Transposition, implementation and enforcement of EU OSH legislation

Copenhagen, Denmark, 19-20 June 2018

Thematic Discussion Paper

DG Employment, Social Affairs and Inclusion

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Executive summary

EU OSH legislation consists of 24 linked Directives (a Framework Directive and 23 individual Directives). Although there are other measures that impact on health and safety at work (such as the Working Time Directive and REACH) these 24 form the basis for a framework of OSH legislation that has been consistently reflected in national legislation across the EU. It appears therefore that the first hurdle, that of transposition of the EU OSH acquis into national legislation, has been successfully achieved.

Although not uniform across employers (with evidence that smaller businesses in particular find some of the demands challenging and difficult to implement) indications are also that the transposed legislation is being implemented within workplaces. However, there are indications that the fact of implementation is not necessarily a true indicator of the quality of that action, with suggestions that 'compliance' is to some extent a paper exercise and is not always reflected in real improvements in working environments.

Although many national authorities have well-developed programmes relating to improving health and safety at work, targeting specific problems in a focussed manner, what (limited) evidence there is suggests that enforcement, accompanied by the threat (and use where appropriate) of legal action is the most effective tool. However, accounts across the EU suggest that ongoing budget constraints have had a considerable negative impact on the extent of such activities, although national bodies have strived to mitigate this by ensuring that their enforcement activities are focussed as much as possible on where they are believed to be most required (or likely to have the most impact). The implicit assumption is that such efforts provide the most efficient and effective use of resources.

1 Policy context –the legal and policy framework of the EU in relation to OSH

OSH legislation within the EU is based around the Framework Directive (Directive 89/391/EEC) and the 23 individual Directives that stem from it. Collectively they provide a common basis for occupational health and safety management within the EU Member States. The ex-post evaluation of these 24 Directives found that, although the manner of their transposition and adoption into national legislation varies, they provide the reference frame for national legislation throughout the EU. The evaluation found that each of the provisions from all of the Directives had been transposed into national legislation, with the exception of those Directives (specifically the electromagnetic Directive - Directive 2004/40/EC) where the deadline for transposition had yet to be reached.

Underpinned by European strategies on Safety and Health at Work (such as that for 2007-2012)[1] this therefore provides for a common legal and policy framework in relation to OSH throughout the EU[2].

Within the Commission, the Advisory Committee on Safety and Health at Work, established through Council Decision 2003/C 218/01, has, as a fundamental remit the task of "…assisting the Commission in the preparation, implementation and evaluation of activities in the fields of safety and health at work." (Article 2). This tripartite committee therefore provides a channel whereby the social partners can have some influence on the work of the Commission, including presumably the development of new OSH legislation. It provides authoritative opinions and assistance (including for example providing oversight of the ex-post evaluation of the OSH Directives) although it is not known how influential its advisory role is in impacting the outcome of such assistance.

Formulated within the Framework Directive, each Directive is built around a series of so-called Common Processes and Mechanisms (CPMs) that ostensibly provide a common skeleton to OSH management. As noted in the ex-post evaluation the CPMs include requirements for employers to conduct risk assessments; provide preventive and protective services; present information to workers regarding the risks and control measures; provide workers with training on how best to work to minimise risks to health and safety; conduct consultation with workers; and provide workers with health surveillance. Although not always obvious within individual Directives these CPMs are repeated to a varying extent within the 23 individual Directives, which add key requirements pertaining to the specific hazard, workplace, or group of workers within the Directives' scope. It is interesting to note that, although it is a requirement of each Directive, the requirement to remove, reduce or manage risks is not explicitly stated as one of these CPMs. During the ex-post evaluation it was explained that this was regarded as an implicit feature of this CPM. This lack of specificity can be a failing as it can lead to a focus on risk assessment, rather than the subsequent management of any risks identified.

However, the commonality of these threads is not always appreciated by employers who, for example, don't see a need for a common risk assessment with different threads (depending on the relevant risks) as envisaged, but instead see each Directive imposing the burden of a need for 'yet another' risk assessment. It could be argued that this is a 'failing' on the part of MSs who failed to implement national legislation in a manner that drew out these CPMs (although some did introduce specific legislation on, for example, the consultation of workers). However, while this might have been a straightforward process had the OSH Directives been released as a single 'package'

[1] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - Improving quality and productivity at work: Community strategy 2007-2012 on health and safety at work

[2] It is assumed here that Croatia, the most recent EU accession state, that did not feature in the ex-post evaluation, has (or will have) a similar regulatory provision.

emphasising this connectivity, the gradual process of publication resulted in national legislation being introduced in an equally piecemeal fashion.

Although in many cases the individual Directives share a recognisable common structure (especially those addressing various physical agents), the ex-post evaluation noted a dichotomy in approach between them. Thus, some Directives (including the Framework) present a goal-orientated legislative approach that requires individual Member States to identify the most suitable means to achieve the aims of the Directive. In contrast, others (for example the Display Screen Equipment Directive, DSE) adopt a much more prescriptive approach, specifying the means to be applied in achieving the intended aim. One of the potential consequences of this (as exemplified by the DSE Directive) is that, where approaches or technology change the prescription lags behind.

Most of the Directives have remained unchanged in recent years. Perhaps the most prominent exception to this is that on Carcinogens or Mutagens (CMD) (Directive 2004/37/EC) where a number of amendments have been published (including since the ex-post evaluation) to add further substances to those already covered[3]. This reflects one of the recommendations from the ex-post evaluation of the CMD that adding additional substances should be considered.

Another Directive subject to change is that relating to Electromagnetic Fields which has been 're-issued' on a number of occasions and, at the time of the ex-post evaluation, the current version (Directive 2013/35/EU) had yet to be implemented (with a date for compliance of 1 July 2016). This uncertainty and change with this Directive was reflected in the ex-post report that questioned the evidence for a general risk arising from EMF exposure (as opposed to those already identified and apparently adequately controlled, such as those relating to MRI scanners). The report recommended reconsidering the necessity for this Directive.

Data for the EU-15, presented as part of the ex-post evaluation of the Framework Directive, showed a notable downward trend in both fatal and non-fatal accidents from 1998 to 2012. However, this and the reports on the other individual Directives generally emphasised that, where there was such a trend, it was not possible to determine how much (if any) of that improvement was attributable to the implementation of the Directives. This was particularly the case for health-related impacts where a general theme of inadequate and insufficient data emerged, even for diseases such as Hand Arm Vibration where a clear connection to work factors could be demonstrated. Other difficulties arise where legislation other than the OSH Directives impacts on an issue. Thus, the REACH legislation[4] makes any impact of the CAD on occupational ill-health relating to exposure to chemicals difficult to establish (exacerbating the lack of appropriate ill-health data).

Since the publication of the ex-post evaluation report, more recent Eurostat data shows that, for the whole EU, the incident rate (per 100,000 workers) of non-fatal accidents has decreased slightly (1,575.91 in 2012 to 1,513.02 in 2015 across the whole EU).

[3] COM(2016) 248 final of 13 May 2016, Proposal for a Directive of the European Parliament and of the Council amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work.
COM(2017)11 final of 10 January 2017, Proposal for a Directive of the European Parliament and of the Council amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work.
COM(2018)171 final of 5 April 2018, Proposal for a Directive of the European Parliament and of the Council amending Directive 2004/37/EC on the protection of workers from the risks related to exposure to carcinogens or mutagens at work.

[4] Regulation 1907/2006 of the European Parliament and of the Council of 18 December 2006 on the Registration, Evaluation, Authorisation and Restriction of Chemicals.

However, the absolute number of such accidents has increased. This applies for the whole of the EU, the EU-27 (addressed by the ex-post evaluation) or the EU-15.[5] Thus, in 2015 (the most recent year for which data are available) there were 3,211,956 such accidents compared to 3,165,414 in 2012.

The same source shows that fatal accidents appear to have levelled out in recent years, with 1.8 (per 100,000 workers) in 2013, 1.83 in 2014 and 1.83 in 2015. Again the absolute numbers have increased, with nearly 4,000 workers (3,876) losing their lives at work in 2015.

Exploring workplace health issues is problematic because of a lack of quality data, with a strong reliance on self-reported data from sources such as the Labour Force Survey (LFS) and the European Working Conditions Survey (EWCS). Both of these have the limitation that they only explore a limited number of health issues. Two generic areas of ill-health that are examined by the LFS are 'musculoskeletal disorders' (MSDs) and 'stress, depression and anxiety'. The latter area of concern, the second highest cause of work-related ill health according to the LFS, is not encompassed by any explicit EU regulation (although arguably covered by the Framework Directive) although a number of Member States do have relevant legislation. MSD risks (the highest cause of work-related ill-health) are covered by two Directives (Manual Handling and Display Screen Equipment) although there are recognised gaps in relation to other sources of MSD risk. In both cases, although there are considerable difficulties in making any attributions to the provisions of the Directives, the ex-post evaluation reports expressed considerable doubt as to whether either Directive had produced any real effect in reducing the incidence of MSDs.

The ex-post evaluation of the manual handling Directive reported that the 2010 EWCS survey showed that almost a half (46.8%) of respondents reported suffering from 'backache' in the last 12 months. Although this figure gives no insight into likely causes of such backache it is interesting to note that a cross-analysis comparing the proportion of time spent either in carrying or moving heavy loads, or in lifting or moving people, showed a clear, positive relationship with reported backache, strongly suggesting that manual handling activities remained relevant.

Against this background, a relatively recently published EU-OSHA article (2017) commented that:

> "…work-related accidents and illnesses cost the EU at least EUR 476 billion every year. The cost of work-related cancers alone amounts to EUR 119.5 billion."[6]

It is clear therefore that work-related accidents and ill-health remain significant and costly issues within the EU. The overall indications from the evaluation of the 24 OSH Directives are that, although there does appear to have been an overall reduction in the rates of both fatal and other accidents, it is difficult to determine the extent to which (if at all) this can be attributed to the influence of the OSH acquis. For work-related ill-health the picture is even less clear due to inadequacies in the underlying data that make it impossible to determine attribution of ill-health to any specific risks and therefore similarly impossible to establish the extent to which any change may or may not be attributable to the provisions of the OSH Directives.

Acquiring better quality, more comprehensive data across the EU relevant to work-related ill-health and the risks to that health presents a major challenge to be faced.

Although the 24 OSH Directives provide the legal basis for related activity within the EU, such activities should also be considered in relation to other EU-level actions that

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[5] Non-fatal accidents at work by NACE Rev. 2 activity and sex. http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hsw_n2_01&lang=en

[6] EU-OSHA (2017) An international comparison of the cost of work-related accidents and illnesses. https://osha.europa.eu/en/tools-and-publications/publications/international-comparison-cost-work-related-accidents-and

influence policy, such as the series of EU OSH strategic frameworks (most recently that for 2014-2020[7]) and the European Pillar of Social Rights[8].

The strategy identifies three major health and safety at work challenges:

- to improve implementation of existing health and safety rules,
- to improve the prevention of work-related diseases,
- to take account of the ageing of the EU's workforce.

It further proposes seven strategic objectives aimed at addressing these challenges, including policy coordination; improving enforcement; and simplifying existing legislation.

In recognition of a need for better data, one specific strategic objective was to "Improve statistical data collection and develop the information base". If the identification of problem areas and, importantly, monitoring or assessing the impact of actions taken to mitigate those problems is to be carried out systematically and objectively then such data is essential.

As its name suggests, the scope of the European Pillar of Social Rights is much wider than workplace health and safety. However, 'Healthy, safe and well-adapted work environment and data protection' is one of the 20 principles enshrined within the Pillar, helping to ensure that workplace OSH and the protection of the health and safety of the workforce is seen in a wider context.

2 Transposition and implementation of EU OSH legislation in Member States

2.1 Transposition

Responsibility for the transposition of the provisions of the 24 OSH Directives into national law in Member States clearly rests with the legislative body concerned within the national government. Although there might have been some consultation with other parties there would clearly be distinct legal liabilities in ensuring adequate transposition (and in responding to claims of failing to do so). Adhering to the provisions of each Directive would not allow much room for manoeuvre over legal issues. Naturally there is a more complex picture in those Member States where responsibility for legislation in different sectors varied, requiring different legislation to be introduced or where there are specific responsibilities in devolved countries/regions. For example, in the UK, Northern Ireland has its own legislature and therefore requires the development of separate legislation (although, as can be expected, this 'borrows' significantly from that for the rest of the UK). In some other Member States (e.g. Denmark) different legislation has been necessary to implement the provisions of some Directives in different sectors (e.g. offshore, air transport).

The ex-post evaluation of the EU OSH Directives[9] and the subsequent Commission staff working document (REFIT)[10] found that there were few instances of the complete non-transposition of specific individual Directives, and that all had transposed the Framework

[7] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions on an EU Strategic Framework on Health and Safety at Work 2014-2020. COM(2014) 332 final. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52014DC0332

[8] https://ec.europa.eu/commission/sites/beta-political/files/social-summit-european-pillar-social-rights-booklet_en.pdf

[9] Commission staff working document: Ex-post evaluation of the European Union occupational safety and health Directives (REFIT evaluation). Brussels, 10.1.2017. SWD(2017) 10 final.

[10] Evaluation of the Practical Implementation of the EU Occupational Safety and Health (OSH) Directives in EU Member States. Main Report. November 2015

Directive and most (if not all) of the individual Directives that build on this. Many of the omissions related to Directives that were irrelevant to the Member State (specifically the vessels Directives that were recognised as being of no value to land-locked MSs that do not have ships sailing under their flags). At the time of the ex-post report another major area was the Electromagnetic Fields Directive that had yet to reach its time limit for transposition (although this has since passed).

A number of infringement proceedings were found to have been instigated by the European Commission, although many of these were on administrative technicalities (e.g. the late notification of measures taken, as in 9 of the 10 actions relating to the Vibration Directive) rather than substantive breaches. Almost half of the total (78) related to the Framework Directive – a fact that was seen as reflecting the challenges sometimes experienced in transposing this legislation. One particular area of difficulty cited related to the inclusion of the public sector within the scope of the legislation, possibly reflecting situations in some Member States where public sector employees are covered by separate national legislation. Reports on individual Directives indicated that most proceedings, especially those relating to administrative infringements, had been resolved and closed. In essence therefore, it appears that most of the provisions of the 24 Directives have been transposed into national legislation.

Details of their transposition and subsequent implementation vary between Member States. In 22 of the 27 Member States examined, national legislation reflects a common structure where the main principles and requirements, principally from the Framework Directive, are transposed in one single piece of legislation. However, this was not necessarily new legislation as a number of Member States already had suitable legislation in place, sometimes requiring relatively simple amendment to correctly align it with any new requirements introduced by the EU OSH Directives. In other Member States, although they had existing OSH legislation in place, the opportunity was taken to review and revise this, permitting a rational overhaul of legislation that had perhaps been developed over a long period of time. One such example, identified in national investigations, was that of the UK where, although not carried out prior to the promulgation of the mining Directives, it was indicated that the opportunity would be taken to review and revise the extensive national legislation on coal mining to prepare new legislation, taking the Directives as a guide. Also in the UK, the CAD and CMD have been combined into a single legislative framework, rather than maintaining the distinction of two separate pieces of legislation.

As noted above, many Member States already had OSH legislation in place, and so the transposition of the OSH Directives did not necessarily have a significant immediate impact on the level of protection provided to workers in these Member States as a result. In Denmark, for example, transposition of EU OSH Directives has mostly:

> "…as been a matter of technical adjustments of the Danish law, as EU Directives not often add new provisions to existing regulation." (Getting in tune, Host country paper).

A similar position prevails in Ireland where, although the opportunity was taken to update the relevant legislation, this involved little substantive change to existing duties. Naturally there are exceptions to this – such as where Directives (and therefore national legislation) imposed specific often prescriptive requirements (such as eyesight testing under the DSE Directive). However, there were no fundamental changes to how OSH legislation was implemented and enforced.

However, as the evaluation report on the earlier strategy (2007-2012)[11] and the subsequent Staff Working Paper[12] found, this strategy had been influential in a number

[11] Evaluation of the European Strategy on Safety and Health at Work 2007-2012. Final Report

[12] Commission Staff Working Document. Evaluation of the European Strategy 2007-2012 on health and safety at work. SWD(2013) 202 final

of Member States in driving the national agenda and raising the political profile of OSH. In new EU states in particular, although it would be difficult to provide tangible statistical evidence, the impression was that the strategy, and the legislative framework provided by the OSH Directives, provided more impetus for change and therefore a greater enhancement of worker protection than might be the case in other Member States.

The Directives present minimum requirements, specifically providing for individual Member States to enact more stringent requirements as they saw fit. The main report on the ex-post evaluation of the Directives presents a summary of these, with some more detail given in the individual Directive reports. Amongst the variations commonly adopted were:

- a considerable number of Member States have set more stringent limits for some substances, or have limits for substances for which there is no EU limit with respect to the Chemical Agents Directive (17/27) and the Carcinogens or Mutagens Directive (8/27).
- eleven Member States have broadened the definition of a 'worker' in the Framework Directive to encompass domestic servants.
- four Member States have not adopted the restriction of the applicability of the Use of PPE Directive that excludes workers in the emergency or rescue services.

In some cases, more detailed requirements relate more to aspects of administering the legislative requirements rather than substantive content. For example the ex-post report on the DSE Directive found that some Member States had introduced a specific requirement in terms of who should carry out the risk assessments required under the terms of the Directive. Another frequently encountered element in the same Directive was for the Schedule (of minimum workstation requirements) to the Directive to be incorporated into the primary legislation.

In this regard, the suite of OSH Directives can perhaps be seen, not strictly to have created the much vaunted 'level playing field' but to have smoothed it by filling in the troughs (but leaving at least some peaks).

Details in the manner of transposition can be considered to largely reflect differences in the structure of national legislation. Thus some Member States considered it necessary to introduce separate secondary legislation on one or more of the CPMs, rather than seeing them as a common strand throughout. This was particularly applicable for the need for health surveillance (14/27) and the provision of preventive and protective services (8/27). Other exceptions apply in respect of those Directives concerning young persons[13] and pregnant workers[14] where the requirements of the Directives are perhaps more wide-reaching than occupational health and safety.

It would appear that, in most (if not all) EU Member States, the body (or in some cases bodies) responsible for implementation has played a major role in the drafting of the national legislation. This helps to ensure not only the accurate transposition of the EU Directives (there were relatively few instances identified of actions brought by the EU for incorrect application or interpretation of the Directives) but also that any resultant new national legislation was fully and correctly integrated with the existing national OSH legislative framework. It also serves to ensure a high level of continuity between transposition of the EU Directives into national legislation and the implementation of that legislation. This largely avoids any challenges that might otherwise arise.

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[13] Directive 94/33/EC on the protection of young people at work (young people)

[14] Directive 92/85/EEC on the introduction of measures to encourage improvements in the safety and health of work of pregnant workers and workers who have recently given birth or are breastfeeding

2.2 Implementation and enforcement

In the same way as the manner of transposition varies between different Member States, so do the arrangements for implementation and enforcement. Thus, in some Member States, not only does legislation covering different sectors require different legislative action but policing and enforcement of the implementation of that legislation falls under a different government body or department. In some instances this relates to specific sectors (e.g. mining, agriculture and/or fisheries) in others it reflects a divergence between, for example, the governance of the public and private sectors. Other differences arise in some Member States with a federal structure of government, where responsibility for occupational safety and health (and consequently enforcement) is devolved to those federations. For example, in Germany, enforcement of OSH is, in general, delegated to the Federal States. In addition, there are special authorities for the mining and seafaring industries. The public authorities of the Federal Government are supervised by the UK Bund, the Statutory Accident Insurance Body of the Federal Authorities. Further inspections are carried out by the technical inspection services (TAD) of the Accident Insurance Bodies which supervise and advise each accident body's member companies.

Other differences between Member States over implementation and enforcement can also be identified. For example, in the UK, Local Authorities, rather than the centralised Health and Safety Executive, enforce health and safety issues in some sectors (retail, wholesale distribution and warehousing, hotel and catering premises, offices, and the consumer/leisure industries). In contrast, in Ireland, the Health and Safety Authority (HSA) is the sole enforcing agency under the Safety, Health and Welfare at Work Act 2005 and the associated health and safety laws. However, one exception to this is maritime health and safety enforcement that comes under the responsibility of the Irish Maritime Administration - IMA). For fishing vessels there is a shared responsibility, with the HSA enforcing occupational health and safety legislation whilst the IMA enforces maritime safety legislation.

In Denmark enforcement is part of the role of the Danish Working Environment Authority (DWEA).

By and large, the systems for coordination in place in different Member States have evolved and been refined over a period of time and appear to have been found to work. Certainly, no information became apparent during the ex-post evaluation to suggest anything to the contrary. Specifically, when questioned (as part of the preparation of the ex-post evaluation Country Summary Reports) experts in the various Member States would generally indicate good coordination and cooperation between the legislative and enforcing authorities.

Given that the main driver determining the content of the national legislation implementing each Directive was the content of the Directive itself, there were no real examples identified during the ex-post evaluation report of significant changes to most of the relevant legislation once introduced (through any system of feedback). Exceptions to this would probably mainly arise in relation to chemicals and carcinogens where national limits were sometimes made more stringent (they could not be less stringent than those defined in the Directive) or limits were introduced in respect of other substances. This was in part a manifestation of the widely held belief that the system for updating these Directives was excessively slow and cumbersome.

Although substantive changes to primary legislation might be unusual some Member States would make use of issuing advice or guidance as a means of 'steering' the interpretation of specific elements of the legislation where uncertainties emerged. This could have the benefit of improving compliance through a better understanding by employers of what was required of them – and how to carry that out.

It seems that, within MSs, feedback on problems in understanding and implementing their OSH duties on the part of employers (possibly identified during enforcement

inspections) leads to a clarification of those duties (perhaps through the development of guidance or application tools – such as the BeSMART tool in Ireland) rather than any change to the underlying primary legislation. This is probably a function of the desire by MSs to remain in line with EU legislation and a consequence reluctanc to change national legislation once that has been accepted as compliant.

At an EU level, the Senior Labour Inspectors Committee (SLIC) appears to provide a useful forum for the exchange of information and approaches to implementation and enforcement, as demonstrated by the numerous publications of guidance and other material relating to specific OSH issues. The objectives of this committee (as defined in Article 3 of the Commission decision establishing it (95/319/EC)), presents a clear picture of cooperation and communication. However, these terms of reference are very practically orientated and it is not known what (if any) influence SLIC has been able to exert on emerging legislation.

The REFIT evaluation working document cited evidence from the ESENER-2 survey identifying a number of the reported main drivers amongst establishments for addressing health and safety issues and therefore compliance with the Directive-based legislation. Not surprisingly perhaps, complying with legal obligations emerged as the main reason, followed by meeting expectations from employees or their representatives and avoiding fines from the labour inspectorate (which was seen as further reflecting the desire to meet legal obligations). The ex-post evaluation project found compliance with the various CPMs varied from 'poor' (40-59% reported compliance in some Member States for consultation with workers) up to 'good' (75-89% reported compliance) for 'prevention and protective services' and 'information for workers'.

On risk assessments (judged to vary from moderate to good) the REFIT report cited material from ESENER-2 showing compliance in different Member States ranging from around 38% (Luxembourg) to almost 95% (Italy and Slovenia)[15]. The low rate of compliance for Luxembourg might in part be due to the suggestion in the Country Summary Report that:

> "While risk assessment is required under the legislation for all types of works, risk assessments are carried out systematically only for highly risky works in practice. In other cases, risk assessments are only carried out following a request from the ITM, occupational doctors or business federations."[16]

Thus, not all employers are required to carry out a formal systematic assessment.

Sounding a note of caution however, the ex-post evaluation report included a comparison of levels of compliance as reported through ESENER-2 with compliance levels as determined via national experts. Although not all of the ESENER-2 countries were included, the comparison found that the ESENER-2 data for the 24 Member States examined consistently suggested higher compliance levels. It was suggested that there was a tendency towards over-reporting of compliance in ESENER-2 (an alternative explanation, although seemingly unlikely, is that the separate experts consulted in each country were all overly pessimistic on this issue).

However, a note of caution sounded in some Member States during the ex-post evaluation was that 'compliance' as assessed by Labour Inspectors during site visits primarily focussed on more administrative aspects. Thus, in the Country Summary Report for Belgium it is indicated, for example, that:

> "…inspectors are bound to limit their assessment of compliance to the fulfilling of tasks of administrative character (i.e. presence of documents attesting that a

[15] Self-report in response to the question: 'Does your establishment regularly carry out workplace risk assessments?' https://osha.europa.eu/DVS/import/questionnaire/Questionnaire_EN.pdf

[16] Ex-post evaluation Country Summary Report for Luxembourg. June 2015

> risk analysis has been conducted, that companies established or are affiliated to appropriate prevention and protection services, etc.)".[17]

Similar issues of paper 'compliance', at least in respect of some Directives, were raised in the reports from other Member States including Bulgaria, Germany and Latvia. In the latter Member State, the ex-post evaluation Country Summary Report cited a national study. This found that, although survey data shows that regular risk assessment had been carried out in 48% of companies, a risk assessment that was followed by measures to improve working conditions and management activities was less frequently reported, with 29% of companies doing a risk assessment followed by setting up of action plan. This could imply a tendency to focus on the administrative recording of a risk assessment, seeing such an assessment as an end in itself, rather than seeing it as a means to the end aim of reducing or removing risks identified and thereby improving health and safety. This might, as an example, be seen in the availability in Ireland of 'off the shelf' safety statements, available for purchase on-line, with the attendant concern that this leads to completion of a paper that bears only a limited resemblance to actual working conditions (and risks).

Perhaps the biggest issue relating to compliance reflects the widely held concerns amongst the EU Member States that small and medium-sized enterprises (SMEs) and micro-establishments experienced difficulties in meeting the challenge of compliance with OSH legislation. The ex-post evaluation reported that almost three-quarters (74%) reported this with a wide variety of reasons given including:

> "A lack of established OSH traditions, lack of managerial experience, lack of information, knowledge and training in SMEs, lack of equipment, lack of financial resources, lack of time, that SMEs are bombarded with excessive and fragmented information, that Directives are open for interpretation or lack clear direction, little synergy between the current implementation of Directives, excessive administrative burdens etc."

This was demonstrated by graphical illustrations of the extent of the impact of the Directive in different-sized organisations, with ratings from different stakeholder organisations (on a scale of 1-5) ranging from between 2.0-2.5 for micro-organisations to 4.0 for large enterprises.

Interestingly however, despite these challenges, the REFIT report presents data from ESENER-2 indicating that the predominant reasons for not regularly carrying out workplace risk assessments, regardless of the size of the establishment, are that the hazards and risks are already well known, or that there are no major problems (rather than citing a lack of expertise or other burdens). In some Member States, such a view is enshrined in the national legislation. For example, in the UK, risk assessments have to be redone if, as expressed in the UK 'umbrella' Directive: "there is reason to believe that it is no longer valid; or there has been a significant change in the matters to which it relates."[18] Thus, there is no specific requirement for them to be redone in any time-frame. Similar conditions apply to other Member States (e.g. Ireland). Others however specify a time-frame for repeating such assessments (e.g. annually in Latvia).

One Directive that has perhaps been more extensively studied than some is the Display Screen Equipment (DSE) Directive (Council Directive 90/270/EEC). This presents an interesting illustration of the challenges over the assessment of 'compliance'. Although this illustration is drawn mainly from experience in the UK, observations in other Member States and references in published reports (see the ex-post report on the DSE Directive) suggest that 'compliance' is assessed primarily through establishing conformance to the Annex of minimum requirements. Put bluntly, the schedule is the equivalent of the list of ingredients for a recipe (e.g. for a cake). It says nothing about

[17] Ex-post evaluation: Country summary report for Belgium. June 2015

[18] Management of Health and Safety at Work Regulations 1992

how those ingredients are to be put together to create a successful cake. In offices, workstation assessments reflect this, rarely considering whether or not the items required (e.g. a chair with adjustable features) are correctly assembled to suit the individual user.

This creates a potential challenge to employers because correctly implementing the Directive requires an assessment of every individual user. Further challenges arise in offices where shared workstations (hot-desking) are used as it is then arguably necessary to assess each use of that workstation.

Experience has shown that a correctly integrated approach (including meeting information and training requirements) can reduce the burden, as this should mean that individuals are largely able to set up their own workstation correctly, with the assessment simply confirming this (or providing assistance where this has not been possible).

3 Enforcement of EU OSH legislation in Member States

The process of enforcement in the different Member States is best summarised by quoting an extensive extract from the ex-post evaluation report.

> "The body competent for OSH inspections varies from one Member State to another depending on the institutional setting of the country. As a rule, the Labour Inspection is the main responsible authority (AT, BE, BG, CY, CZ, DE, EE, EL, ES, FR, HU, IT, LT, LU, LV, NL, PT, RO, SE, SI), or the main authority falls under the Ministry of Health (OSH inspectorates under the Ministry of Social Affairs and Health in Finland), or there is an autonomous authority dedicated to OSH (the Health and Safety Authority in Ireland and the Health and Safety Executive in the UK). In Poland, the enforcement responsibilities are shared between the labour and health authorities (the National State Labour Inspectorate and the State Sanitary Inspectorate). In Slovakia, while the National Labour Inspectorate is responsible primarily for safety aspects, the Public Health Authority is the main enforcement authority in relation to the chemical, biological and physical agents Directives.
>
> In two countries, the institutional setting is specific. Denmark has a rather atypical setting whereby responsibilities are distributed among the Danish Working Environment Authority, under the auspices of the Ministry of Employment, for work environment on land; the Danish Maritime Authority at sea; the Danish Energy Agency for offshore installations and the Danish Transport Authority for the civil aviation. In Malta, the main authority in charge of OHS legislation enforcement is the Occupational Health and Safety Authority OHSA under the authority of the Ministry for Social Dialogue, Consumer Affairs and Civil Liberties.
>
> In most Member States, specific authorities are responsible for certain Directives to varying degrees. This is typically the case with mineral-extracting industry Directives, vessels Directives, chemical agents Directives and sometimes vulnerable workers Directives. Other specific aspects, e.g. fire safety, may be covered by other inspection bodies.
>
> For instance, in Slovenia, the Energy and Mining Inspectorate is in charge of mining operations and underground construction works using mining operation methods and the inspectorate competent for protection against natural and other disasters supervises the implementation of fire safety, rescue and evacuation measures. In Sweden, while the only authority in charge of OHS legislation enforcement is the Swedish Work Environment Authority, the Swedish Transport Agency supervises all shipping vessels, including working conditions on ships/vessels.

> These authorities can be the only ones responsible for enforcement or share responsibility with the main authority in charge of the enforcement of OSH legislation. One example is the ATEX Directive in Finland, whereby the Finnish Safety and Chemical Agency is the enforcement authority while the OSH Inspectorates within the Regional State Administrative Agencies (Ministry of Social Affairs and Health), are responsible for all the other risks, workplaces and group of workers.
>
> Even when there is no specialised inspection for certain sectors or issues, for several Member States, specialised units within the enforcement body deal with particular sectors, risks or groups of workers. For instance, Austria has labour inspectors dedicated to specific tasks or groups of workers, such as protection of young workers, construction sites, pregnant and breastfeeding workers and workers in the catering industry.
>
> Most of the time, there is a combination of generic and specialised inspectorates. An illustration of this type of setting can be found in Belgium, where the main authority in charge of OSH legislation enforcement is the Directorate General for the Control of Well Being at Work under the Federal Public Service for Employment, Labour and Social Dialogue, and its eight regional directorates. Within the Directorate General for the Control of Well Being at Work, the Department for control on chemical risks is specifically responsible for chemical risks, hence for the four chemical-related OSH Directives. With regard to the two mineral-extracting Directives, the competent authority for enforcement is the Federal Public Service Economy. For the two Directives on vessels, it is the Federal Public Service Mobility who is responsible.
>
> In most countries, inspection services operate at the regional or local level.
>
> Three countries have different inspectorates for the public and the private sectors, which reflects the fact that they have implemented separate, distinct OSH legislation for the public and the private sector. There are: the Czech Republic (enforcement bodies subordinated to the Ministry of Interior and the Ministry of Defence), France (General Directorate of Administration and Public Services) and Luxembourg (the National Service for Occupational Safety of the Public Sector). Thus, Austria and Portugal, the remaining two MSs with distinct public sector legislation (ref. MQ1), do not also have separate enforcement inspectorates."[19]

The report calculates the number of workers per labour inspector (based mainly on the numbers of inspectors reported in the National Implementation Reports submitted by each Member State to the Commission together with employment numbers from Eurostat data). The figures show widespread variation, ranging from 5,708 in Denmark up to 73,505 in Italy, with an average of slightly under 12,000 (11,982 workers per inspector). These values reflect considerable variation in numbers in the period 2007 – 2012 during which time there was an average reduction of 2%. This figure averages values ranging from -37% in Portugal (i.e. a decrease in the number of workers per inspector) to an increase of 47% in Sweden.

The National Implementation Reports, prepared by each Member State and submitted to the Commission in 2013, indicate a considerable variation between Member States in the number of infringements resulting in legal action. Comparisons are difficult because of national differences in the punitive measures taken (e.g. a greater use in some Member States of advisory actions, and other activities, falling short of legal action). Clearly, this reflects national differences in the strategic approaches taken. Although the numbers for any one Member State vary substantially from year to year, illustrative

[19] Ex-post evaluation report. pps 138-139

figures range from around 300 (workforce ~4.5M) to about 200,000 (workforce 3.5M). Number of employers would provide a better metric but this figure is not available.

The ex-post evaluation report identifies sanctions as a key element of the enforcement system, covering both administrative and criminal measures. Sanctions referred to included fines and imprisonment but also a range of other remedial and punitive measures, such as suspension of the activity or improvement notices. The ex-post evaluation found that, most Member States have set both criminal and administrative sanctions, with a limited number of exceptions to both. As a rule, the same sanctions apply across the whole OSH acquis.

A spectrum of sanctions usually exists, ranging from instruction to improve the workplace (with the actual or implied threat of more punitive sanctions for failing to do so) up to sanctions such as fines and imprisonment.

In some Member States, an inspector can order the immediate cessation of work. This can relate either for the individual worker concerned (e.g. in Luxembourg in respect of blatant breach of the rules on minimum age for work, working time and night work, compliance with the weekly rest, statutory holidays, or protective rules on the conditions of employment of pregnant/breastfeeding and young workers) or for the whole establishment (e.g. the 'stop' notices issued in a number of Member States such as the UK). In such cases, where an inspector considers that a situation might constitute an immediate threat to workers' safety or health, they can order the complete cessation of activities until the defect is corrected.

In a systematic review of the published international literature, Tompa et al (2017) found 'limited evidence' of no general deterrence effect on health and safety outcomes (such as lost time accidents) of the probability of inspections. The authors also found 'moderate to limited evidence' of no effect of actual inspections alone, but 'strong evidence' of an effect of inspections with penalties. All of the papers identified were from the USA and it is not known whether differences in national jurisdiction would have influenced these outcomes.

More recently, a report to the DWEA (Andersen et al, 2017) presented a further systematic review. Commenting on the earlier work by Tompa and co-workers, the authors suggest that, in their more recent review, they adopted different evaluative criteria resulting in more positive outcomes. The authors concluded that there was 'moderately strong' evidence for an effect of legislation on injuries/fatalities and for effects of inspections on both compliance and, again on injuries/fatalities. However, the authors concluded that there was a major research gap in respect of any effect of OSH regulation targeting psychological and musculoskeletal disorders.

A very recent paper (Casey et al, 2018) described an exploratory shift in one Canadian province away from the prevailing approach of a compliance framework (promoting voluntary resolution of complaints) followed by more punitive actions such as ordering restitution or otherwise penalising violations (that were described as rarely invoked). Instead the Provincial government increased the role of proactive inspections and tickets, regarded as a low-level deterrence measure with relatively limited CAD295) fines. Early findings suggest that there remains a reluctance on the part of inspectors to issue violations, perhaps signifying a need for a change in inspection culture that might be difficult to develop.

In many instances it appears that reliance on legal sanctions is limited, with inspectors using a variety of other approaches to enhance workplace health and safety. For example, in the UK the enforcing authorities use a mixed intervention approach in which priority is given to the provision of good practice advice, the use of awareness campaigns, and working with stakeholders to influence behavioural change and awareness in preference to enforcement of the law. However, where failures to adequately manage health or safety risks has resulted in serious injury or illness then

legal action remains an option (including the option of holding individual directors personally responsible for deficiencies in the activities of their company).

According to the UK HSEs published Enforcement Policy Statement[20]:

In addition to providing published information and verbal advice, the enforcement methods available to its inspectors include:

- providing written information regarding breaches of law;
- requiring improvements in the way risks are managed;
- stopping certain activities where they create serious risks;
- recommending and bringing, prosecutions where there has been a serious breach of law.

In applying these methods, the Policy states that inspectors will:

> "..ensure that our enforcement action is proportionate to the health and safety risks and to the seriousness of any breach of the law. This includes any actual or potential harm arising from any breach, and the economic impact of the action taken."

This pattern appears to be reflected in all Member States, with a pattern of campaigns, concerted actions and specific initiatives on particular issues or in specific sectors depending on national priorities. One example of this can be derived from the Host Country report (circulated to this meeting) that describes an initiative relating to the implementation of new rules for manual handling in masonry (Construction Industry).

Although a number of papers, such as those outlined above, have explored the role of enforcement in the implementation of legal requirements by employers, no papers have been found that have examined wider aspects of any relationship, such as any feedback to inform the process of transposition.

It is clear from the transposition and implementation within the different Member States that the primary focus (and that against which they were/are policed by the Commission) is on the accuracy of that transposition. It follows that there is therefore likely to be little opportunity for subsequent revision or amendment of any underpinning legislation in response to any feedback, without change to the underlying EU Directive(s) on which the legislation is based.

Experience suggests that the focus is more on providing information and guidance on interpretation of the existing regulatory requirements (where issues arise) rather than amendments to the underlying national legislation. As cited earlier, ESENER-2 presented evidence that compliance with legal requirements is one of the main drivers for OSH action by employers suggesting that it is important to ensure that the legislation underpinning the OSH acquis is focussed, valid and up to date.

Earlier sections commented that some Directives are framed around a more goal-based approach to OSH than others that place a greater emphasis on compliance. This is also reflected at national level within Member States where some have a more compliance-based culture while others seek to judge primarily by outcome (i.e. improved health and safety). That is not to suggest that all Member States do not share a common aim of reducing accidents and ill-health but that, for some, how that result has been achieved is of less importance than the process of doing so.

[20] http://www.hse.gov.uk/pubns/hse41.pdf

4 Key findings and conclusions

OSH legislation within the EU is based around the Framework Directive (Directive 89/391/EEC) and the 23 individual Directives that stem from it. Collectively they provide a common basis for occupational health and safety management within the EU Member States.

Underpinned by European strategies on Safety and Health at Work (such as those for 2007-2012 and 2013-2020) and the European Pillar of Social Rights, this therefore provides for a common legal and policy framework in relation to OSH throughout the EU. To date, although there has been an evaluation of the earlier strategy, there has yet to be any formal assessment of the impact (if any) of the current strategy or the Pillar.

Formulated within the Framework Directive, each Directive is built around a series of so-called Common Processes and Mechanisms (CPMs) that ostensibly provide a common skeleton to OSH management. As noted in the ex-post evaluation the CPMs include requirements for employers to conduct risk assessments; provide preventive and protective services; present information to workers regarding the risks and control measures; provide workers with training on how best to work to minimise risks to health and safety; conduct consultation with workers; and provide workers with health surveillance. However, the commonality of these threads is not always appreciated by employers.

Evaluations such as that of the 2007-2012 strategy and the ex-post evaluation of the 24 OSH Directives suggest a mixed picture in terms of the overall impact of these measures. Some Member States already had a clear OSH strategy (prior to the EU 2007-2012 strategy) and many of these already had a package of existing OSH legislation. For these, although the EU initiatives created a common framework (and introduced some specific legal requirements), the overall impact was limited. For others, the 2007-2012 strategy was considered to have raised the profile of OSH politically and, with a less well-developed framework of pre-existing national OSH legislation, the OSH Directives probably had a more significant influence on national legislation.

The ex-post evaluation focussed primarily on the overall EU picture with relatively little analysis of the situation at national level. Data for the EU-15, presented as part of the ex-post evaluation of the Framework Directive, showed a notable downward trend in both fatal and non-fatal accidents from 1998 to 2012. However, this and the reports on the other individual Directives generally emphasised that, where there was such a trend, it was not possible to determine how much (if any) of that improvement was attributable to the implementation of the Directives. This was particularly the case for health-related impacts where a general theme of inadequate and insufficient data emerged, even for diseases such as Hand Arm Vibration where a clear connection to work factors could be demonstrated.

Since the publication of the ex-post evaluation report, more recent Eurostat data shows that, for the whole EU, the incident rate (per 100,000 workers) of non-fatal accidents has decreased slightly (1,575.91 in 2012 to 1,513.02 in 2015 across the whole EU). The same source shows that fatal accidents appear to have levelled out in recent years, with 1.8 (per 100,000 workers) in 2013, 1.83 in 2014 and 1.83 in 2015. Again the absolute numbers have increased, with nearly 4,000 workers (3,876) losing their lives at work in 2015. Such figures do not suggest a major impact of workplace interventions in recent years.

Examination of the individual National Implementation Reports (NIRs) submitted to the EU Commission by each Member State (2013) seems to reinforce the overall downward trend for accidents, with most Member States indicating a reduction in accident incidence rates across the reporting period (2007-2012) with a possible trend towards levelling out in the last few years. However, as this period also encompasses a shift in the nature of industry within the EU (with reductions in employment in many of those

traditionally regarded as presenting a high accident risk such as steel manufacture) it is difficult to attribute these trends to the development of a new OSH acquis.

For occupational diseases the picture that emerges is less clear, with some NIRs reporting a progressive reduction and others a more complex picture (often with an initial increase). Again, interpretation of such data in the context of the OSH Directives is problematic, not least because of the lack of quality data covering specific health issues.

The exploration of workplace health issues is problematic because of a lack of quality data, with a strong reliance on self-reported data from sources such as the Labour Force Survey (LFS) and the European Working Conditions Survey (EWCS). Both of these have the limitation that they only explore a limited number of health issues. Two generic areas of ill-health that are examined by the LFS are 'musculoskeletal disorders' (MSDs) and 'stress, depression and anxiety'. MSD risks (the highest cause of work-related ill-health) are covered (incompletely) by two Directives (Manual Handling and Display Screen Equipment). In both cases, the ex-post evaluation reports expressed considerable doubt as to whether either Directive had produced any real effect in reducing the incidence of MSDs. The latter area of concern, the second highest cause of work-related ill health according to the LFS, is not encompassed by any explicit EU regulation (although arguably covered by the Framework Directive) although a number of Member States do have relevant legislation.

An EU-OSHA article from 2017 estimated that work-related accidents and illnesses cost the EU at least EUR 476 billion every year. Within this figure, the cost of work-related cancers alone amounts to EUR 119.5 billion. It is clear therefore that work-related accidents and ill-health remain significant and costly issues within the EU.

The overall indications from the evaluation of the 24 OSH Directives are that it is difficult to determine the extent to which (if at all) any reduction in accidents can be attributed to the influence of the OSH acquis. For work-related ill-health the picture is even less clear due to inadequacies in the underlying data that make it impossible to determine attribution of ill-health to any specific risks and therefore similarly impossible to establish the extent to which any change may or may not be attributable to the provisions of the OSH Directives. Acquiring better quality, more comprehensive data across the EU relevant to work-related ill-health and the risks to that health presents a major challenge to be faced.

It appears that there are few instances of the complete non-transposition of specific individual Directives by Member States. All have transposed the Framework Directive and most (if not all) of the individual Directives that build on this, with the omissions mainly related to Directives that are irrelevant to the Member State concerned. With careful and detailed scrutiny by the Commission and legal action against those Member States considered to have transgressed, the close legal comparability between the Directives and national legislation is unsurprising.

Details in the manner of transposition can be considered to largely reflect differences in the structure of national legislation. It would appear that, in most (if not all) EU Member States, the body responsible for implementation has played a major role in the drafting of the national legislation. This helps to ensure not only the accurate transposition of the EU Directives but also that any resultant new national legislation was fully and correctly integrated with the existing national OSH legislative framework. It also serves to ensure a high level of continuity between transposition of the EU Directives into national legislation and the implementation of that legislation.

Evidence from the ESENER-2 survey identifies a number of the reported main drivers amongst establishments for addressing health and safety issues and therefore compliance with the Directive-based legislation. Not surprisingly perhaps, complying with legal obligations emerged as the main reason given.

There would appear to be some issues over 'compliance' with suggestions that the estimates formed from the (self-reported) ESENER-2 survey over-estimate the degree of compliance. In addition, evidence suggests that, in some Member States at least, the quality of compliance (which was not assessed by ESENER) falls short of what might be expected.

Differences in national structures and cultures are reflected in variations in the manner of enforcement, including differences in who enforcement is assigned to; the numbers of inspectors (and inspections); and the number of legal actions as an enforcement tool. Many Member States adopt a graded approach to enforcement, depending on the nature and severity of any health and safety failing, with the provision of guidance and advice preceding more onerous sanctions (with legal action regarded as a last resort or a tool to be used for more severe failings).

The ex-post evaluation found that there were many factors that potentially influenced the OSH picture within the EU, including changing patterns in employment; the inadequacies in statistics; and differences in reporting and recording systems. Collectively, these (and other factors) make it difficult (if not impossible) to develop a clear picture of the impact of the EU OSH legislation since the publication of the Framework Directive almost 30 years ago and the development of EU-wide strategies.

It seems that the body of legislation has been consistently transposed into national legislation and there are signs that at least the main planks of this legislation are being implemented (and enforced) within Member States, although questions can be asked over the quality of some aspects of that implementation. However, it is clear that many challenges remain if we are to make the workforce of the EU as healthy and safe at work as possible.

5 References

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