Preventive services

One key aim of the 1989 Framework Directive was that preventive services should be developed that would be accessible to all workers, with a remit covering the vast sphere of preventive activities defined by the Directive.

The aim was part of a new, more holistic approach to occupational health and safety. International Labour Organization Convention No 161 adopted in 1985, in particular, showed that reform of preventive services was on more than just the European Community agenda.

The Framework Directive came into force on 31 December 1992. More than ten years on, we have tried to take stock of where preventive services now stand in the European Union. What we found was that the number of workers still not covered is very high, and has even risen in some countries. Multidisciplinary working is anything but established everywhere, and serious questions arise about what contribution these services can even make to a prevention policy to protect workers' life and health.

An account of all facets of the problem is beyond the scope of this report. Simply, starting from an examination of different national systems, it raises a number of issues that are both crucial and common to most EU countries. Issues around health surveillance will be addressed in more detail later. The situation of preventive services in the new accession countries will be examined in a workshop at the joint ETUC-TUTB Conference being held in Brussels in January 2004.

With this, the *TUTB Observatory on the application of the directives* means to step into the debate on the review of the application of the Community directives set to unfurl in the second half of 2003.

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Preventive services in the European Union – fighting a losing battle?

The 1989 Framework Directive imposes a strict liability to protect the health and safety of workers, laying down a series of obligations in the form of procedures and means to be put in place to achieve that end: participation by workers and their organizations in preventive activities, risk assessment, procedures for use in situations of serious and imminent danger, etc. The preventive services are intended to play a prominent part in all this. The Directive rightly points to the vast scope of preventive activities. The very concept of prevention means that expertise will often have to be drafted in to analyse and give a predictive judgement about the possible consequences of various aspects of working conditions. The Framework Directive may be less clear-cut in certain respects than International Labour Organization's Occupational Health Services Convention 161 and Recommendation 171, but there is a continuum between them. International labour standards are a useful benchmark for framing a coherent policy through which to deliver the Framework Directive's objectives.

When the Framework Directive was adopted, therefore, trade unions stressed its potential for giving impetus to preventive services reform, because nowhere in the EU did existing legislation fully address the Directive's aims, and assessments of existing services showed up obstacles to their attempts to really add to prevention in every country. Trade unions have consistently argued that preventive services reform must address four priorities: universal coverage, multidisciplinary occupational health services, setting up internal company provision first, supplemented if need be by externally-enlisted expertise, oversight of preventive service activities by workers and their organizations to ensure that they really contribute to prevention.

By and large, the 1989 Framework Directive's objectives for preventive services have not been met. What is most disturbing is that it is in the four most populous countries where, for different reasons, things have advanced least. Arguably, the United Kingdom has gone backwards. In France and Germany, little has really changed in ten years. Despite sweeping reforms in Italy, preventive services remain one of the weakest links in the new system - and could get weaker under the present Berlusconi coalition government's plans for a radical deregulation of workplace health legislation under the vaguest of parliamentary mandates[1]. Other countries have made real progress on some of the parameters examined (coverage, multidisciplinarity, operation as an established service). But serious queries arise about other factors (the priority given to an overall prevention policy, independence and relations of trust with the workers). Finally, bodies to collectivize the experience of these services remain under-developed in all EU countries, where they even exist (see article p. 36). A sort of heavily-fragmented prevention market is developing which does not really square with a coherent national policy.

Universal coverage ? For the 50% that are !

Workplace health issues affect all workers whatever their employment status, size of firm or industry segment. In all but a very few cases, self-employed workers are not covered by preventive services anywhere in Europe. The exceptions include some coverage in Finland, agricultural workers in France, and the activities of public preventive services in Italy. Generally, however, the states concerned have neglected this aspect of prevention activity. That also stems from one of the failings of Community legislation - the position of self-employed workers has only been recently addressed in a Recommendation[2], and we know from experience how little effect non-binding instruments have on national situations.

Among employed workers, the Community legislation excludes domestic staff, so that as a general rule they (overwhelmingly women) have no access to preventive services in the different member states.

Coverage of other employed workers is very patchy between countries. Estimates done for the Swedish SALTSA Programme research project on the quality of preventive services[3] on data collected in 2000 suggested that probably 50% of employed workers had access to preventive services in the European Community, with wide variations ranging between 25% and 95% according to country.

Some countries come close to universal coverage by requiring firms that lack a company preventive service with sufficient aptitudes to sign up to an external service. The Netherlands, Luxembourg and Belgium are cases in point. France limits universal coverage to occupational health services. Austria also has universal coverage in principle, which in practice extended to just over 70% of all workers in

[1] The Simplification Act passed by the Lower House in December 2002 and the Upper House in March 2003 writes the executive an effective blank cheque to roll back health and safety reforms on the guiding principle of making it "compatible with the essentials of business management and organization".

[2] Recommendation of 18 February 2003, *OJ*, L 53, p. 45, 28 February 2003.

[3] R.-M. Hämäläinen *et al.*, *Survey of the Quality and Effectiveness of Occupational Health Services in the European Union, Norway and Switzerland*, Finnish Institute of Occupational Health, Helsinki, 2001.

2003[4] compared to the estimated 55% in 2000. Coverage is still often fairly notional in small firms because the minimum service times of occupational health doctors and safety engineers are so low (1.2 and 1.5 hours, respectively) that many firms with under 50 workers simply use the preventive service set up by the industrial accident insurance system (AUVA)[5]. Medical examinations aside, there are few organized preventive activities[6].

Data for Spain show mixed trends: many firms, especially smaller ones, have no preventive service[7]; and most that do use an external service which has little impact on workplace prevention. Only medical examinations are relatively widespread. In 1999, the 4th national survey of working conditions reported that 24% of firms had no organized prevention activity, 52.3% had arranged medical check-ups, and 30.2% had done an initial risk assessment. More recent surveys reveal little further progress than that (see article p. 32).

Little significant progress has been made in the Nordic countries. Finland is near to achieving universal coverage (between 95% and 100% of workers, according to the source). Sweden has retreated from the 1980s when nearly 80% of workers were generally thought to have access to preventive services. Now, it could be more like 60%, but this is a very rough-and-ready estimate because the statistics on preventive service coverage in Sweden are quite inconsistent. The obtainable data put the figure in a bracket between just over 50%[8] to 72%[9] of workers. This surprising lack of certainty in a country with copious workplace health statistics, reflects the current lack of organization in services and linkages into a national prevention policy. Coverage in Denmark is estimated to be between 35 and 40% of workers. In the early '90s, plans were made to gradually increase achieve full coverage. Progress has been very slow. The only recent extension has been to the hospital sector. A deal had been struck in spring 2001 between the then-ruling social democratic party and two left-wing parties in connection with the budget vote to extend preventive services to all workers by the end of 2005[10]. The process was halted at the end of 2001 when a liberal-conservative coalition government took office with parliamentary support from the People's Party - a neo-liberal xenophobic grouping of extreme right wingers. General coverage of workers by preventive services is not an objective for the new government which has plans to roll back coverage in sectors where it is currently compulsory. Firms certified as pursuing a sound working environment improvement policy will be able to dispense with a preventive service. It is reasonable to assume that between a market for certification and a market for preventive services, workers' specific needs will not be a priority.

The United Kingdom paints the most disturbing picture[11]. The number of workers with access to a preventive service has fallen dramatically. Growth in the number of small firms, the spread of subcontracting under different guises and the privatization of public services have been major factors in this. The British trade union confederation (TUC) reports a fall in the number of workers with access to health and safety professionals from 12 million in 1992 to 7.5 million in 2002. In percentage terms, that equates to a fall in coverage from 50% to 30% of the national workforce. A survey done by the Institute of Occupational Medicine for the Health and Safety Executive throws the situation into stark relief. The survey focuses on selected functions, missions and tasks rather than organizational procedures. It claims that barely a seventh of workers (employed in 3% of all firms) are covered by occupational health activities relatively narrowly defined as including training, job engineering, risk factor measurement, health monitoring. 7.5 million workers (15% of firms) have access only to a sort of minimal service comprised of risk factor identification, risk management and information. Specialized health and safety staff are found in about half of firms that have organized prevention activities. The three most frequently cited professions are health and safety officers (in 45% of cases), general practitioners (29% of cases) and occupational health nurses (29%). The Health and Safety Executive's strategy for giving a new impetus to prevention in the United Kingdom does not have the development of preventive services as a priority. The government has so far turned a deaf ear to trade union demands for a legislative framework to make the use of preventive services compulsory, instead favouring employer self-regulation backed up by possible employer-trade union partnerships. In a political setting where the government feels it would be asking too much of employers to force them to investigate work injuries that have occurred in their workplaces, specific rules for preventive services seem a remote prospect (see box p. 23). This makes the European Commission's responsibility to ensure proper transposition of the Framework Directive even more essential.

[4] The estimate for 2003 is based on information supplied to the TUTB by Dr Erich Pospischil on 27 March 2003 that coverage is about 98% in firms with over 250 workers, about 85% in firms with 50 to 250 workers, and about 65% in firms with under 50 workers. But 80% of workers in Austria are employed in the latter group of firms.

[5] According to a letter of 2 April 2003 from the Central Labour Inspectorate to the TUTB, 35% of firms with under 50 workers have opted for this arrangement.

[6] Information supplied to the TUTB by Mr Michael Lenert of the Vienna Labour Federation, 1 April 2003.

[7] About a quarter of Spanish firms employing fewer than 10 workers have no organized prevention and a quarter have left responsibility for preventive services to the employer. Detailed data are supplied in the 4th national survey of working conditions done at the end of 1999 : http://internet.mtas.es/Insht/statistics/4enct_orga.htm

[8] S. Marklund (ed.), *Worklife and Health in Sweden 2000*, Stockholm, 2001, p. 65.

[9] Swedish Institute, Occupational Safety and Health, *Fact Sheet on Sweden*, March 2002, pp. 2-3.

[10] A. H. Riis & P. L. Jensen, Denmark : Transforming Risk Assessment to Workplace Assessment, *in* D. Walters (ed.), *Regulating Health and Safety Management in European Union. A Study of the Dynamics of Change*, Brussels, P.I.E.-Peter Lang, 2002, pp. 59-80.

[11] The figures in this paragraph are sourced from: L. Ponting, The sad case of occupational health provision in Britain, *Health and Safety Bulletin*, No. 311, August - September 2002, pp. 11-14.

The necessary aptitudes

The Framework Directive does not specify what aptitudes preventive services must have. It leaves that responsibility to the member states. Obviously, the Framework Directive has to be looked at as a whole, not separating off article 7 on preventive services from the other provisions, especially the very wide definition of the scope of prevention (article 6) and the need to ensure access to health surveillance for all workers. Logically, then, the necessary aptitudes should relate to the main disciplines involved in prevention. This is how the Directive was transposed in some countries (Belgium, the Netherlands, Spain), while multidisciplinary working was already an established practice in the Nordic countries[12]. There is a sort of recognizable common core of disciplines involved in occupational health - plus some paramedical specialities - comprised of safety, industrial hygiene, ergonomics and psychology. The precise designation of some of these disciplines may differ between countries and, so far, only occupational medicine has been the subject of Community harmonization measures for the recognition of diplomas.

Spain, however, is a case apart. Its regulations refer to a range of disciplines, but allow employers to choose just two to comprise a preventive service. The situation as regards training is also worrying. A report by the President of Spain's Economic and Social Council, Mr Durán, publishes evidence that training of specialists in hygiene, safety, ergonomics and psychosociology is nothing short of shambolic.

Austria and Portugal stand out among those countries that opted for a single preventive service - they only require preventive services to comprise occupational health doctors[13] and safety engineers. This narrow approach to multidisciplinary working has stopped other players like ergonomists, psychologists and industrial hygienists being given a precise status.

The only aptitude specified with varying degrees of precision by all states is occupational medicine, even though health surveillance is not always carried out by occupational health doctors[14]. But this is by no means organized into services covering all workers in many countries. It bears pointing out that the Community directives do not require health surveillance of all workers, but do make surveillance compulsory in certain circumstances (e.g., exposure to hazardous chemicals, workers using display screen equipment, workers at risk of injury from the manual handling of heavy loads, etc.) with the proviso that each worker should be able to receive health surveillance when they want it. Many countries fall far short of achieving these aims. Compulsory surveillance, especially of workers in insecure/casual jobs and in small and medium-sized firms, seems to be flouted wholesale in countries with no universal coverage by preventive services that include occupational medicine. On-demand access to health surveillance for workers is rarely guaranteed in firms with no compulsory surveillance obligation. Also, a dangerous lowering of standards has occurred in Italy, where doctors that provide health surveillance in firms (described as "competent doctors" in the Italian legislation) do not need to be qualified in occupational medicine since reforms introduced by Silvio Berlusconi's government at the end of 2001[15]. The really big problem, however, remains the weakness of the link between individual medical check-ups and a prevention policy which puts a priority focus on radical changes to collective working conditions.

Statutory occupational health nurse provision is also made in many countries. This is one of the most widespread specialities, but also one of the most disregarded in all preventive service activities, since is generally seen as purely a support function to occupational health doctors. Occupational health nurses were among the first workplace health specialists to set up a European organization: the Federation of Occupational Health Nurses within the European Union (http://www.stthl.net/fohney.html).

Some countries in their transposing legislation failed to specify the precise aptitudes that preventive services should have, thereby leaving employers free to decide what aptitudes their services should have, or even their independent experts not acting in coordination with others within one or more services. Ireland, Luxembourg[16], the United Kingdom, Sweden and Italy are cases in point. Sweden's transposition of article 7 of the Framework Directive requires no more than that the experts enlisted by the employer should have "sufficient competence"[17], whereas the Directive requires member states to define the capabilities and aptitudes they must have. As yet, the Commission has only instituted default proceedings against Italy, which was found to be at fault in an ECJ ruling of 15 November 2001 (see *TUTB Newsletter*, No 18, March 2002, p. 7).

12 The regulatory framework played only a supporting role in the Nordic countries. The move towards multidisciplinary working was essentially a response to social demand, the general thrust of a national prevention policy, and support from public funds for improvement of the working environment. The lack of binding rules and regulations could put these gains on the line in Denmark and Sweden where the general context had radically changed.

13 Occupational health doctors in firms employing at least 250 workers have the assistance of occupational health nurses. The number of occupational health doctors in Portugal is estimated at 1 000 to 1 200 (according to information supplied to the TUTB by Ms Claudia Matos of the IDICT in March 2003).

14 In Germany, occupational health doctors (in the strict sense of doctors qualified in occupational medicine) account for under a third of all doctors involved in health surveillance of workers (4 112 out of 13 395 in December 2000).

15 The specialities that enable doctors to be classed as "competent doctors" for workplace prevention now include insurance medicine, hygiene and forensic medicine. Might the latter be for carrying out post-mortem examinations on workers killed in accidents? See Order in Council No 402 of 12 November 2001.

16 In Luxembourg, regulations specifying the aptitudes of preventive service staff are finally in the works more than 8 years after the legislation transposing the Framework Directive came into force.

17 Swedish Work Environment Authority Guidelines on systematic work environment management, 15 February 2001. See in particular section 12.

Do work accidents need investigating ?

The answer seems self-evident. How can prevention plans be updated without factoring in the experience of work-related accidents and health problems? The Framework Directive itself says that reports have to be drawn up on accidents and submitted to the workers' representatives. In most Community countries, there is no question about the obligation to investigate work-related accidents and ill-health. Often, it has to be done with assistance from a (company or external) preventive service, and involve the workers' representatives. In Belgium, legislation[1] now provides that on top of the employer's internal investigation into serious work accidents, the labour inspectorate will also appoint an expert to produce a report which will be submitted to the employer and discussed with the workers' representatives. The cost of this indirectly comes out of the employer's pocket (it is paid for by the employer's insurer, who can claw it back from him).

At the end of 1998, Britain's Health and Safety Commission launched a consultation exercise on introducing a legal obligation for employers to investigate workplace accidents, dangerous occurrences and diseases. The idea won unanimous backing from trade unions and an overwhelming majority of prevention professionals. Aside from the obligatory knee-jerk complaints about any attempt to improve the legal framework of health and safety, employer opposition was not especially vehement. After the first consultation exercise which prompted 684 responses, a second round of consultations was held in 2001[2]. Obstructive as the delay was, the final result seemed to be in no doubt. After more than four years, the Health and Safety Commission made up its mind on 3 December 2002, but held off publishing its decision until 31 January 2003. The answer was no. The message is clear: British employers now know that they have no duty to investigate work accidents. Obviously, they can do if they wish, and guidance will be published to help such benevolent and inquisitive employers. An HSE survey claimed to show that, in any event, employers failed to see the value of such an exercise. The HSC's press release reveals that the political climate is what swayed matters: regulation of business is not on the agenda; preference goes to encouragement for "voluntary initiatives". The government does not want a tight regulatory hand to interfere with "business as usual".

This typifies the British authorities' strategy towards implementation of the Framework Directive[3]. The Directive's main provisions were transposed by copying out the wording, but the general mood of opposition to legislation that protects workers has effectively emasculated many of its provisions. What is the point in consulting workers on a report concerned with work accidents if the employer does not even have to investigate them? It is likely to be no more than a straight record of occurrences of no real value in prevention terms.

The estimated cost of the proposed measure was around £18 million a year (calculated by the HSE in 2001), i.e., under £1 per worker.

The General Secretary of the TUC, Brendan Barber, said that "until employers investigate accidents and near misses as a matter of course, the job will be left to (union) safety reps, HSE inspectors and, in the worst cases, public enquiries".

[1] Prevention (Improved Provision) Act of 25 February 2003, *Moniteur Belge*, 14 March 2003.
[2] The consultation document can be found at: http://www.hse.gov.uk/consult/condocs/cd169.pdf
[3] See D. Walters (ed.), *Regulating Health and Safety Management in European Union. A Study of the Dynamics of Change*, Brussels, P.I.E.-Peter Lang, 2002.

The failings of the United Kingdom's public authorities are partially offset by the system of accreditation and registration of health and safety professionals set up by private agencies[18]. The main professional body for this is the Institution of Occupational Safety and Health which groups together some 25 000 people classed into three groups by level of training and professional experience. The IOSH has grown considerably over the past 10 years. Other bodies also act as training certifiers. But none of this intervention by private agencies is enough to regulate the prevention market because employers are always free to employ people who do not meet the standards set by them. Also, voluntary organization of professions does not give sufficient guarantees of the independence of those concerned.

The freedom that Italian employers have to appoint the head and personnel of the preventive service unfettered by specific requirements as to aptitudes or approval has created a situation where most of these officials play only a backseat role due to lack of authority, means and sometimes capabilities[19]. This has emerged clearly from most of the surveys done in recent years. Company preventive services are certainly one of the weakest links in the Italian prevention system, and a vast unorganized market in external expertise has grown up separately to that of inter-company services. Mostly, it addresses immediate demands from employers, chiefly that of drawing up formal documents like the risk assessment plan[20]. It is questionable whether that will result in planned, integrated prevention. A national survey on the status of prevention stressed the problems faced by the heads of preventive services in the following terms: "preventive service heads feel deeply short-changed by what they do. They talk about the limitations and the difficulty of being front-line players in workplace prevention when they lack the power to take big decisions that have practical effects (...). Few heads talk openly about the organization of workplace protective and preventive services; their role is essentially administrative and technical, and their single overriding concern is whether the employer is complying with the law[21]".

Multidisciplinary or two-track working ?

Historically, prevention practices were long nothing more than offshoots of compensation for work-related risks. Workplace health was so bound up with the idea of occupational diseases that in many countries health surveillance was compulsory only where there was a specific risk of an occupational disease. Safety was about avoiding work accidents. Work organization, ergonomics, and a series of health problems with long latency periods or not resulting in incapacity for work were disregarded.

Most recent reforms have put a focus on multidisciplinarity in preventive services[22]. But not so in all countries. In Germany, in particular, the existing system was kept largely unchanged. Most firms must have safety engineers, and must entrust health surveillance to occupational health doctors. Obviously, linkages do exist between the two forms of intervention, but, by and large, prevention practice is not often found to be multidisciplinary.

The legislation passed in June 1994 to transpose the Framework Directive in Luxembourg preserves a two-track system[23]. Firms must have both a occupational health service for health surveillance, and a preventive and protective service for general preventive safety. While occupational health services' remit includes advising employers and employees on issues like hygiene and ergonomics, the only compulsory aptitude is occupational medicine. The Luxembourg legislation does not prevent company or external occupational health services from also doing the job assigned to preventive and protective services. It allows multidisciplinary services to be set up, but only after an operational needs assessment by the service. The non-health specialists cited as examples by the regulations are safety engineers, health engineers, ergonomists, psychologists and engineering technicians[24]. In practice, introducing a multidisciplinary approach is proving an uphill struggle. According to figures supplied by the Health Department in April 2003[25], the 7 occupational health services currently in existence have 45 full-time occupational health doctors, 10 nurses and 19 specialists in all other areas (9 safety engineers/technicians, 1 hygienist/toxicologist, 3 ergonomists, 4 psychologists, 1 interior designer and 1 physiotherapist).

Austria has gone down a different road. Where a single service has been set up, it must include both an occupational health doctor and safety engineer. But employers can preserve a two-track arrangement by enlisting a safety engineer and an occupational health doctor separately. This has not really helped create multidisciplinary practices. Rather, it is a means of facilitating cooperation between occupational

[18] C. Dyer, Getting the ticket, *Health and Safety Bulletin*, No 313, November 2002, pp. 15-20.

[19] Following the ECJ ruling against Italy, the government passed a legislative decree in June 2003 defining the capabilities of the service head and personnel. It is far from being universally endorsed. One main problem is that the decree preserves the "established situations" of most of the service heads and personnel who were already in place. Also, it requires only a fairly low level of skills for large and high-risk companies.

[20] A survey of small and medium-sized firms in Emilia-Romagna found that in 94% of cases, employers had contracted their risk assessment out to outside consultancies (see: Istituto per il Lavoro, *Salute e sicurezza in Emilia Romagna*, FrancoAngeli, Milan, 2001).

[21] L. Birindelli, E. Montanari, M. Sordini, Da soli si fa male. Il sistema partecipato di prevenzione e sicurezza sul lavoro, *Quaderni Rassegna Sindacale*, No. 4, Oct.-Dec. 2001, p. 153.

[22] This was not a new idea in the Nordic countries, where it had been brought in under a variety of guises in the 1970s.

[23] The Occupational health services Act of 17 June 1994, and the Safety and Health of Workers At Work Act of 17 June 1994 (both published in the *Mémorial* (Official Gazette), A-No. 55 of 1 July 1994.

[24] Grand-Ducal Regulation of 2 April 1996 on the personnel, premises and facilities of occupational health services (Official Gazette, A-No. 26 of 26 April 1996).

[25] Information supplied to the TUTB by Dr Steffes and Dr Goerens on 2 April 2003.

health doctors and safety engineers without really extending the scope of prevention to other disciplines. In practice, most occupational health doctors still provide their services on an individual basis rather than as part of a preventive service. Figures supplied by Dr Pospischil in March 2003 suggest that prevention provision currently comprises about 1 280 doctors, from 3 000 to 4 500 safety engineers and well short of a dozen industrial hygienists (trained in Germany or in the Nordic countries, there being no specific training in Austria). The figures for safety engineers are far from certain as they are often production staff for whom prevention is a small if not marginal part of their job. The number of ergonomists employed in workplace prevention is estimated at between 12 and 15. Also, while the Austrian Society of Psychology has 124 registered occupational psychologists on its books, it is hard to tell how many of them are directly employed on prevention in firms[26]. Neither ergonomists nor psychologists have official standing in the regulation.

Greece has also kept an essentially two-tier arrangement. All employers must appoint a safety officer regardless of the size of the workforce. In firms regarded as lower-risk, the employer can act as the safety officer subject to following a fairly cursory 10 hours' training. Also, firms employing at least 50 workers (with lower thresholds for special-risk firms) must make health surveillance provision by contracting an occupational health doctor. A service need not be set up for either speciality. The method of organization can vary from appointing an employee to contracting outside services. No overall data on the specific methods of organizing provision were available. Signing up to an external preventive service which will necessarily have both safety and occupational medicine abilities is only one possible method of organizing preventive services. In one region (Eastern Attica and the northern Aegean islands), nearly half the firms (196) that use a doctor contract individually for his services not as part of a preventive service, while 183 firms use doctors who are part of external preventive services, and 17 have doctors on their staff. For safety engineers, more than half (631 firms) contracted individual external provision, compared to 228 that used external preventive service technicians and 309 that employed one[27].

The debate in France on overhauling occupational medicine services has been going on for years. The solutions so far are nowhere near establishing multidisciplinary workplace provision. Unlike Germany, there is no regulatory framework governing the activities of prevention personnel other than occupational health doctors[28]. That severely limits their independence, the links they have with employee representation bodies, and puts them in a sort of legal limbo. No firm, whatever its size or risk potential, is obliged to have a company preventive service. On the other hand, occupational medicine services have been renamed "occupational health services" since they now include personnel who are not occupational health doctors. The predominant approach to multidisciplinarity is minimalistic. At 1 January 2002, occupational health services comprised 7 067 occupational health doctors (approximately 5 260 full-time equivalents) assisted by 5 182 medical secretaries and 3 747 nurses. Other than this, occupational health service personnel totalled 236 people, plus 1 534 clerical staff. The ratio of "other prevention personnel" (with specific skills not reported in the statistics and not defined by the regulations) to doctors clearly shows that the former play a purely incidental role. What is more, there are fewer prevention personnel than services, meaning that some "occupational health services" remain exclusively occupational medicine services. There are 180 personnel in a total of 363 inter-company services, and 56 personnel in a total 765 company services[29].

The current lack of movement in France stems from powerful lobbying by employers pursuing a double agenda which is a million miles from assessing prevention needs. One is the demand for zero cost reform, and a purely business management policy approach to multidisciplinarity, which means using least-cost subcontracting by having some occupational health doctor duties done by others for lower pay and without guarantees of professional independence. They also clearly mean not to forfeit their absolute control over company prevention specialists, who they can hire and fire at will, and can keep distanced from health and safety committee activities. This has exposed the current state of occupational health services in France to a welter of criticism. Government proposals have so far failed to address the crucial issue of company prevention specialists and restricted the debate on multidisciplinarity to just two aspects: the relationship between different public external agencies and the introduction of the odd technical assistant to occupational health doctors. The title of a recent article in the magazine *Santé et Travail* aptly captures this uneasy situation: "Multi-disciplinarity off the rails"[30]. The author summarizes the debates as

[26] Mr Michael Lenert estimates the number of psychologists at in the vicinity of 375. His figures include occupational and organizational psychologists.
[27] Data for 1 860 firms employing a total 68 120 workers supplied to the TUTB in March 2003 by Ms Katsakiori, KEPEK (occupational hazards prevention centre) safety inspector. The figures given are for the number of contracts signed by a firm with a doctor, whether self-employed or part of a preventive service. One doctor may obviously have contracts with several firms.
[28] The decree of 24 June 2003 published in the *Journal Officiel* of 26 June 2003 changes the situation somewhat. It was published after this article was written. It will be considered elsewhere, as its content nowhere near covers all the prevention experts currently working in or for firms.
[29] Labour Relations Department, *Conditions de travail. Bilan 2002*, restricted publication.
[30] I. Mahiou, La pluridisciplinarité dévoyée, *Santé et Travail*, No 42, January 2003, pp. 20-21.

follows: "it isn't happening. The draft order establishing multi-disciplinarity in the new occupational health services has drawn the combined fire of trade unions and occupational health doctors, all of whom fear seeing the independence of occupational health professionals challenged by a tightening of employers' control over what they do".

Italy has developed a cross between a multidisciplinary and a two-track system through a statutory differentiation between the preventive and protective service - which does not in fact have to be a service and whose personnel have no clearly defined aptitudes - and the "competent doctor" who is not and does not have to be part of a preventive service. Since the Order in Council of 12 November 2001, the "competent doctor" does not even have to be an occupational health doctor. But the separation is offset by a statutory requirement for regular relations to be established between the competent doctor and the preventive service, in particular through periodic prevention meetings which must be held at least once a year in firms employing more than 15 workers. Proposals recently put forward by craft industry employers would do away with the need for competent doctors to be informed about actual working conditions and restrict their role to individual health checks[31].

Finally, questions may be asked about how far multidisciplinarity exists in countries with no preventive services as such (United Kingdom, Ireland).

Case-specific, uncoordinated activities

The Framework Directive requires a coherent overall prevention policy to be developed. Part of that involves giving meaningful sense to the concept of service(s) used in heading of article 7. Arguably, two points should be taken up here:

- The main focus should be on setting up a company service. External services are to be enlisted only for things that a company service cannot do[32].
- Generally, the needs for (internal and external) expertise should be defined by reference to the requirement of a prevention policy. That means that external expertise should not be enlisted on an ad hoc basis, that linkages should be established between the different sources of expertise, as well as between the activities of company and external services. In particular, the evidence is that publicly- approved external services overseen by watchdogs that include trade union representation guarantee better conditions than the piecemeal provision of expertise and consultancy services by individuals or for-profit companies.

In many countries, size criteria determine whether company services are compulsory. The thresholds vary widely from 20 workers in Belgium to 500 in Spain (but 250 workers for high-risk industries). In Portugal, it is 400 workers (50 workers in a list of high-risk sectors). In Italy, it differs by sector from 10 workers in farm businesses to 30 workers in craft and industrial firms, up to 200 workers in other firms. Otherwise, the employer himself can assume the responsibilities of the company service, but unfortunately is not always required to have proper training[33]. Luxembourg sets the bar highest: a company occupational health service is only mandatory in firms employing at least 5 000 workers[34] (or 3 000 workers if 100 are subject to health surveillance due to working in safety-critical jobs or exposure to the risk of an occupational disease).

The Belgian regulations make a company service compulsory in all firms employing at least 20 workers, and supplementary assistance from external services must also be enlisted by any firm whose company service cannot fulfil all the regulation responsibilities and tasks. The unity principle is clearly established for company and external services alike, aimed at ensuring integration and permanence in the approach taken by services. The Netherlands, Finland, Denmark and Spain also have rules requiring external services to be approved or subject to other forms of control. The relationships between company and external services differ widely from one country to another.

There is a clear focus on company services in Belgium and Germany (only as regards safety), in contrast to the Nordic countries, where the emphasis is on external services, although their activities must be integrated into a comprehensive employer's policy to ensure health and safety (e.g., Sweden's rules on "internal control"). The Netherlands, Spain and France have put the focus on external services (essentially limited to occupational medicine in France). The lack of a specific regulatory framework in the United Kingdom means that most prevention professionals are not part of organized services. Unlike other countries, even external prevention provision mostly operates in large firms.

In many countries, there is evidence that a fairly unstructured and unregulated market in all kinds of

[31] Confartigianato, *Proposta di legge di modifica del DL 626*, Congress of Sirmione del Garda, 5 April 2003.
[32] The European Commission has taken a firm stance on this and put pressure on several member states in the informal pre-litigation stage of infringement proceedings to give priority to the setting-up of a company service. See in particular, the infringement proceedings against the Netherlands on this issue (case C-441/01). The Court has not yet published its judgement, but the submissions made on 16 January 2003 by Advocate General Mr Ruiz-Jarabo Colomer concur with the Commission's arguments.
[33] No training requirement in Belgium, very cursory training in Italy, etc.
[34] The Luxembourg legislation allows an occupational health doctor to be responsible for up to 5 000 workers, which is at odds with the threshold laid down in the Community Recommendation of 20 June 1962 by which an occupational health doctor should not be responsible for more than 2 500 workers, or fewer where the workers are exposed to particular risks.

expertise has been formed. External expertise is not necessarily consolidated in preventive services in Italy, France (apart from occupational health doctors), Germany (including occupational health doctors), the United Kingdom or Ireland. Even in countries where external experts operate through a clearly defined structure, the approval and control procedures for external services are not always satisfactory. So, in Portugal, the regulations require external services to be approved by the public workplace health agency - IDICT - but it has neither yet set the criteria or started to grant approvals. As a result, a vast market of about 400 different external services has grown up. The assessment of one of our Portuguese correspondents, Mr João Fraga de Oliveira, is that lack of effective public control of these services has meant that many unaccredited preventive services are now already operating, generally with a "business-driven" approach. There is no guarantee that they have either the human and technical means or the capabilities to provide good quality, regulation prevention services.

Spain has a two-tier market: one in preventive services, and one in other expertise contracted either by external preventive services or directly by firms.

Independence and workers' confidence

Preventive services must have full professional independence in how they do their job. That means that health protection must override all other criteria that the employer might seek to impose (profitability, health-based recruitment, absence controls, etc.). Independence does not mean taking a neutral stance half-way between employers and workers, because it is workers' lives and health that may be at risk. Also, workers' insights are key to identifying the risks and putting effective prevention strategies in place. As regards professional ethics, finally, it is important to bear in mind that in many circumstances (especially with respect to health surveillance), workers have no choice but to use these services, so their confidence is an essential element. A Dutch trade union publication asks the pointed question: should you be absolutely open with your occupational health doctor?

Independence means that there must be effective protection for prevention personnel against any pressure that employers might apply. Few countries have specific rules to protect against dismissal, suspension or retaliatory action by the employer[35]. This loophole has just been plugged in Belgium by new legislation[36] giving all prevention personnel in company and external services alike the same kind of protection as that already enjoyed by occupational health doctors. The grounds of dismissal must not infringe the independence of prevention specialists, and allegations of incompetence must be substantiated. The onus of proving good cause therefore lies on the employer. Control is exercised at several levels: a compulsory prior agreement by the workers' representatives, mediation by the labour inspectorate, judicial review. An employer who fails to fulfill the substantive and procedural requirements will be liable to pay the prevention expert compensation equal to two or three years pay (according to length of service).

In the French situation as it stands, prevention specialists who are not part of a "occupational health service" (the new title for occupational medicine services) lack any guarantee of their professional independence. In practice, almost all prevention specialists other than occupational health doctors are in the same subordinate position to their employer as any other unprotected worker.

Few countries have given any meaningful content to the idea of "balanced participation" by workers in the operation of preventive services. The idea of including this formula in the Framework Directive was to get something more than a simple procedure for information and consultation in which workers' representatives would only be able to give an opinion on decisions that the employer intended to take. The existence of widely differing labour relations systems and policy differences prompted the Community law-makers to adopt this cryptic formula for which each country was meant to replace the unknown quantity with substantive content.

Most member states did not go too far. The Luxembourg legislation refers to "balanced participation" but fails to define what it means. This is a drawback of implementation by copying out the wording of Community provisions. Only a handful of countries spelled out the rights of workers' representatives by giving them powers of control that go beyond mere consultation. For preventive services, different forms of co-decision procedures are found in Germany, Belgium and the Netherlands. While these do not necessarily extend to all decisions linked to preventive service activities or all firms[37], they nevertheless give workers' representatives a more effective way of

[35] External preventive services, furthermore, must be doubly independent: from the employer of the service, and from the employers of firms using the service. Experience teaches that pressure from business employers can undermine the employment status of the most proactive and honest prevention specialists in external services.

[36] Act of 20 December 2002.

[37] In Belgium, co-decision is found only in firms with a Workplace Prevention and Protection Committee (50 workers upwards) or a union delegation set up under an industry collective agreement laying down a workforce size or other variable criteria for establishing a delegation. In the Netherlands, co-decision is found only in firms with a works council (35 workers upwards). In Germany, the threshold for setting up a works council is much less restrictive (5 workers).

Two approaches to violence

An industrial psychologist tells of the difficulties he faced in a large European-scale bank, dealing with violence as part of the company preventive service. His survey found a direct link between the bank's business policy and the increased incidence of verbal and physical violence by customers. The bank had decided to rid itself of low income customers - chiefly the unemployed, pensioners on low incomes, etc. - who were judged unprofitable and too "costly" in staff time. Its sales department had asked branch managers to deliberately increase queuing times for service in targeted branches (in working-class districts). Staff reports reveal the contempt in which this type of customer was held: at one training session, sales managers caricatured elderly ethnic women. The prevention officer put in his report to management, stressing the linkage between this business policy and the rise in violence. He also described discontent among the staff of this privatised former public bank who had always seen themselves as having certain social responsibilities and were ready to take the necessary time to give customers proper information regardless of their "profitability". Some of the staff saw the new business culture as an affront to their professional dignity, making it harder for them to relate to customers. Management did not dispute the facts set out in the report, but politely asked the prevention officer to stick to his job: "set up staff training on how to deal with violence and stay off the other issues. If it comes to the point of needing extra security staff, we can think about that". The prevention officer nevertheless put his report forward to the health and safety committee where he received the backing of the union reps. He has since been sidelined, assigned to purely administrative tasks, and allowed no contact with branch staff.

acting to block an employer's decision which does not address their preventive health requirements. In Belgium, an external service prevention specialist who has lost the confidence of the workers' representatives must be replaced at their request.

Preventive responsibilities. Creeping doubts...

Judged by the criteria of size of workforce covered and multi-disciplinarity, the Netherlands is well above the Community average. But it is probably the country where the activity of preventive services has brought most complaints from workers (see article p. 34).

The crisis of confidence in preventive services in the Netherlands is not just about that country's prevention system. It gives a clearer handle on problems encountered in different ways in all EU countries about the free-market perversities of a competition-based system where preventive services are sold to firms. In Holland, these misdirected for-profit approaches are tightly bound up with private quality control systems.

There are serious issues about the preventive character of what services do in Spain (see article p. 32) where most firms are affiliated to external preventive services set up by the insurance companies responsible for compensating work accidents and diseases (*mutuas*) resulting in large-scale outsourcing of preventive activities. The *mutuas* seem to favour individual medical checks at the expense of collective prevention. Also, since 1994, the *mutuas* have been increasingly involved in the management of incapacity for work due to ordinary diseases or accidents as a result of the privatization of certain social security activities[38]. The *mutuas'* preventive health and safety role and their role in absence controls are very apt to be in conflict, the more so as they are run entirely by the employers[39]. On top of that, the choice of a particular *mutua* to insure against work-related risks is purely the employer's decision, when that choice also to some extent dictates the preventive service chosen, because an employer who is affiliated to one *mutua* as his

[38] The workforce covered by the *mutuas* for the management of "ordinary" incapacity is estimated at 8.1 million in 2002 against 1.1 million in 1996, and 5.4 million in 1999 (*Gara*, 19 February 2003).

[39] A tripartite agreement reached in December 2002 provides changes to give the trade unions a role in running the *mutuas*.

insurance company cannot enlist the preventive service of a different *mutua*.

What Spain and the Netherlands share is having combined a market-driven approach with an insurance approach in which prevention is focussed on the highest short-term cost items.

In Spain, this insurance approach is supported by the *mutuas* which have set up most of the external preventive services and have now set out to capture new markets in the public health system[40]. In financial terms, workplace prevention is little more than a marginal activity for mutual insurance organizations (barely over 2% of their 2002 spend[41]), so it would be hardly surprising to find the organization of preventive actions governed by other priorities than occupational health.

In the Netherlands, services have generally come about in a different way, through the gradual transformation of inter-company occupational medicine services. But the insurance approach was given impetus by government policies which made cutting the absence rate the main political priority of workplace health reforms. In both cases, employers' direct demands clearly take precedence over a long-term prevention policy. But there is one difference. In the Netherlands, strong pressure from the employers to cut absence rates (which represents a high direct cost for them) has resulted in major perversities like health-based recruitment (greatly aided by contingent employment) and individual-focused rehabilitation and resumption of work which hardly goes back to the root causes of ill-health. In Spain, employers are mainly concerned to protect themselves against legal controls or proceedings: all efforts are focused on creating the impression of a working prevention policy, while in practice, preventive services are confined to what least affects work organization: individual medical examinations, boiler-plate risk assessments which have no bearing on reality, grandiose prevention plans that are never implemented (prevention plans may even simply be photocopied from firm to firm!).

Arguably, the Spanish and Dutch experiences are only the distilled expression of pan-EU trends. Sweden presents certain similarities, notwithstanding its different labour relations and public occupational health policy contexts.

Undermined and in a crisis of legitimacy

Changing patterns of work and the new approaches to prevention laid down by the Framework Directive have to some extent undermined preventive services from the outside.

The Framework Directive rightly focuses on the central responsibility of the employer. It gives him a strict duty to ensure health and safety and lays down a precise hierarchy of preventive measures. It also sets a very wide scope for preventive activities: work equipment, chemical substances, work organization, labour relations, eliminating monotonous and repetitive work, etc. It stresses the importance of participation by workers and their organizations in preventive activities. All these factors dramatically change the traditional role of preventive services. They entail a series of big changes in the preventive approach from tailored "risk by risk" technical or medical responses to an overall socio-technical approach which embraces all the things that make up work organization and the interaction between them. It holds out new prospects for prevention specialists, but at the same time puts question marks over the traditional foundations of their legitimacy as regards employers. Employers' readiness to admit the legitimacy of purely technical or medical expertise for specific risks (which is not the same as fully accepting its conclusions) is matched by their unwillingness to accept a critical analysis of all aspects of their management based on the dictates of workplace health. The case history reported in the box (see previous page) may seem anecdotal, but it is indicative of the way many prevention specialists are undermined.

Also, changes in the world of work are contributing to undermine preventive services. The spread of casualization, wholesale use of subcontracting, creation of inter-worker rivalries that set workers against one another are all imperative reasons for getting away from a technical approach and getting to grips with the firm's strategic choices. Against this background, employers are trying to downgrade the preventive service function to a sort of damage-limitation social support, focused on improved induction and training, coordinating certain preventive activities, etc. But that support function is not enough because it cannot challenge the deregulation of work that this onslaught on the work sphere by unbridled commercial competition represents.

[40] See F. Rodrigo Cencillo, Presente y futuro de las Mutuas de accidentes de trabajo y enfermedades profesionales de la Seguridad Social, *Cuadernos de Relaciones Laborales*, No. 14, 1999, pp. 69-97.

[41] According to J. Basterra ("Las mutuas controlan al 73% de los trabajadores ocupados", *Gara*, 10 June 2003), out of a total 2003 budget of € 7,143.4 million, 70% goes to compensating incapacity for work and other insurance benefits, 14.1% to health care, 7.2% to asset administration, 6.6% to administrative expenditure, and just 2.1% to workplace preventive activities.

Where an activity is contracted out at least cost, an induction meeting on health and safety can easily turn into disingenuous lip-service. At worst, the prevention specialist is being asked to help tighten the stranglehold on subcontracted workers by specifying requirements that they cannot possibly meet.

Generally, the following conclusions can be ventured. The employers' first strategy was mainly one of evasion, digging their heels in and opposing the Framework Directive's new reforms on the grounds of cost or curbing competitiveness. This was essentially a defensive strategy in that it had nothing new to offer but simply blocked change. Then the employers changed tack and counter-attacked by taking up arms on a number of new issues, admitting, to some extent, the deep-reaching crisis in preventive systems. The central plank of this new strategy is to lock workplace health into a framework which makes it completely subservient to their business objectives and raises the workplace drawbridge against all outside control. So it does not necessarily need to hold out against all reforms. This about-turn makes workplace health instrumental in consolidating the company pecking order, the dominance of customer firms over their subcontractors, and shuts the public authorities out of the "private" sphere of economic activity. Granted, neither of these two strategies is pursued all-out, but they can be found in combinations that vary with the specific features of the different national labour relations systems. What gives a measure of effectiveness to the employers' arguments is the real difficulty that the other parties (trade unions, public authorities) have in coming up with effective proposals for overall reform of prevention.

This brief overview gives the backcloth to a crisis in preventive services. But it is also an opportunity for the trade union movement to forge alliances with prevention specialists to work out a new joint strategy. It is a monumental challenge: can the preventive services continue to make an effective contribution to workers' struggles to stay healthy? ■

Suggested trade union priorities

The European Commission is due to submit a report this year on how the Framework Directive is being applied in the different member states. Trade unions will be looking to use the discussions on this report to renew the debate on preventive services. It may be helpful to set some priorities for that. The following suggestions are offered to set the debate rolling.

1. Ensure that all workers are covered by preventive services.
2. Ensure that service work on a multidisciplinary basis. This means that regulations as well as approval or control systems must lay down a clear, minimum level of professional skills. That means that prevention experts with different areas of expertise (occupational medicine, safety, industrial hygiene, ergonomics, psychology, etc.) must act on a regular basis as part of a unitary service, ensuring that their activities complement one another within an overall approach.
3. Coherent multidisciplinary working means creating a real two-way exchange between the expert knowledge of prevention specialists and the collective knowledge, priorities and insights of workers. This receptiveness to knowledge which generally goes unrecognized either by the different disciplines or the social division of labour in the firm is vital.
4. Ensure that company services and external services enlisted to provide expertise which the company service lacks work hand in glove. Particularly to be avoided is any buying-in of prevention activities as insurance against prosecution or to procure a compliance certificate.
5. Ensure that activities are prevention-centred and follow the hierarchy of preventive measures. That in particular means no short-termism aimed at cutting business costs more than improving working conditions. The lessons of countries where reducing absence rates is given top priority shows the real risk that exists of turning preventive services into health-based recruitment or policing services.
6. The linkage between preventive management by the employer and preventive service activities is a key issue for seeing that prevention criteria are given maximum importance in the general running of the business, but that they are not set in self-limiting terms that simply square with management's business objectives on all points.
7. Define health surveillance criteria that link in more effectively with prevention and avoid deflections of the system like genetic testing or more use of predictive medicine.
8. Ensure that prevention specialists are independent of the employer through effective protection measures (against dismissals in particular).
9. Provide continuing training and facilitate links between prevention personnel and research institutions.
10. Set up procedures for workers' representatives to oversee their activities. If external preventive services are used, strengthen the links between the workers' representatives in the user firms and the union representatives in the inspection bodies that cover these services.
11. Set up procedures for public control of these services, especially through approvals. Quality criteria must be set that allow for the public interest goals of these services and conflicts of interest between the ostensible customer (the firm) and the final user (the workers).
12. Ensure that prevention experiences are collectivised through a public occupational health policy.