and import of which did not match the requirements of the Directives.

consistent with the approach of the Framework Directive which makes the development of an overall prevention policy a central element of company preventive practice. The French employers vehemently opposed what they saw as a transposition far in excess of the minimum requirements (although their attacks were somewhat muddled, directed first against the Directive itself, then the French transposing legislation, then the alleged failure of the other Member States to transpose it). Leaving aside the fact that article 118A allows standards higher than the minimum requirements, what really incensed the employers was less the putative exceeding of the Directive's objectives than the practicalities of enforcing it.

Community's failure to give political leadership

If transpositions are to be coherent, the objectives must be clearly framed. This is not always so with the Directives. This would not be a particular problem had the Commission implemented the machinery provided for in its Decision of 24 February 1988, which was designed to promote wide-ranging consultations before transposing legislation or regulations reached the drafting stage. Many fears could have been allayed through such consultations. Sadly, nearly 10 years after it was taken, the decision remains dead in the water.

The Directives have been transposed nationally, where there is no scope for discussion of common problems. An extreme example of this is provided by the transposition of article 7 of the Framework Directive in different countries. In France, the rules on preventive services apply only to occupational health. In the Scandinavian countries, the Netherlands and Spain, they apply to multidisciplinary services and the public authorities have laid down relatively precise capabilities and enforcement procedures. The United Kingdom has left it to employers to define the capabilities and aptitudes of the preventive services. Italy's rules lay down precise capabilities, but the services cover all prevention specialists apart from occupational health doctors.

Other common questions, like the precise scope of risk assessment, have had to be addressed separately, resulting in wide country-to-country disparities. Systematic cooperation and an open debate (with unions and employers' organizations) would certainly have produced more coherent criteria for transposition.

The transition to practice

Methodological problems

It is clearly too early for anything like a systematic assessment of the transition to practice - we need the perspective of time. But there are two classes of methodological difficulty, too:

- The Directives prescribe an organization for prevention systems, and so properly combine procedural obligations (carrying out a risk assessment, establishing a preventive service, setting up a health and safety committee, etc.) with specific requirements on a number of risk factors. Collecting reliable and coherent information on all the procedural obligations is a daunting task in itself. The very best that can be offered are general descriptions which could usefully be filled out by more comprehensive studies of specific aspects. But - and it is a big 'but' - there is no guarantee that compliance with the minimum requirements on procedural obligations will automatically produce improved working conditions.
- Another possible (and complementary) approach would be to look at the safety, health and welfare outcomes. But that requires caution. For one thing, preventive measures obviously require time to produce their health effects. Some measures may be almost immediately effective (replacing dangerous equipment by safer equipment, for example), while others may be so only in the longer-term (e.g., substitution of carcinogens). But time alone does not stand between preventive measures and their health consequences. Generally, the health effects of prevention are mediated through a series of social factors which bring into play far more crucial determinants of working conditions. For the same preventive arrangements, the unemployment rate, the segregation of women into low-skilled jobs, the level of job insecurity, and changes to work organization will all make a significant difference to workers' health.

Declining working conditions - an urgent challenge

That said, all the available information suggests that putting the Directives into practice at work is proving harder than expected. But there is no denying the urgent need for it. The surveys on working conditions carried out by the Dublin Foundation point to a decline in many areas caused, among other things, by job insecurity, flexibility and the increased demands of productivity. Harsh reality has given the lie to the rosy view of a decade ago that increased production and profits would automatically lead on to better working conditions. Instead, we have a polarization between groups of workers whose working conditions are improving and a growing body of others whose are not.

This brings us to a key challenge of prevention - the crying need to extend its scope. Occupational health is more than the sum total of traditional indicators of occupational risks, which restricts prevention activities proper (even broadly defined) to only a limited few of the determinants of occupational health. The strategic choices about production, work organization and labour relations which weave the micro-social level of the firm into wider society are not covered by prevention activities in the strict sense. The most that can be asked of prevention practitioners is to inform the choices and expose their visible health consequences. Charting the bounds of prevention may lead to the conclusion that one solution is to integrate occupational health management more closely into the other aspects of business management. Integration is undeniably important - but so are the limits. And the most significant of these is that occupational health is not a corporate objective as such. Its context differs radically from that of quality management or productivity. It is rooted in opposing social interests, and the purpose of worker participation is to confront those interests. Consequently, anything which tends to reduce occupational health management to the framing of a coherent set of measures which give effect to objectives set by company management, risks giving rise to prevention activities whose main aim is to avoid direct costs to the firm (accidents, prescribed diseases, absenteeism) rather than problems whose costs are socialized and hence concealed. The second limit is that occupational

health does not stop at the factory gate: combatting gender inequalities, job insecurity and unemployment, setting public health objectives which address working conditions all necessarily transcend the workplace.

Flaws in the structure of Community law

I said earlier that poor drafting has sometimes muddied the intended outcomes of Directives. But these are minor failings compared to the flaws which are to be found in the structure of Community occupational health law itself.

Article 118A has been interpreted in very different ways. Its very general and deliberately ambiguous phrasing refers to the "working environment", a concept used in the Scandinavian reforms of the '70s to extend the traditional scope of industrial safety and health. The trend in the Council and Commission - opposed by the trade union movement and the European Parliament alike - is to restrict most of the Directives based on article 118A to industrial relations rules, omitting any reference to the machinery for control and socialization which are essential if company prevention policies are not to widen the inequality gap between strong sectors (where a relatively effective prevention policy might be established) and weaker sectors. Any national preventive system comprises a complex set of public and private players. By acting only on relations between employers and "their" workers, the Directives are self-vitiating. To take one simple example: there is no point saying that workers must be consulted on the choice of work equipment if there is no database from which they can extract relevant information. But setting up such databases is far beyond the capacities of the individual employer.

This failure to legislate on public and collective responsibilities is aggravated by the changing face of work. In particular, the legal concepts used are not really relevant to large-scale casualisation and job insecurity[12]. The increase in "atypical" employment relationships, refocusing on core business lines, the rise in outsourcing (especially multi-tier subcontracting) and other factors all combine to undermine rules designed to apply to secure jobs in large or medium-sized firms. Aside from the fact that procedural duties (e.g., setting up health and safety committees, joining an occupational health service, etc.) tend to be based on size criteria which exclude vast numbers of workers, job insecurity damages health in specific ways that cannot be brought down simply to the physical factors of traditional occupational risks (safety of equipment, chemical, physical and biological agents). Much recent research has pointed out that the employer/worker relation which underpins casualised work itself represents an obstacle to improved health.

Steering a proper transition from principle to practice?

Putting the legal rules into practice is more than just a matter of certainty in the law; it is a major challenge which demands commitment from the entire trade union movement. Between complete harmonization which I do not think achievable (or desirable in the present political context) and simply taking what comes, I think middle ways can be found that address the requirement of harmonization while maintaining the improvements made, i.e., upgrading national preventive systems with the two-fold aim of improving national situations and attaining a number of shared aims. Exchanges of experience, different forms of cooperation, creating common instruments of socialization must be central to this. That could be combined with creating a suitable framework for resource allocation. I believe that the Scandinavian Working Environment Funds can give a valuable lead here: they do not just provide simple financial incentives for firms to meet their obligations, but play a dual role of guidance and supervision based on clear priorities and the dissemination of experiences.

[12] For a detailed analysis of the connection between job insecurity and occupational health, see Hoots (1994) and Appay and Thébaud-Mony (1997)

■ I referred earlier to the lack of Community political guidance in transposition. The problem is not just one of interpretation of the Directives. Many Directives are drafted in fairly general terms, so intermediary implementing instruments are needed to give practical guidance on how they should be applied. With the odd exception[13], these problems have been addressed only at national level. In Italy, the Conference of Regions produced a series of guides to facilitate the application of the Directives. In the United Kingdom, there has been a flurry of activity from the Health and Safety Executive in some areas (manual handling of loads, in particular). On all these matters, the pooling at European level of problems, experiences and solutions could have considerably eased the transition to practice[14]. Regrettably, it has to be said that even in cases where Directives have expressly provided for Community action - like the guide to risk assessment for pregnant workers - it has come too late in the day to support national transpositions[15].

■ Indicators should be a priority. Most Community documents refer only in passing to employment injury figures, and sometimes only fatalities (between 6,000 and 8,000 according to year). Such indicators certainly point to the enormity of failure to comply with safety obligations (no other form of crime takes so high a toll of human life), but they are not a solid enough foundation for a policy. They are biased by being derived from financial compensation systems and, at the end of the day, represent only a small proportion of work-related health problems. Deaths from work-related diseases are probably much higher than those from employment injuries. Systematic collection of data and the framing of different types of indicator are essential. The Dublin Foundation has made a good start on this with its surveys of working conditions but it has to be said that, overall, the Community system is relatively distanced from the realities. The rise in musculoskeletal disorders, work related mental health problems and occupational cancers are just examples of areas where we have only a patchy view of the wider picture. The health impact of job insecurity is being researched nationally in only a small number of Community countries, while information on women's occupational health is virtually non-existent.

■ What is also needed is a Community information system attuned to changing patterns of work which would collect systematic data on problems connected with work equipment, production processes and the substances used. Community capabilities in the free movement of goods have produced a substantial body of legislation and have been extended as regards equipment in CEN's standardization work. But they receive virtually no feedback of information on problems experienced by those who use equipment, processes and substances. The TUTB is trying to plug this loophole with its network of trade union experts, but obviously there is only so much we can do. Ultimately, the problem created by the interlock between article 118A Directive and single market Directives will only get worse if workplace experiences are not assimilated to assess the risks of the equipment used. That feedback of experience should also help systematize the data on replacing dangerous substances by other safe or less-dangerous ones.

13 The main exception being a guidance document on risk assessment drawn up by the tripartite Luxembourg Advisory Committee. Regrettably, the Commission did not stand by its pledge to turn it into a non-binding Community legal instrument (a Communication), but simply published it with the disclaimer that it did not necessarily reflect its opinions.

14 The Manual Handling of Loads Directive, for instance, cannot be applied properly without meaningful evaluation systems. See Grieco, Occhipinti, Colombini and Molteni (1997).

15 The Directive was adopted in 1992 to enter into force by October 1994 at the latest. It was due for revision in October 1997. But the planned guide to risk assessment will not be ready before 1998.

■ More systematic exchanges of experience are needed on enforcement and penalties. They are and will remain a national responsibility, but the Community has an obvious interest in avoiding major disparities in the application of common rules. It has to be said that in all the countries concerned, penalties are disproportionate to the frequency and severity of the offences committed. Extending the employer's safety obligation to all work situations within his control (regardless of employment status: employee, agency/loaned/subcontracted worker, self-employed worker, etc.) would clearly be more in tune with changing patterns of work. Community initiatives could also help propagate a more varied range of penalties. So, Spain's rule banning firms that have committed serious breaches of occupational health legislation from government procurement contracts is probably an extremely effective penalty. The Directives on government procurement could be amended to make compliance with public social policy a selection criterion. Multi-tier subcontracting also creates unacceptable safety risks. Here, too, it would be irresponsible not to tie the free movement of services to detailed rules putting an end to competition on the back of workers' health and lives.

■ Remedies against improper transposition lie too much within the Commission's discretion. Without getting too technical, it is significant that the only way for individuals to challenge a transposition before the Court of Justice of the European Communities is through a reference for a preliminary ruling, which means meeting a series of complex conditions.

This situation could be improved by taking a lead from the International Labour Organization. There is no reason why we should not have a twin-track system of redress: legal proceedings (facilitated in different ways) before the Court of Justice of the European Communities, and political remedies through a tripartite system of monitoring the application of the Directives.

■ The Community Directives contain principles inspired by the labour struggle of the 70s. These principles remain valid, but their effectiveness in changed circumstances depends on two inseparable elements. One is the development of a new bargaining power to reaffirm that people's health comes before business competitiveness. The other is the ability to invent new ways of covering all work situations in a context of globalization and job insecurity. Bargaining power can never be built on the defence of past gains alone. That is why the two requirements can never be uncoupled. While it is too soon to predict the shape of things to come, pointers do already exist. Working conditions have been central to a spate of recent disputes (UPS in the United States, the French lorry drivers' strikes in 1996 and 1997). This resurgence of an issue overshadowed by other priorities for nearly a decade is a valuable launchpad for the future.

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