European Agency for Safety and Health at Work

Analysis of findings from ESENER 2019 on cover and contribution of prevention services to supporting OSH in establishments in Europe

Report

European Agency for Safety and Health at Work

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This report was commissioned by the European Agency for Safety and Health at Work (EU-OSHA). Its contents, including any opinions and/or conclusions expressed, are those of the authors alone and do not necessarily reflect the views of EU-OSHA.

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1 Introduction

In this report we explore findings from the 3rd European Survey of Enterprises on New and Emerging Risks (which we refer to throughout this paper as ESENER 2019 to distinguish it from previous surveys) undertaken by the EU-OSHA, on the role of prevention services in providing support for the delivery of arrangements for healthy and safe working conditions in enterprises in the Member States of the European Union (EU 27). The primary aim of the project, for which this report is the first of its two deliverables, was to interrogate this data in order to improve knowledge and contribute to current discourse concerning:

- current practice, in terms of forms and functions of prevention services;
- the efficiency of prevention services in terms of the quality and coverage of the existing models of delivery of their service provision in the EU;
- the quality of the services they provide;

Its objectives therefore include:

- A systematic and structured analysis of ESENER 2019 data related to OSH preventive services / OSH specialists, which includes, where appropriate, comparison with those of ESENER 2014.

However, these findings also provided the background and point of departure for a Discussion Paper[1] (see Walters D., Wadsworth E.,). That paper addresses the second aim of the project commissioned by EU-OSHA overall, which is to contribute to current discourse on the role of prevention services in supporting substantive compliance in ways that that will help to inform future EU policy. In combination with an exploration of previously identified sources of qualitative and quantitative data on prevention services in the EU and elsewhere, drawn from the recently published EU-OSHA report on 'securing compliance' (EU-OSHA 2021 a and b), and a search of the additional literature published during the last 12 months, the Discussion Paper explores:

- the role played by preventive services in the context of a changing world of work and its reorganisation and restructuring;
- their marketisation and its effects on provision (including the influence of market demands, structures and professional capacities)
- changes in the nature of OSH professions, their orientations and practice and how these impact on the provision and delivery of support for securing substantive compliance with OSH requirements in the EU.

The ESENER 2019 data that are analysed in the present report contributes to this second objective of this project.

To be clear however, what follows in the present report is concerned with a descriptive analysis of the ESENER 2019 findings on the experience of specialist support for OSH among the respondents who participated in the survey in participating establishments of EU 27 Member states.

As we explore further in the following section on the research methods used, in analysing the data used in this report, among the issues that ESENER (2019) sought to address was the experience of supportive services for OSH among respondents, who were managers or owners of the establishments or their employees, thought to be the most knowledgeable about the arrangements for workers' safety and health in the enterprises that participated in the survey. In particular, ESENER 2019 asked several questions concerning their experience of 'external health and safety consultants', 'external consultants', 'OSH specialists' and so on. As well as some further relevant questions concerning the role of expertise

[1] https://osha.europa.eu/en/publications/occupational-safety-and-health-prevention-services-experts-europe

in supporting particular arrangements for managing OSH such as workplace risk assessment. However, it is important to be aware of the limitations of the ESENER data in terms of what it can and cannot tell us concerning the experience of this support.

In the following section of the paper therefore, as well as describing our approach to the research methods we have employed, we define the parameters of our inquiry and note their limitations. Importantly, this includes defining what we mean by prevention services/OSH experts and consultants, with reference to regulatory requirements and business and professional practice.

Following this, we present our main findings drawn from the quantitative analysis and comparisons we have made in order to assess what information ESENER 2019 provides concerning the cover and quality of the delivery of support for substantive compliance with OSH standards in the Member States of the EU. In the Discussion Paper mentioned above we refer to these findings in order to situate them in relation to the wider discourse on the role of professional help in achieving substantive compliance, thus helping to also identify the limits of current knowledge and the key questions for future policy and research. But first we report the descriptive analysis of ESENER 2019 data on OSH prevention services in what follows here.

2 Research methods and some definitions

This section first outlines the methods used in the descriptive analysis of the ESENER 2019 data. This is followed by some qualifying definitions concerning the nature and content of 'OSH prevention services' and a brief account of some of the consequent limitations of the ESENER 2019 data and the analysis presented in this report

2.1 The descriptive analysis of ESENER data on prevention services

The analyses of the ESENER data were limited to descriptive statistics. In particular, the focus was on making two broad groups of comparisons. First, we considered differences between groups of enterprises within the ESENER 2019 dataset. These included comparisons by: enterprise size; sector; Member State and country group. The latter grouped Member States in the same way as previous analyses of the ESENER data (see for example, EU-OSHA 2013; Walters and Wadsworth 2014), as follows:

- Western EU: Austria, Belgium, Germany, Luxembourg, Netherlands, Switzerland
- Nordic: Denmark, Finland, Iceland, Norway, Sweden
- United Kingdom (UK) and Ireland
- Southern/Latin EU: Cyprus, France, Greece, Italy, Malta, Portugal, Spain
- Central and Eastern EU: Bulgaria, Croatia, Czech Rep., Estonia, Hungary, Latvia, Lithuania, North Macedonia, Poland, Romania, Serbia, Slovenia, Slovakia

Second, where appropriate we also made comparisons between the ESENER 2014 and 2019 datasets. Here the focus was on overall changes, and on those apparent at the Member State level.

Unless otherwise specified, the report's text, tables and figures present data based on the EU 27 respondents to the ESENER 2019 survey.

2.2 Definitions and limitations

Problems of meaning are often challenging for the administration of questionnaire or telephone interview-based surveys and especially for international ones in which both language and culture can introduce further complications. These challenges are therefore relevant to ESENER 2019 in general, but they are particularly acute in the case of OSH prevention services since, there are a variety of

understanding of what constitutes such services as well as in the agents involved in providing this support in the Member States of the EU and elsewhere.

'OSH prevention services' is a generic term used to capture the functions of all these forms of support for securing substantive compliance with OSH standards. It embraces a range of competencies in occupational medicine, nursing, hygiene, safety engineering, safety science and management, ergonomics, health psychology and so on. As several writers have discussed, for several decades since the introduction of principle and process-based regulation on OSH and the changes from a manufacturing to a service-based economy which occurred at the same time in the Member States of the EU, these services have increasingly included the role of generalist safety and health practitioners, whose skills and qualifications embrace various elements of these more specialist competencies that are considered appropriate to advising on the management of OSH (Hale 2019; Pryor et al 2019). Thus such practitioners tend to have more wide-ranging general competencies in OSH as opposed to particular specialist skills in one of its many component elements.

OSH prevention services may be provided by organisations external to the establishment that are contracted by them to deliver such support for competencies — external services. Or they may be provided by the establishment itself in the form of persons with such skill sets among its employees, who in larger organisations may be organised into departments or units with such a function. Consequently, in multi-establishment firms such provision may be based outside any one particular constituent establishment but still be an internal service for the firm as a whole. However, both internal and external OSH prevention services can range from single individuals, to larger organisations with multiple employees and competencies.

The regulatory basis for the provision in the EU generally, is Article 7 of the Framework Directive, which requires employers to designate one or more workers to carry out activities related to the protection and prevention of occupational risks for the undertaking and/or establishment (7.1). If such protective and preventive measures cannot be organised for lack of competent personnel in the undertaking/establishment, Article 7.2 states that the employer shall enlist competent external services or persons. In all cases:

- The workers designated must have the necessary capabilities and the necessary means;
- The external services or persons consulted must have the necessary aptitudes and the necessary personal and professional means;
- The workers designated and the external services or persons consulted must be sufficient in number to deal with the organisation of protective and preventive measures, considering: the size of the enterprise, the hazards to which the workers are exposed and their distribution throughout the entire enterprise.

A key aim of the Framework Directive was to achieve a harmonised approach to managing the risks associated with work and to prevent harm to workers in the Member States of the EU, in which a variety of systems already prevailed but with varying degrees of workplace cover and difference in operation. Such variety was especially apparent in national requirements for supporting duty-holders to manage such risks competently. Studies show a host of different historical approaches among the Member States, ranging from those quite precisely defined by statute in some countries, in which particular competencies are defined with requirements on their use specified in relation to particular processes or numbers of employees, to systems in other countries that had evolved under largely voluntary, professional or market-based influences (see for example the accounts of various national practices in the EU and elsewhere in Westerholm and Walters eds. 2007). Others were the result of public health reforms and state provision. Nowadays, approaches in some Member States continue to bear the hall-marks of their origins, while others are amalgams of all these influences (EU-OSHA 2021 b). Additionally, principle and process based regulatory requirements on OSH, allow statutory duties to extend to a more

comprehensive range of employers in work activities across more sectors and establishment sizes than were covered by past prescriptive standards and require employers to use competent advice to manage OSH risks. Thus, creating a market for the provision of such advice without necessarily specifying a comprehensive qualifications framework required of those providing it. This, in some European countries, has led in to the proliferation of a wide range of external consultancy services offering support for OSH, including some with little in the way of recognised OSH competencies.

It is also important to understand that each different national approach has been largely determined by the wider social, professional, political, economic and historical contexts in which they developed. These are not static but subject to on-going changes and as argued elsewhere, such change has had considerable influence over the evolving form and function of OSH prevention services (see for example, Vogel, 1994; Walters 1997; Westerholm 1999; Walters et al 2022). The extent to which the Directive has been able to exert a harmonising effect on these quite complex and diverse systems is therefore itself problematic. As Bridget Froneberg (2005) wrote some fifteen years following the adoption of the Framework Directive:

'The tripartite European Council Framework Directive 89/ 391/EEC …. should have paved the way for equal occupational health services for all workers alike, independent of company size. Despite the tripartite legislative basis, the general transposition into the national legislation of all European Member States, and the considerable efforts of all stakeholders of organized civil society, the goal has obviously been achieved, or nearly so, in only a minority of Member States.'

Nearly 20 years later, the influence of much of this underlying diversity remains in evidence, with structural and organisational changes in work and its role in the economies of EU Member States, along with the inclusion of further countries and models of preventive services into the EU adding further layers to an already complicated picture (Walters et al 2022). It is therefore far from certain that precisely the same things will be understood by respondents in different Member States when they are asked about the support they receive from these services. And indeed, as we outline below, these limitations are inherent in the way the ESENER questions are formulated, as is evident from the descriptive analysis in the following section.

As already noted, the respondents in the ESENER 2014 and 2019 surveys from whom telephone interviews were sought were the persons within them who were regarded by the participating establishments as knowing most about the OSH arrangements in place (even if in practice these arrangements were undertaken by an external provider). This meant that the majority of respondents were owners, managing directors or site managers of the establishment (42 per cent), while other respondents included managers without a specific OSH responsibility (16 per cent) OSH specialists or managers with an OSH responsibility (13 per cent) or other employees in charge of OSH (20 per cent).

In an effort to formulate questions that could be similarly understood by these respondents across the range of national, sector and size differences in establishments included in ESENER, as well as to address the interests of the European Commission, the architects of its telephone interviews crafted a number of questions about respondents' experience of the use of OSH prevention services. The key questions were:

- What health and safety services do you use, be it in-house or contracted externally?
- Has your establishment used the services of any external provider to support you in your health and safety tasks in the last three years?
- How would you, all in all, rate the health and safety services you obtained from external providers?

The choices open to respondents in answering the first of these questions allows them to specify the use of an occupational health doctor; a psychologist; a generalist on health and safety; an expert for

accident prevention; or an expert dealing with ergonomic design as the service used. While it is quite likely that respondents would identify some of these competencies clearly and such an identity would be the same across Member States (such as is probable in the case of the use of an occupational health doctor for example), it is far less clear how they would have distinguished between others — for example between a generalist on health and safety; a specialist in accident prevention; or an expert dealing with ergonomic design, or whether the same distinctions would be constant for respondents in establishments of different sizes or sectors and situated in different Member States or indeed whether some of the services used actually possessed such competencies. This may not be especially problematic in terms of the contribution of ESENER 2019 to information on the extent of the use of services and perceptions of their overall usefulness. But, it is less helpful in contributing to wider discourse concerning the role of prevention services in the OSH systems of EU Member States and changes occurring in professional support for OSH, including in the role of its constituent competencies, since different possible interpretations and understandings of the competencies identified in the interview schedule make distinctions between them in the analysis of responses somewhat unreliable.

Moreover, turning to the question on the use of an external provider, when respondents are asked how they would rate these services, they are not offered the opportunity to distinguish the various categories of provision as above. Consequently, such detail cannot be explored in the analysis and therefore again, it is not possible to contribute very much further information to the wider discourse on the possible experience of changes in the nature professional support, in this case, that provided through external services.

Further relevant questions asked of respondents were:

- Are workplace risk assessments mainly conducted by internal staff or are they contracted to external service providers?
- Has your establishment used health and safety information from any of the following organisations? (of which one was ‘contracted health and safety experts’)

This allows some possibilities for documenting experiences of support for the process of risk assessment used in establishments, however it can throw little light on the question of what kind of support is provided since it is restricted to distinguishing between ‘internal staff’ and ‘external service providers’. Responses also provides some data on the use of information, although in this latter case, it would be surprising indeed if respondents were to indicate that, having used ‘contracted health and safety experts’, they had not used the information supplied by them. The second question also introduces yet another term for specialist support – that of a ‘contracted health and safety expert’. This would seem to create two further problems for the reliability of the analysis. Firstly, while the term might be assumed to mean an expert external to the organisation, this is not necessarily the case. Some respondents may have understood it to refer to the contract of employment of an expert employed at the establishment. Secondly, the use of different terminology to that used in previous questions also introduces some further problems for the comparison of the responses to this question with those of previous ones, crated by a definitional uncertainty regarding exactly what is being compared. And finally of course the notion of an ‘external expert’ is left to the respondent to define and subjective interpretation of what is meant by ‘expert’ may vary considerably between respondents in establishments of differing sizes and sectors.

Interestingly, respondents were also asked several further potentially relevant questions concerning the absence or inadequacy of expertise, thus potentially allowing some degree of corroboration concerning the role of support with questions addressing its absence:

- Are there any particular reasons why workplace risk assessments are not regularly carried out? Please tell me for each of the following whether it applies to your establishment or not?

- What are the main difficulties in addressing health and safety in your establishment? Please tell me for each of the following options whether it is a major difficulty, a minor difficulty, or not a difficulty at all.
- What are the main obstacles to dealing with psychosocial risks in your establishment?

In all three, 'a lack of expertise' was one reason suggested to respondents for such obstacles/difficulties. However, as will become evident in the following section, the responses to these questions pose some challenges for interpretation because it is not always clear what respondents may have understood by them in the context of their own experience. While responses offer some potentially useful sources of data for considering possible gaps in provision of relevant support for OSH, analysis is restricted to a fairly generic level since respondents are not offered an opportunity to indicate more precisely what might constitute the form of expertise they regard as lacking.

3 Key findings from ESENER 2019

There have been three sets of published ESENER data from three separate surveys undertaken during the past decade. Unfortunately, changes in questions and survey methodology mean time series comparisons of many areas of the surveys are not reliable. This is so in the case of prevention services, although it is possible to make some limited comparisons between the most recent data from the ESENER 2019 and that from the previous survey, ESENER 2014. What follows is however mostly based on ESENER 2019 unless stated otherwise and addresses the cover, use and quality of what the surveys mostly refer to as 'OSH services', which for the purposes of this report, can be regarded as synonymous with OSH prevention services (although see the further distinctions made in the previous section on research methods).

3.1 The Cover of OSH Prevention Services

There are several questions in the ESENER 2019 survey that provide data on the extent of use/cover of prevention services.

Focusing on the EU 27 respondents to ESENER 2019, over three-quarters report using an occupational health doctor and just under 20% a psychologist, with the use of a generalist on health and safety, expert for accident prevention, and expert dealing with ergonomic design falling between these proportions (Figure 1). This spread of reported use is apparent when the data are broken down by enterprise size, sector, country group and country (Figures 2 to 5). In addition, what might be anticipated differences in service use are as expected. That is, the reported use of all services, increases with enterprise size (Figure 2); is more common in the public and producing sectors than in private sales and services (Figure 3); and in terms of the national groupings into which we have organised the data following previous analyses of ESENER data (see for example Walters and Wadsworth 2014), it is most often reported in the Nordic countries and least often in the UK and Ireland (Figure 4). In the latter, some variation in use of specific services is apparent (for example in relation to reported use of an occupational health doctor), and this is also seen when the data are considered at the country level (Figure 5).

The overall figures also suggest there has been little change in this pattern of use since ESENER 2014 as is shown in Table 1.

Figure 1: Proportion (%) of enterprises reporting use of each service (Q151)[2]

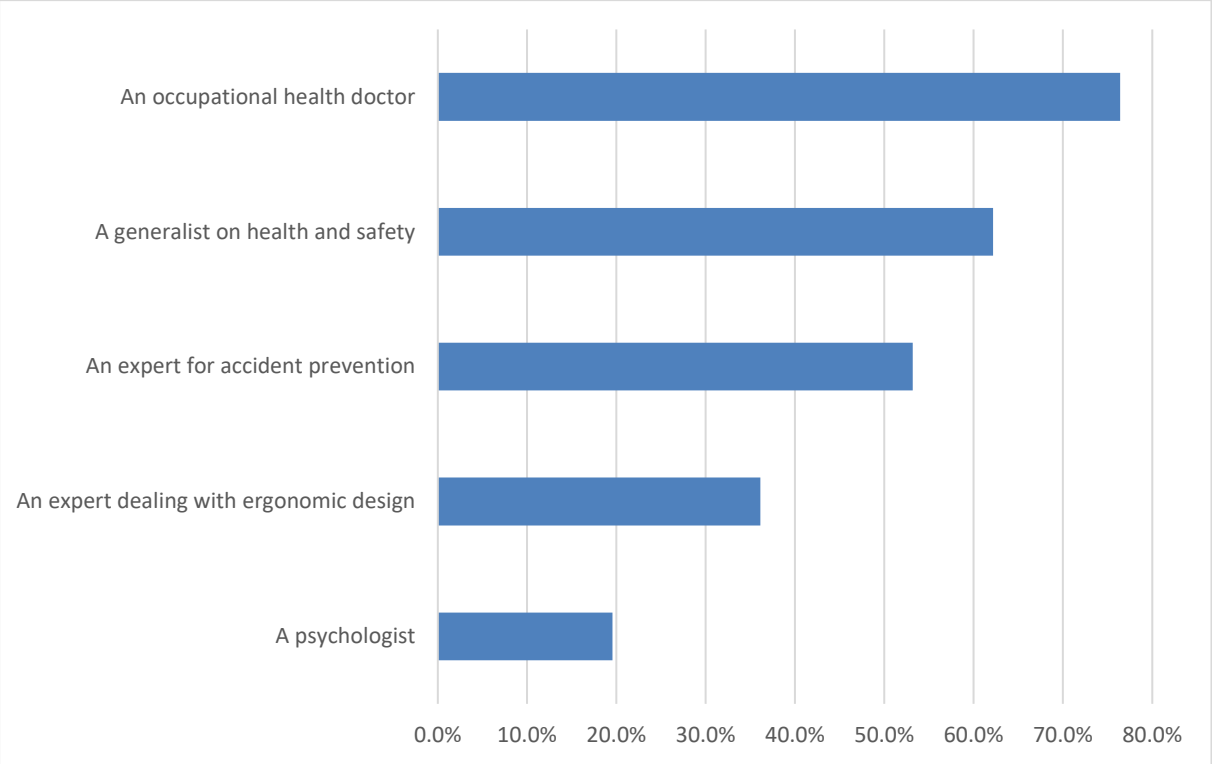
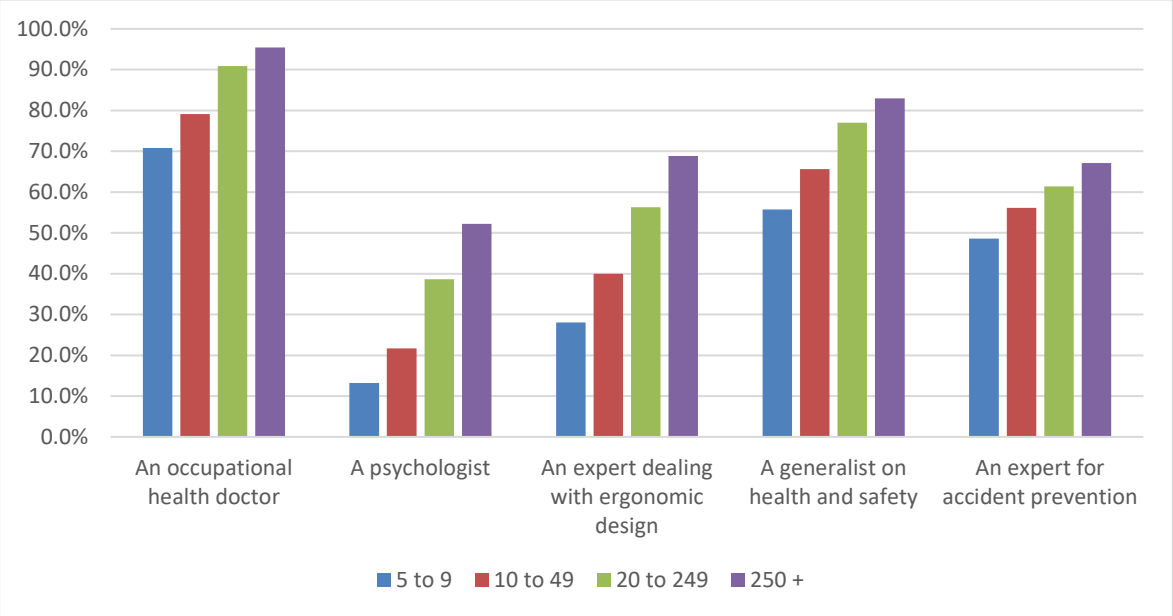


Figure 2: Proportion (%) of enterprises reporting use of each service (Q151) by enterprise size



[2] Throughout the report (mainly in the title of the figures) references to the questions from the ESENER questionnaire are made (for instance, in this specific case, Q151). The ESENER questionnaire is available at: https://oshwiki.eu/wiki/File:Master_questionnaire_2019.pdf

Figure 3: Proportion (%) of enterprises reporting use of each service (Q151) by sector

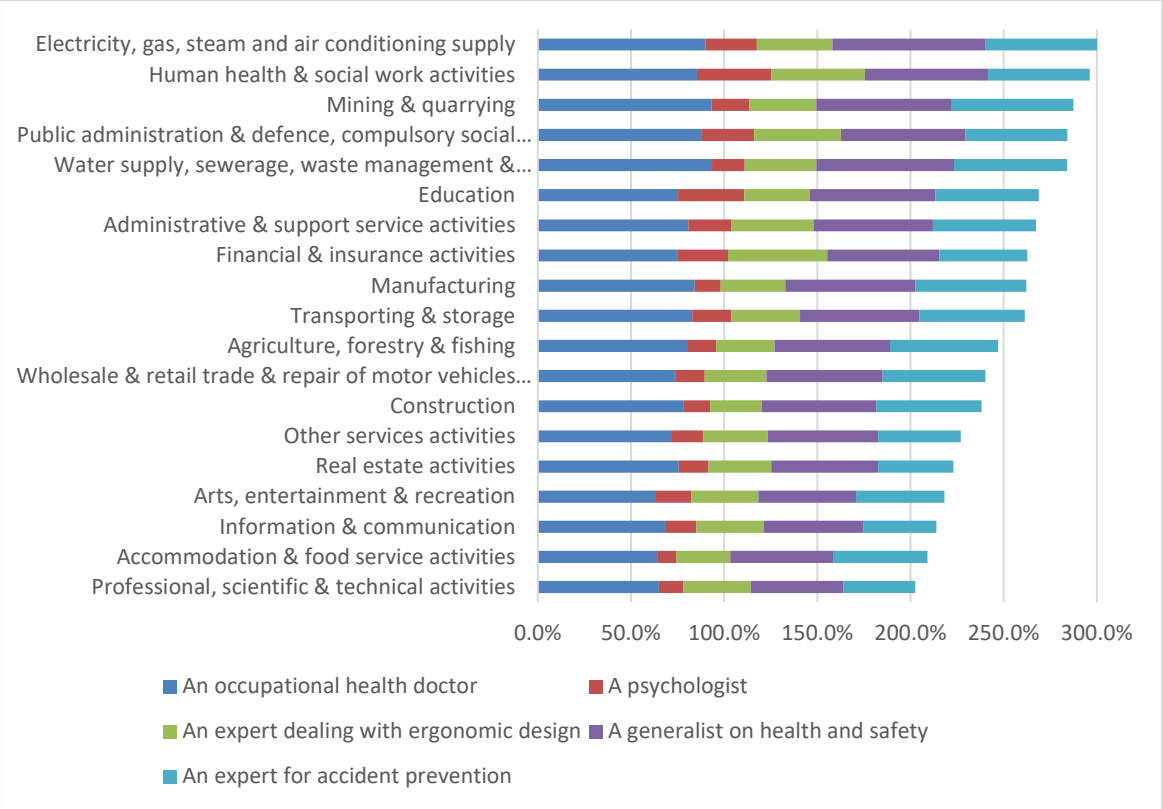
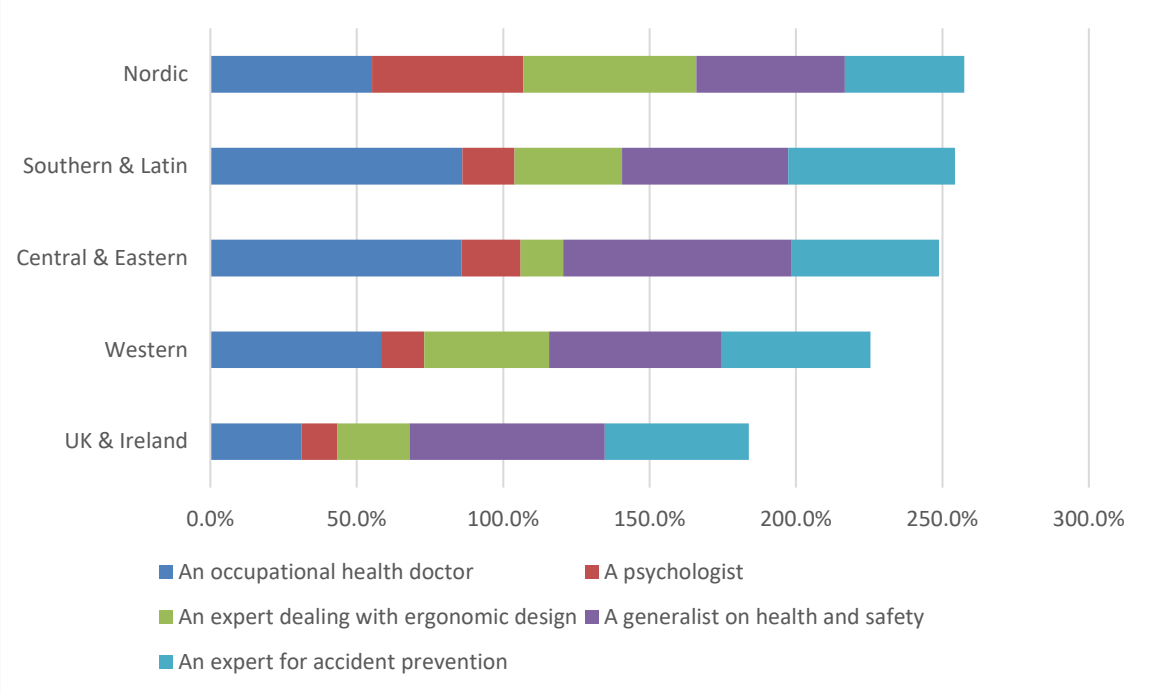
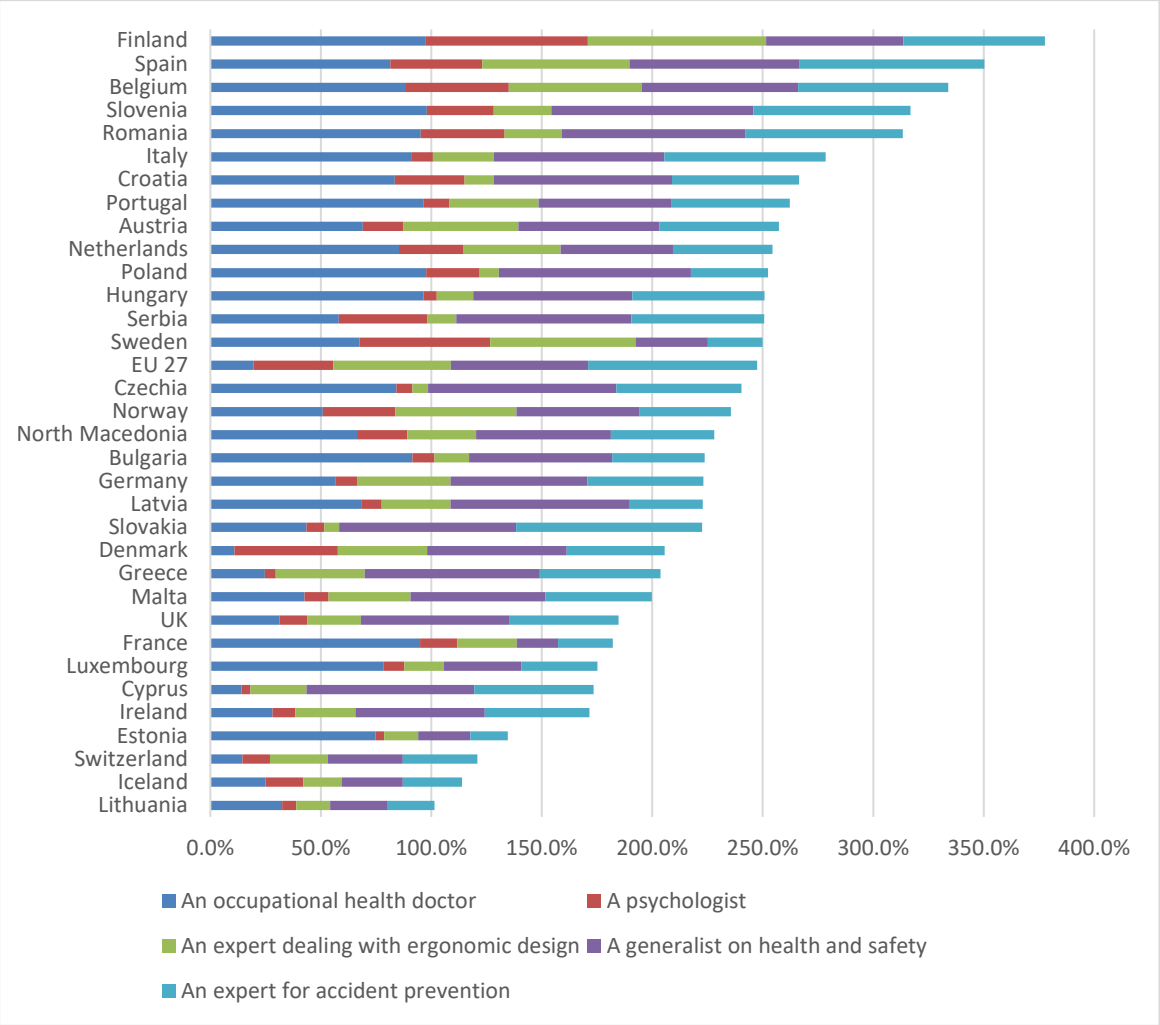


Figure 4: Proportion (%) of enterprises reporting use of each service (Q151) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 5: Proportion (%) of enterprises reporting use of each service (Q151) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Table 1: Comparison between ESENER 2014 and ESENER 2019 (Q151)

	2014	2019
Occupational health doctor	75%	76%
Generalist on health and safety	63%	62%
Expert for accident prevention	53%	53%
Expert dealing with the ergonomic design	35%	36%
Psychologist	17%	20%

Note: Based on respondents from the EU 27 Member States within the 2014 and 2019 surveys.

3.2 External or internal provision?

Answers to Q152[3] (use of any external provider to support health and safety tasks) suggest 63% of enterprises use external providers. This proportion increases to 76% with increased size and varies by sector, country group and country, as shown in Figures 6 to 9.

Figure 6: Proportion (%) of enterprises reporting use of external services (Q152) by enterprise size

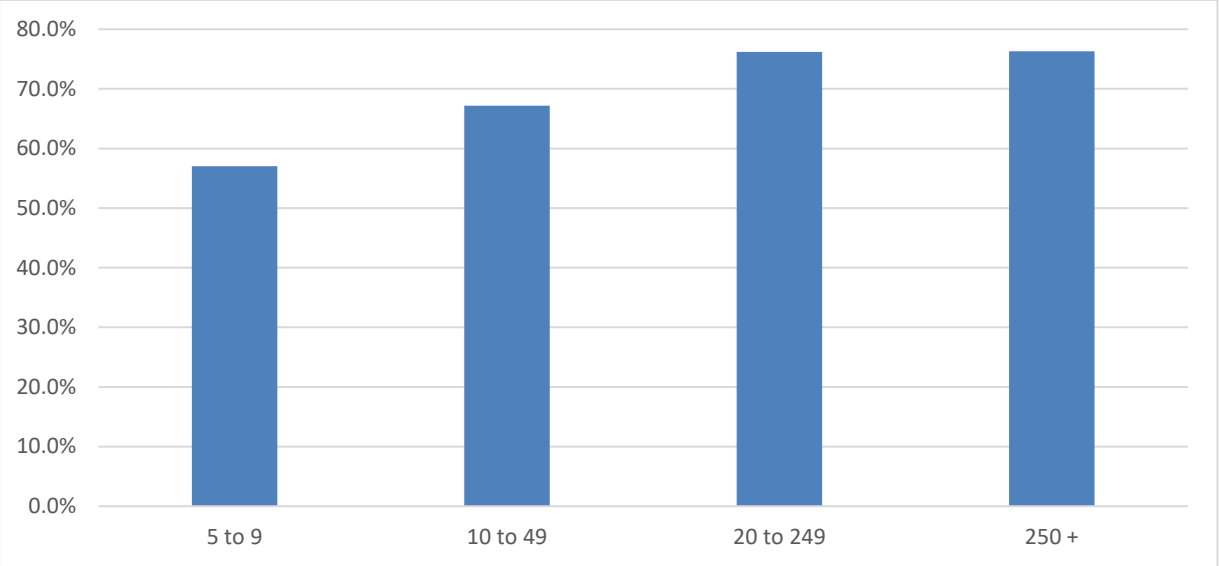
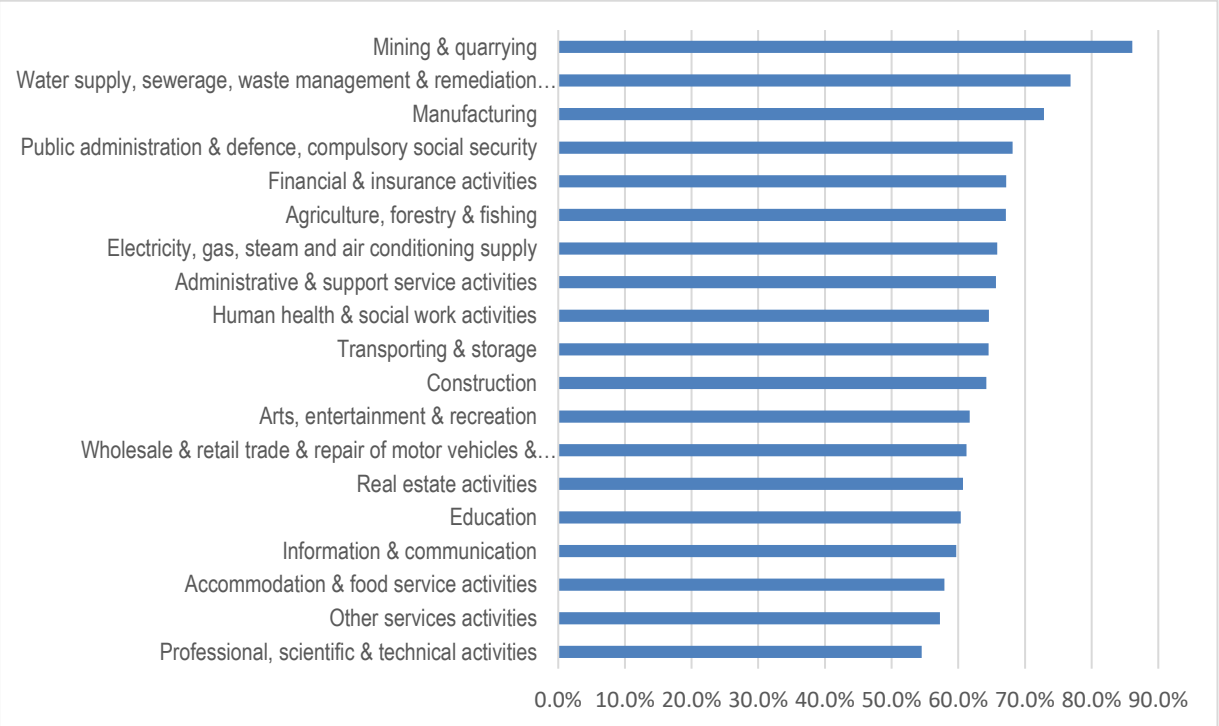
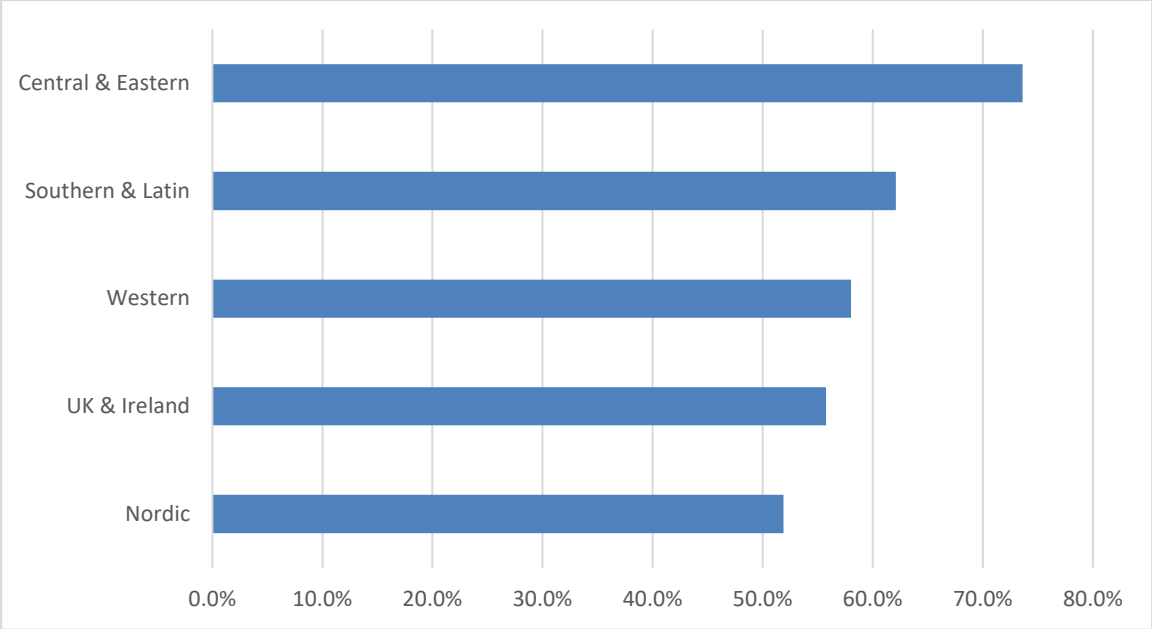


Figure 7: Proportion (%) of enterprises reporting use of external services (Q152) by sector



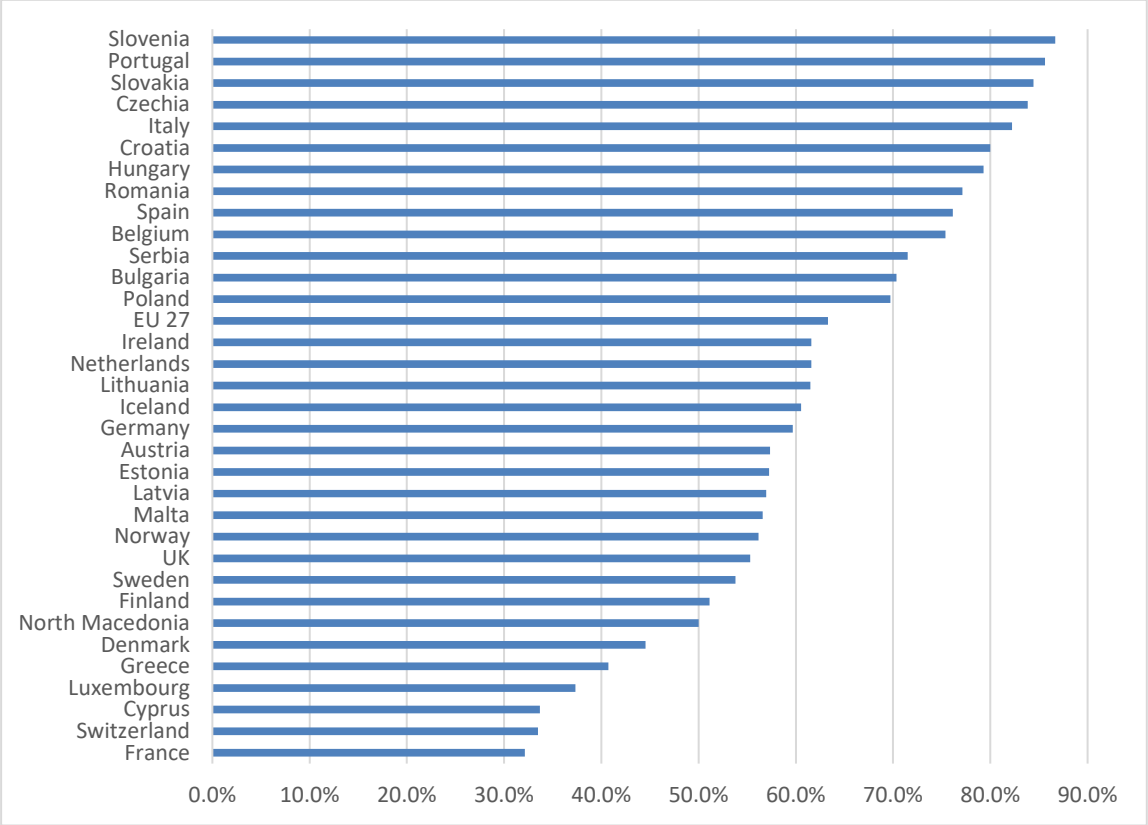
[3] Throughout the report references to the questions from the ESENER questionnaire are made (for instance, in this specific case, Q152). The ESENER questionnaire is available at: https://oshwiki.eu/wiki/File:Master_questionnaire_2019.pdf

Figure 8: Proportion (%) of enterprises reporting use of external services (Q152) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 9: Proportion (%) of enterprises reporting use of external services (Q152) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Some further exploration of the data was carried out to consider the relationship between Q151 (use of health and safety services whether in-house or externally contracted) and Q152 (use of any external provider to support health and safety tasks). Those reporting use of any OSH service were also likely to report use of an external provider (Figures 10 and 11). Seven percent of respondents reported no use of OSH services or external providers, with 6% reporting use of all 5 OSH services and external provision (Figure 12). Among those who do not report using external services, nearly 5% report using all 5 OSH services (Figure 13). Figure 14 shows all possible combinations of OSH services and external provider use. The most commonly reported combination was: an occupational health doctor, a generalist on health and safety and an expert for accident prevention;, followed by use of an occupational health doctor only; an occupational health doctor, an expert dealing with ergonomic design and set-up of workplaces, a generalist on health and safety and an expert for accident prevention; and then no use of OSH services or external provision. We will discuss this further below, but while these various combinations suggest a significant use of external provision they do not make for a clear distinction between this use and the use of forms of specialist support from within establishments.

Figure 10: Proportion (%) of enterprises reporting use of external services (Q152) by any service (Q151)

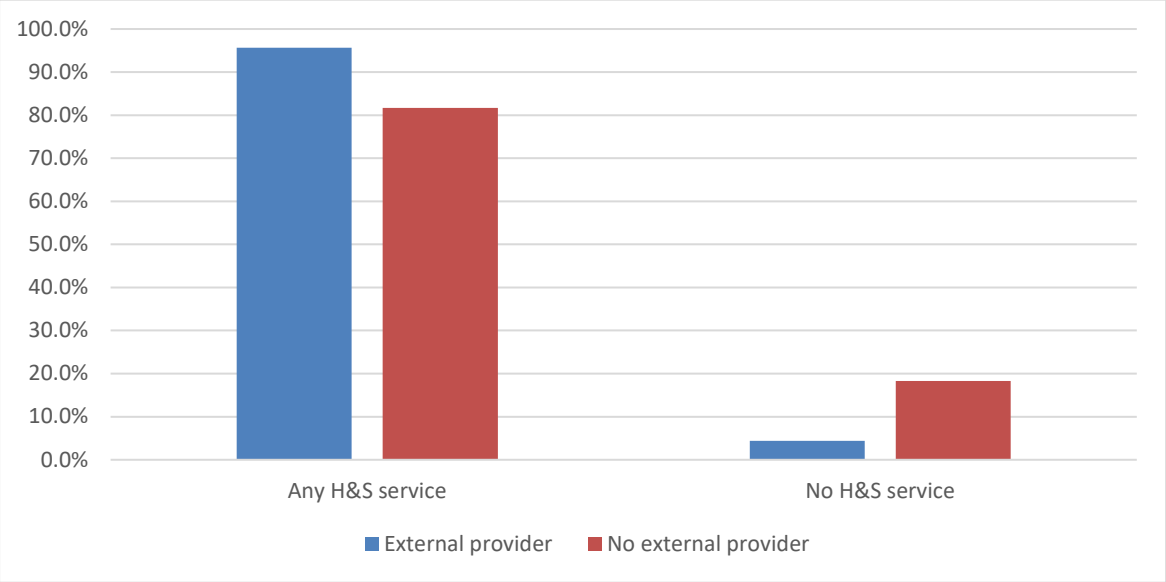


Figure 11: Proportion (%) of enterprises reporting use of each level (none to all 5) of services by use of external services

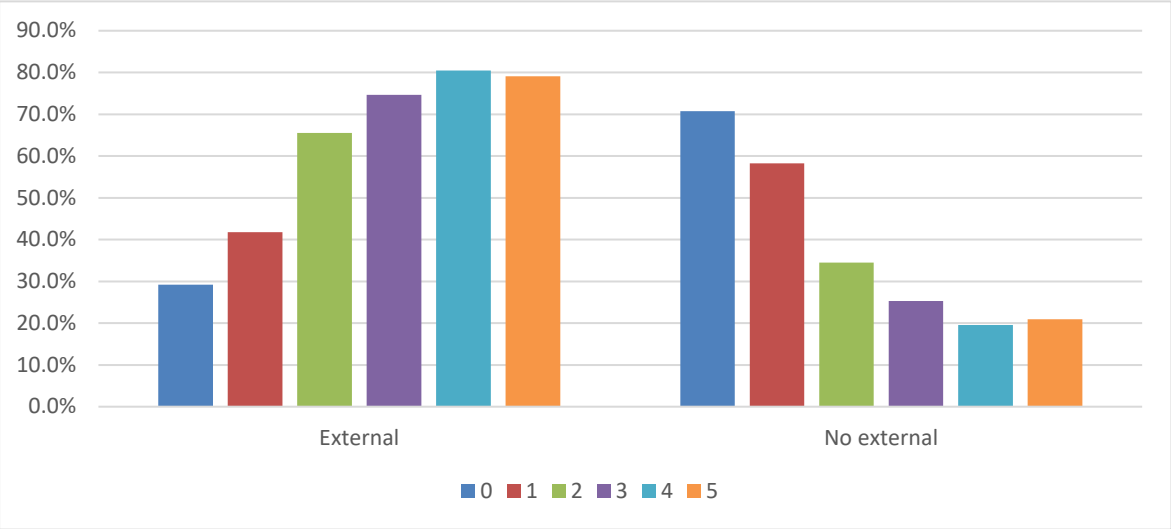


Figure 12: Proportion (%) of enterprises reporting use of each level (none to all 6) of services plus external services

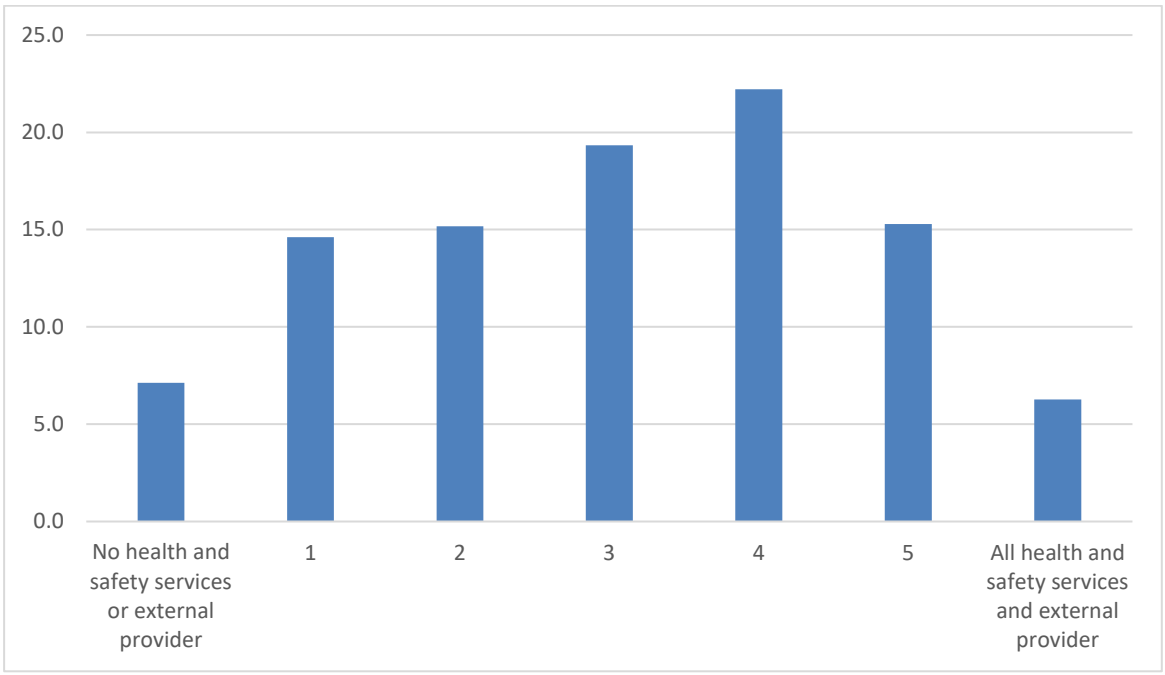


Figure 13: Proportion (%) of enterprises reporting use of no services and all health and safety services by use of external services

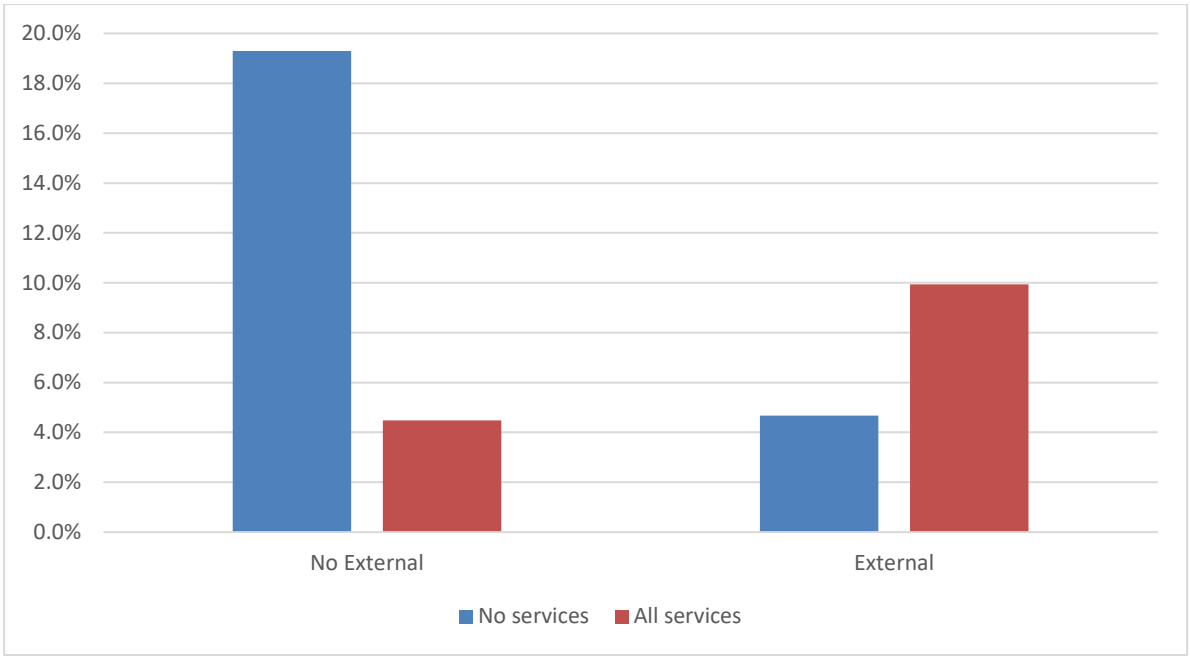
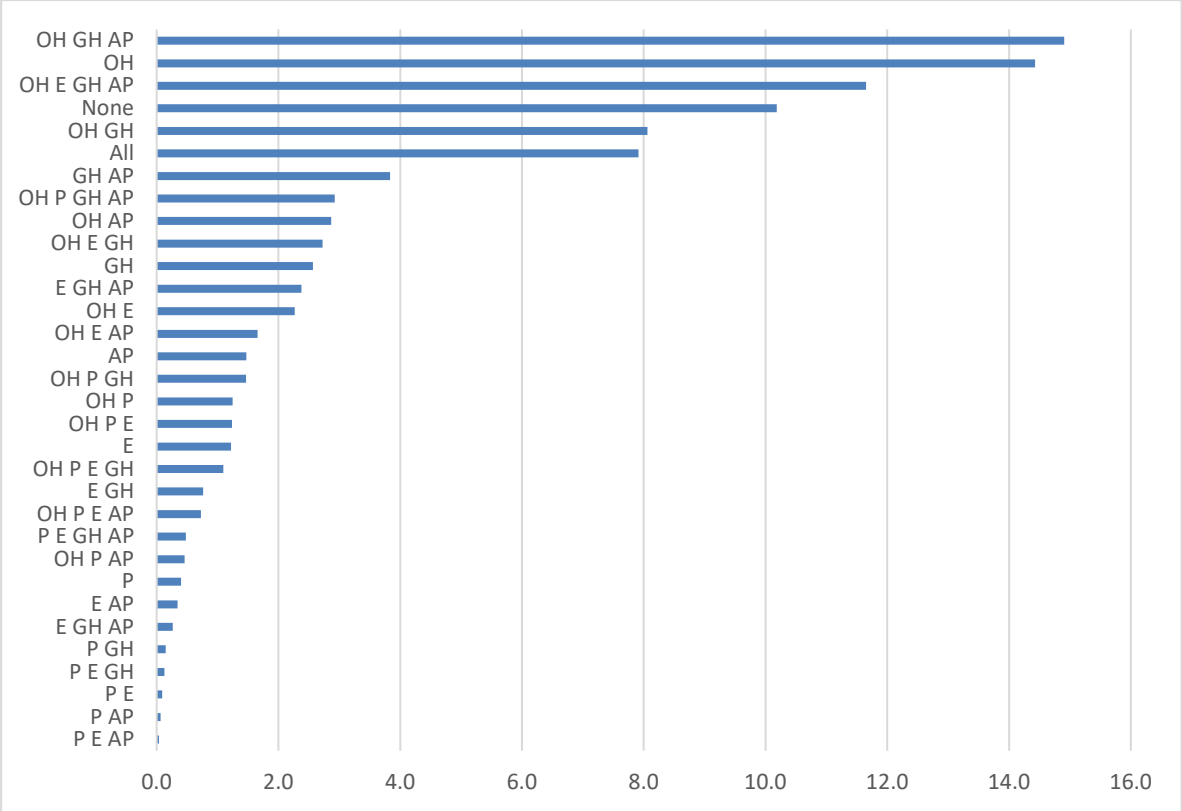


Figure 14: Proportion (%) of enterprises reporting use of each combination of services



KEY: OH = Occupational health doctor; P = Psychologist; E = Expert dealing with ergonomic design and set-up of workplaces; GH = Generalist on health and safety; AP = expert for accident prevention.

Taken together, these findings suggest that the use of some form of external services to provide support for OSH is widespread among establishments in EU Member States and that many of these services are perceived to involve combinations of the specialisms identified in the interview guide. They also suggest that a large majority of the respondents were happy with the service they received (answers to Q 153 indicate 88% of those who had used external services rated the services they received from external providers as very good/quite good). However, there is no information on how many providers they had used, how this rating related to each services used or why they rated these services as such.

As detailed in the section of this report on Research Methods, the way the questions in the survey are worded along with differences in the likely perception of their meaning among the wide range of respondents from establishments of different sizes and sectors, in different countries makes it difficult to be more precise concerning their choice of these services or their reasons for making it.

The proportion of respondents indicated they have used some form of OSH prevention service in ESENER 2019 is remarkably higher than that reported by other surveys and estimates. For example, Rantanen et al 2017, estimated that overall the coverage of the working population was low, with only a quarter of the total employed population included in their study estimated to be covered by any form of prevention service. And this is typical of other estimates too. For example, a review undertaken by the ETUI in 2014 estimated that the coverage of workers in different EU Member States varied between 20% to 100%. The same report further qualifies this estimate by indicating that a significant proportion of the cover was in fact by services without appropriate professional competencies (ETUI 2014). While in the UK, recent estimates suggest that only 21% of employers provide occupational health services, with this figure only rising significantly (to 44%) in the case of those engaged in 'Public Administration, Education

and Health'. Moreover, nearly half of the employers who were found to provide such services did so on a 'case-by-case-basis, while just one in four reported having engaged a provider on a long-term contract (Tu et al, 2019). Other UK government research meanwhile suggests that only around 26% of private sector employees and 63% of public sector ones have access to occupational health services, with the coverage of such services varying considerably (from 10-52%) across different sizes of organisation (Young and Bhaumik, 2011). There is also widespread agreement among such studies that workers in micro and small enterprises and those in contingent forms of work are least well served (a finding that is also reflected in the ESENER 2019 data — see Figure 2).

Previous literature has explored the development of different modes of OSH prevention services and has to an extent, associated their use with different EU member states. For example, they demonstrate the historical development of medical, hygiene and safety engineering models of prevention services in many advanced market economies, both within and beyond Europe, to be associated with industrialisation and particularly with large enterprises in heavy industry, mineral extraction and manufacturing, as well as with nationalised undertakings and the public sector (see for example Vogel 1994; 1998; Weindling (ed) 1985; Elling 1986; Melling 2005). They suggest that determinants of this development have varied according to the structure of the economies of different countries as well as with their political orientations, the perceptions of risks associated with different occupational exposures and capacity of organised labour, employers and trade bodies to influence policies on all these matters (Hämäläinen and Lehtinen 2001; Abrams 2001; Rantanen et al 2017). They also show, to some extent, how support for occupational health has fared in public policies during the development of welfare capitalism and subsequently (Walters 1996), and how these wider policy and political orientations help to explain some of the differences seen in the character of national provisions between Member States — their role as part of public health provision in Finland, the historical domination of occupational medicine in France, the growth of 'integrated services' in Scandinavian countries like Denmark, or the quasi enforcement role of local health units in Italy are some examples whose origins and disproportionate development in different EU Member States can to some extent, be explained in this way (Walters 1997). While they also further note the spread of more generalist OSH practitioners whose functions embrace advising on the delivery of appropriate corporate responsibilities for OSH management (Walters 2007; Hasle et al 2014; Hale 2019; Hale and Ytrehus 2004) as mentioned previously.

As we have previously noted in relation to Figures 1-5, it is clear that there are differences between sectors and between EU Member States concerning the experience of the use of OSH prevention services and the analysis corroborates findings in other studies pointing to the greater experience of such use in public sector organisations than in the private sector and also greater use in manufacturing than in private services. By sector they further suggest establishments in education, health and other public sector services make greater use of psychologists than those in other sectors, while the use of other types of competencies is more or less proportionally similar between sectors. National differences, include greatest proportional use of services in Finland and least in Lithuania and by national groupings, greatest in Scandinavian countries and least in establishments in the UK and Ireland. Unfortunately, the detail and orientation of the questions asked in ESENER 2019 do not allow its analysis to contribute reliably to further understandings of the influences on these differences such as those discussed in the studies mentioned in the previous paragraph.

3.3 How are OSH services used by establishments?

ESENER 2019 provides some information on how establishments made use of OSH prevention services in support of their management of OSH in their responses to the survey's questions on risk assessment and on use of information. In addition, ESENER 2019 included several questions concerning challenges perceived by respondents in delivering appropriate OSH arrangements in which those involving access

to OSH prevention services were further relevant. The following paragraphs summarise the descriptive analysis of the responses to these questions.

Role in risk assessment*:* Answers to Q250 and Q251 suggest that a quarter of enterprises did not carry out risk assessments or gave no response (25%), while around a third each indicated that risk assessments were mainly undertaken by internal or external staff (31% and 35% respectively) with 8% suggesting they were undertaken by both (Figure 15). But this doesn't indicate who were the internal staff (i.e. whether they were from internal OSH prevention services services), nor does it provide information on the kinds of risk assessments involved (i.e. what was the range between specialist types requiring specialist risk measurement skills etc and more general workplace assessments). Figure 16 shows these proportions vary by country group, with internal staff most common in the Nordic countries and UK and Ireland and external services most common in Southern/Latin and Central/Eastern countries. Which suggest some possible differences that may be attributable to the national influences on the development of different models of service provision discussed in the literature mentioned in the previous section.

Use of internal staff also increases with enterprise size (Figure 17); use of external services is most common in electricity, gas, steam & air conditioning supply and manufacturing (Figure 18); and there is substantial variation in the comparative proportions of reported use across EU (Figure 19).

Figure 15: Proportion (%) of enterprises reporting that risk assessments are mainly conducted by internal staff or by external providers (Q250 and Q251)

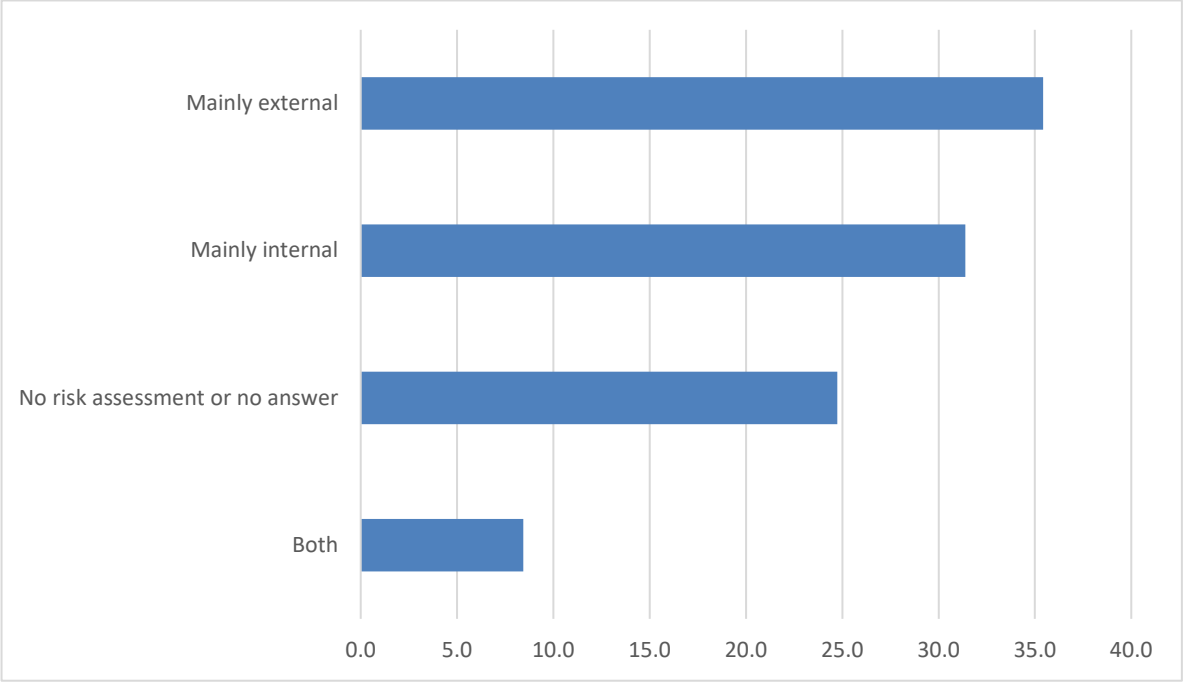
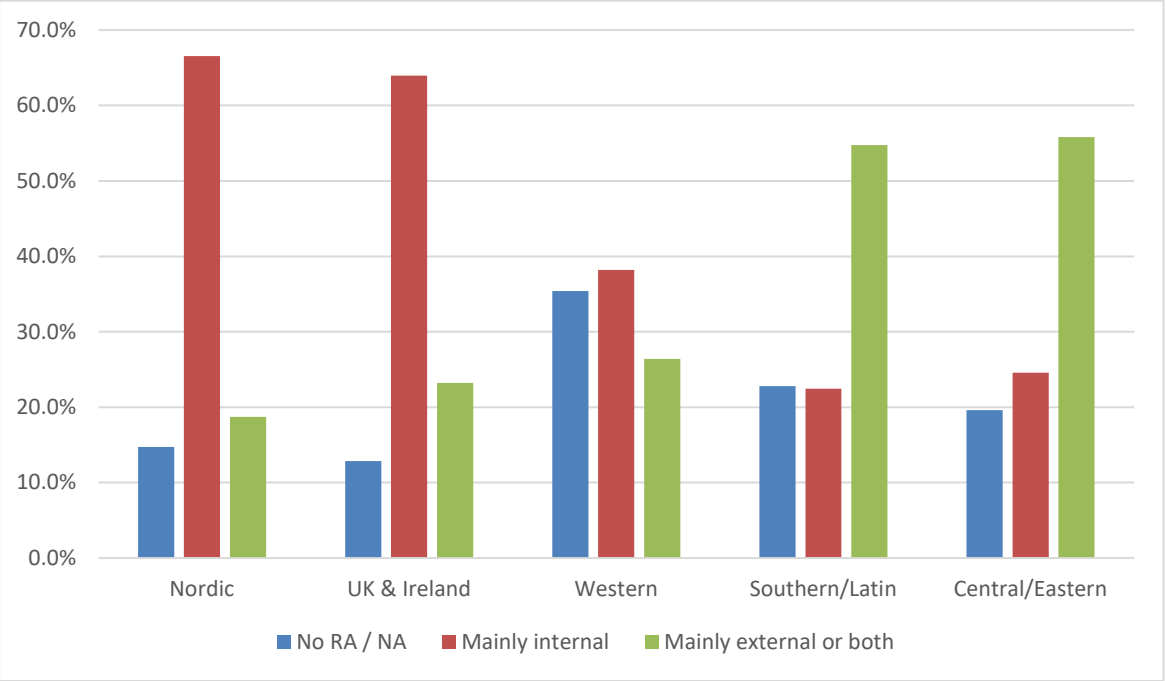


Figure 16: Proportion (%) of enterprises reporting that risk assessments are mainly conducted by internal staff or by external providers (Q250 and Q251) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 17: Proportion (%) of enterprises reporting that risk assessments are mainly conducted by internal staff or by external providers (Q250 and Q251) by enterprise size

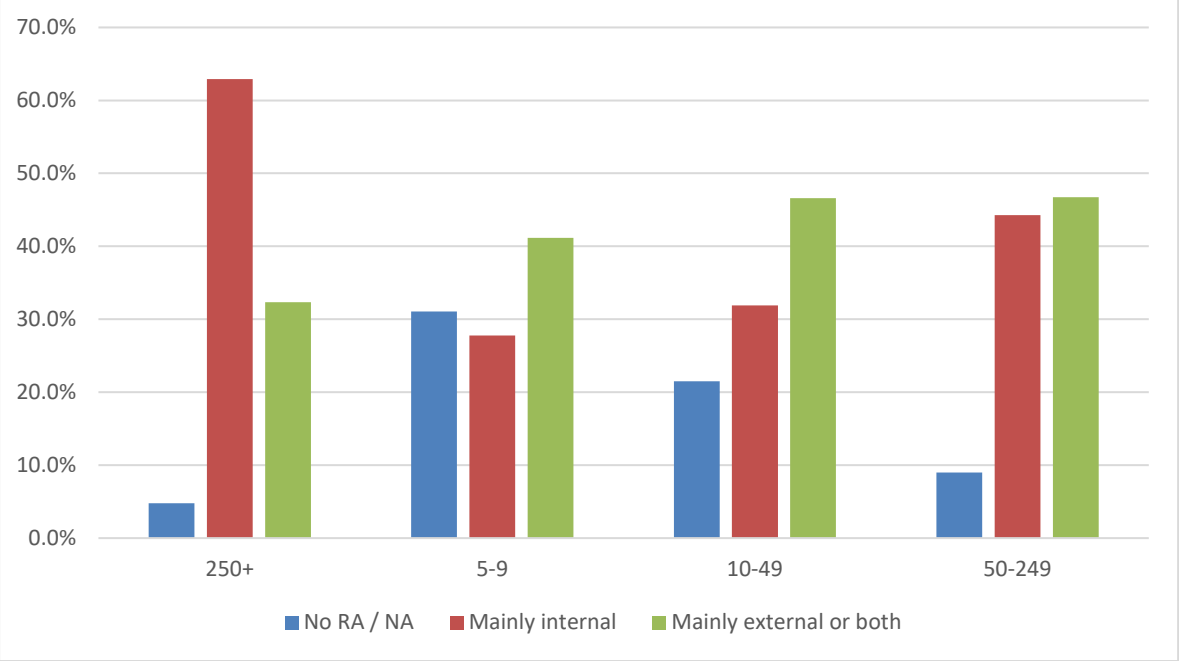


Figure 18: Proportion (%) of enterprises reporting that risk assessments are mainly conducted by internal staff or by external providers (Q250 and Q251) by sector

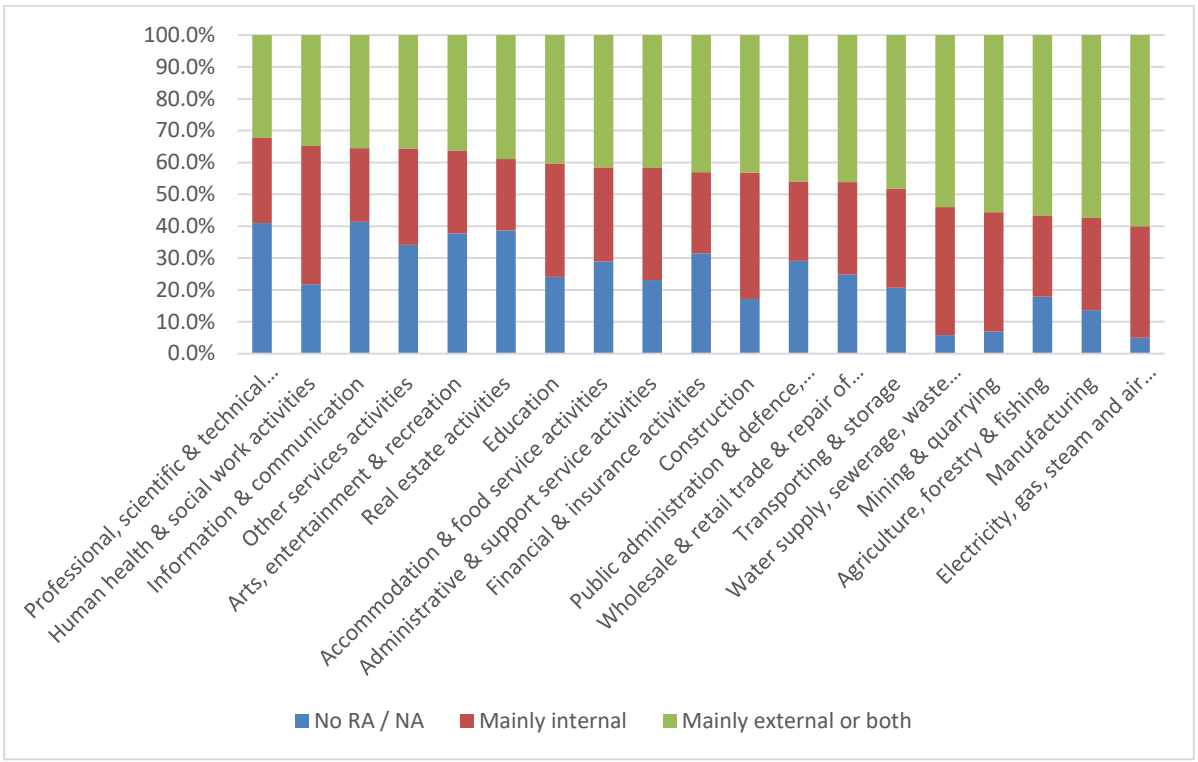
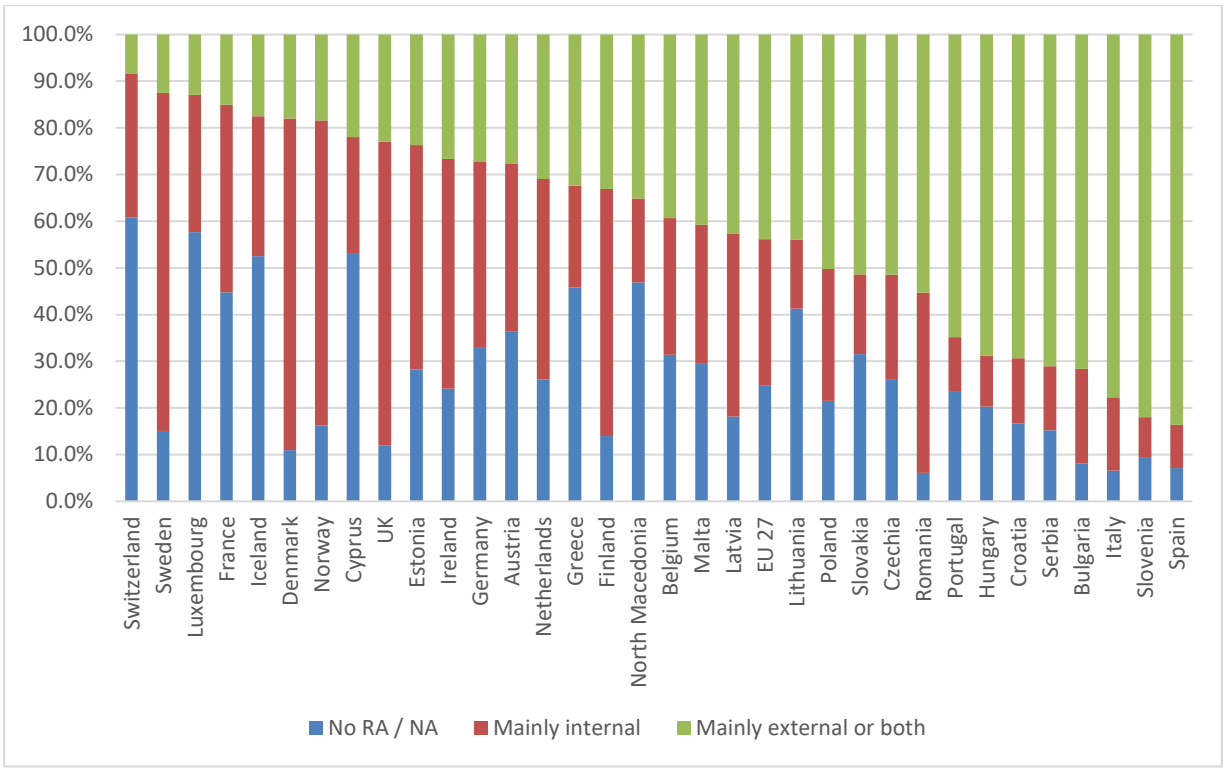


Figure 19: Proportion (%) of enterprises reporting that risk assessments are mainly conducted by internal staff or by external providers (Q250 and Q251) by country:



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Turning to the use of OSH information, analysis of answers to Q358 indicate about two thirds of respondents reporting using health and safety information from contracted health and safety experts (Figure 20). This was most commonly reported in the Central/Eastern countries and among medium and large enterprises (Figures 21 and 22), with some variation by sector and country (Figures 23 and 24). This doesn't seem especially surprising, as would be more unusual for respondents to suggest that they had not made use of information from 'contracted health and safety experts', although it is perhaps a further indication that they have found these experts 'useful'.

Figure 20: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3)

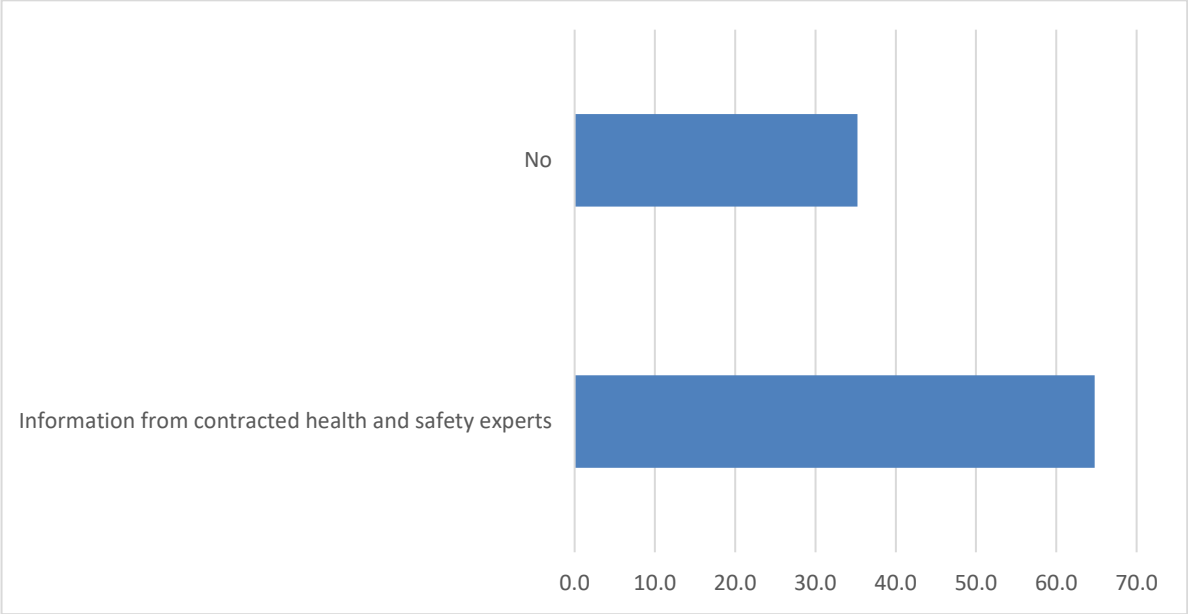
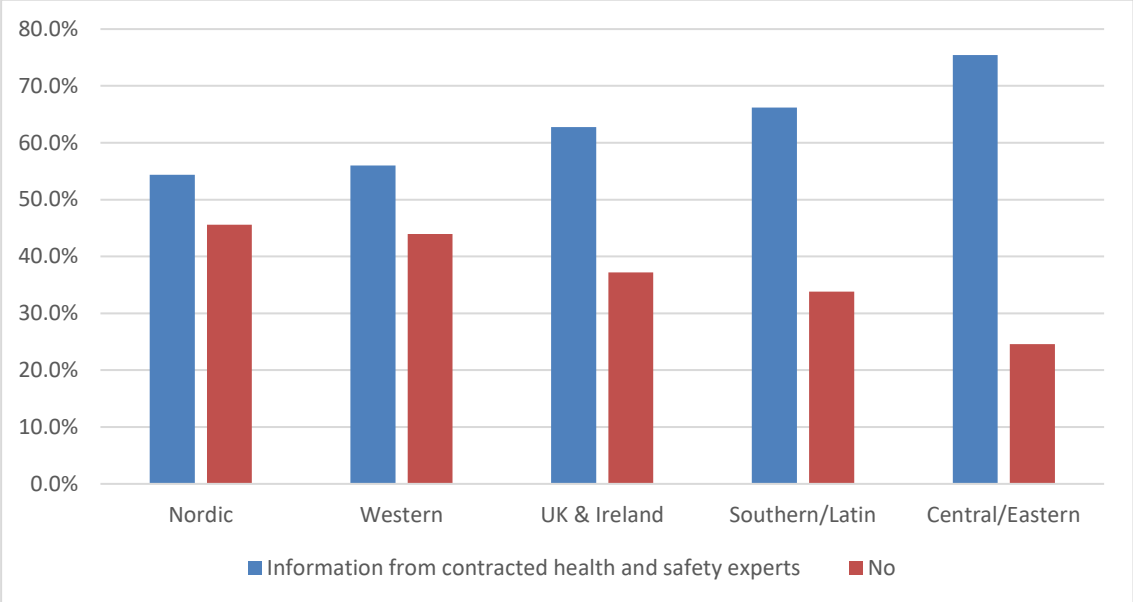


Figure 21: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 22: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3) by enterprise size

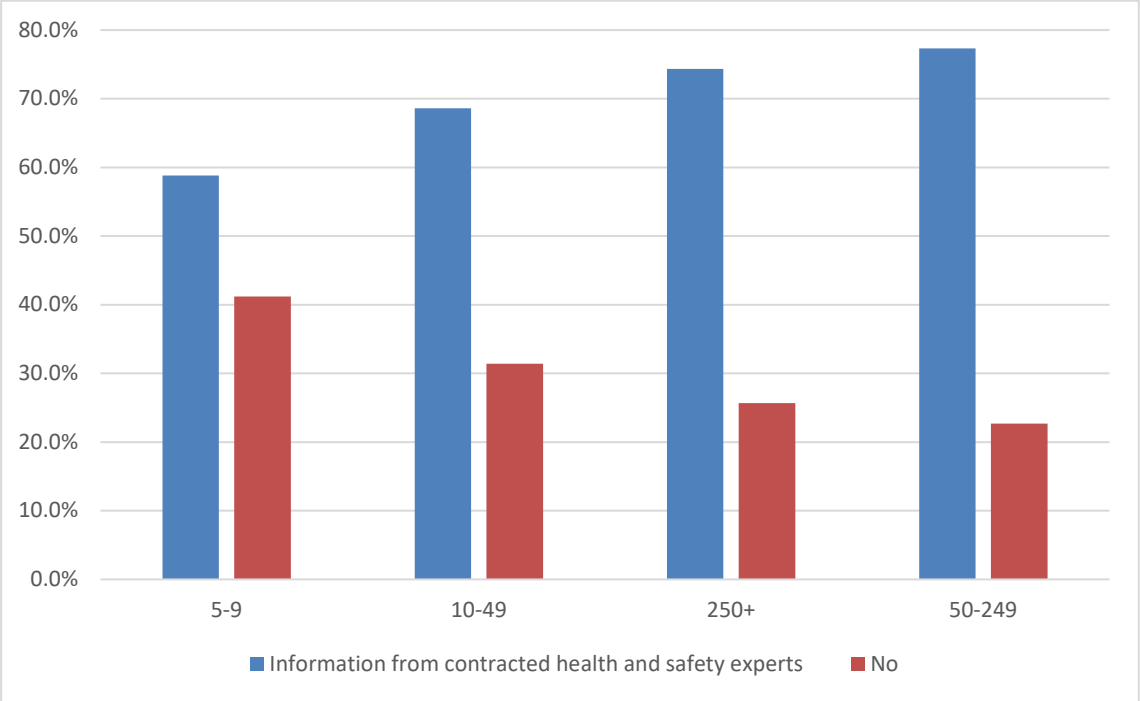


Figure 23: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3) by sector

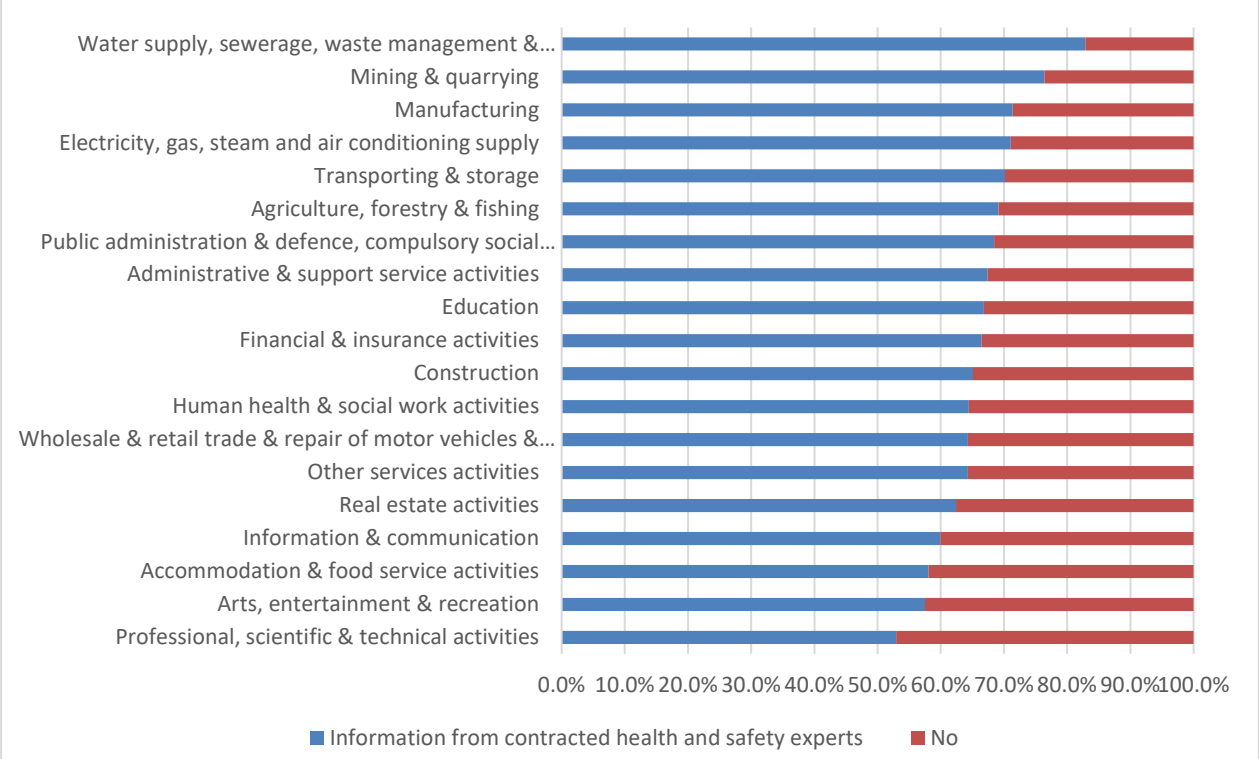
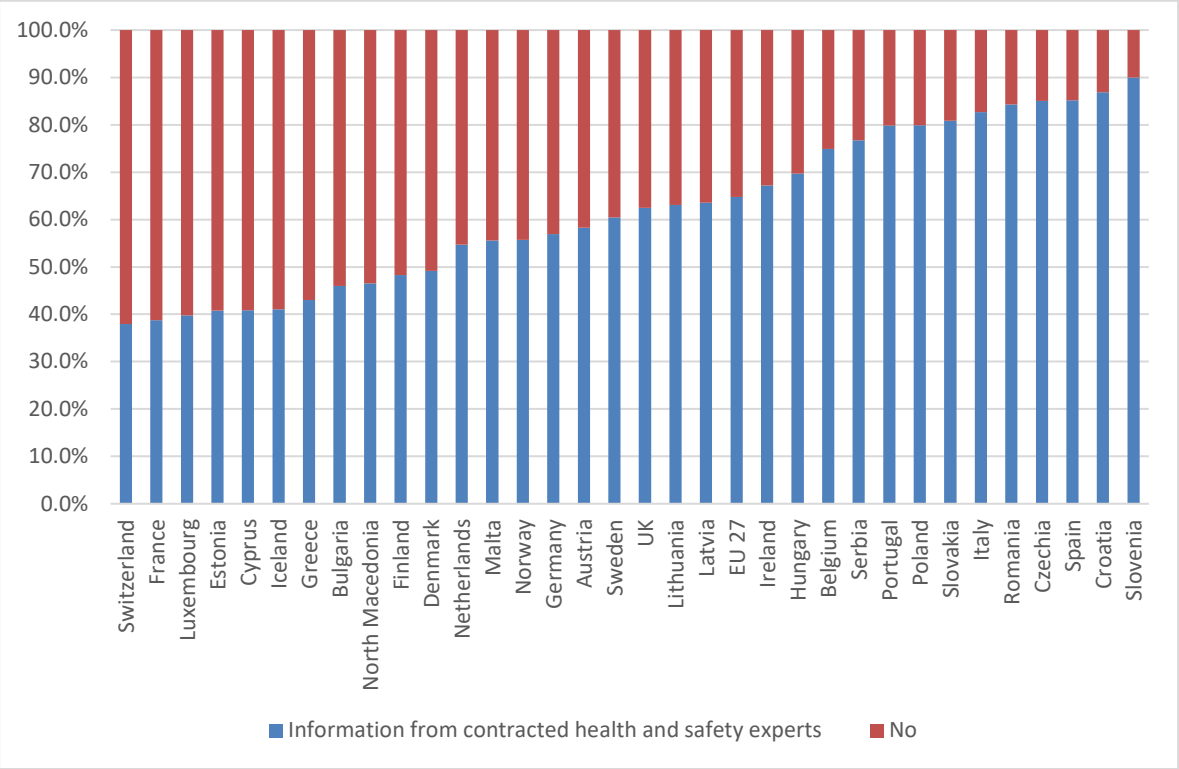


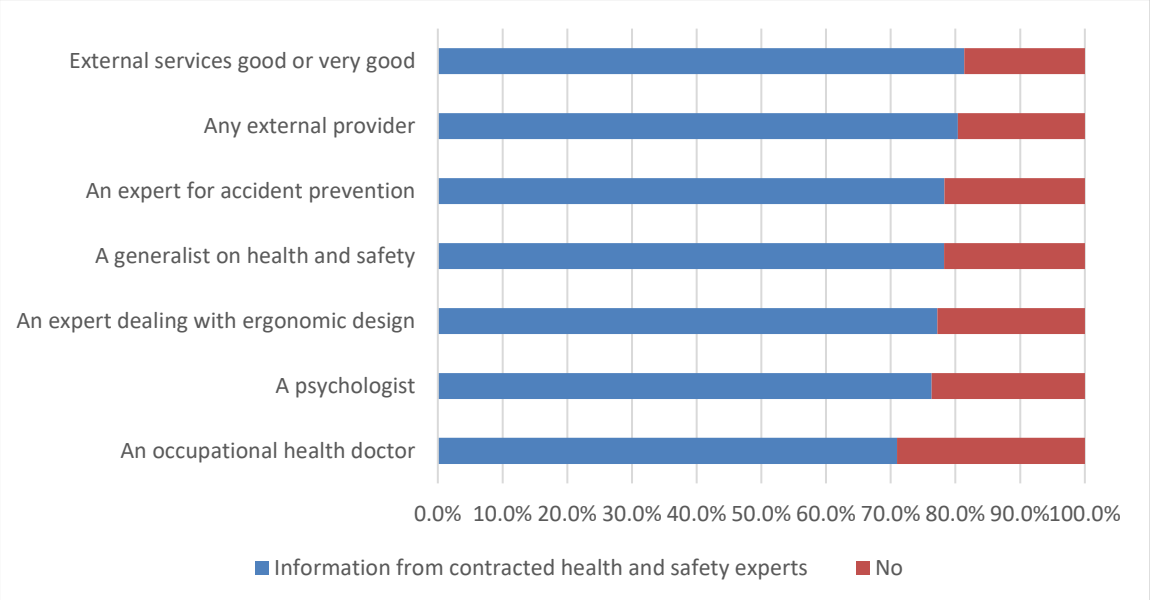
Figure 24: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 25 shows little variation in the proportion reporting the use of health and safety information from contracted health and safety experts when broken down by the reported use of health and safety services, external services, or positive rating of external services.

Figure 25: Proportion (%) of enterprises reporting the use of health and safety information from contracted health and safety experts (Q358_3) by use of services (Q151), external services (Q152) and rating external services as quite or very good (Q153)



Turning to responses to ESENER 2019 questions concerning challenges perceived by respondents in delivering appropriate OSH arrangements, analysis indicates that a little under a third of respondents report that 'lacking the necessary expertise' is a reason risk assessments are not regularly carried out (Figure 26). This varies by country group, from 37% in the Southern/Latin countries to 19% in the Central/Eastern countries (Figure 27). Lack of expertise is also most commonly reported among medium sized enterprises (Figure 28), those in the electricity, gas, steam & air conditioning supply, education and mining & quarrying sectors (Figure 29) and those in France (Figure 30).

Figure 26: Proportion (%) of enterprises reporting that the necessary expertise is lacking as a reason risk assessments are not regularly carried out (Q260_4)

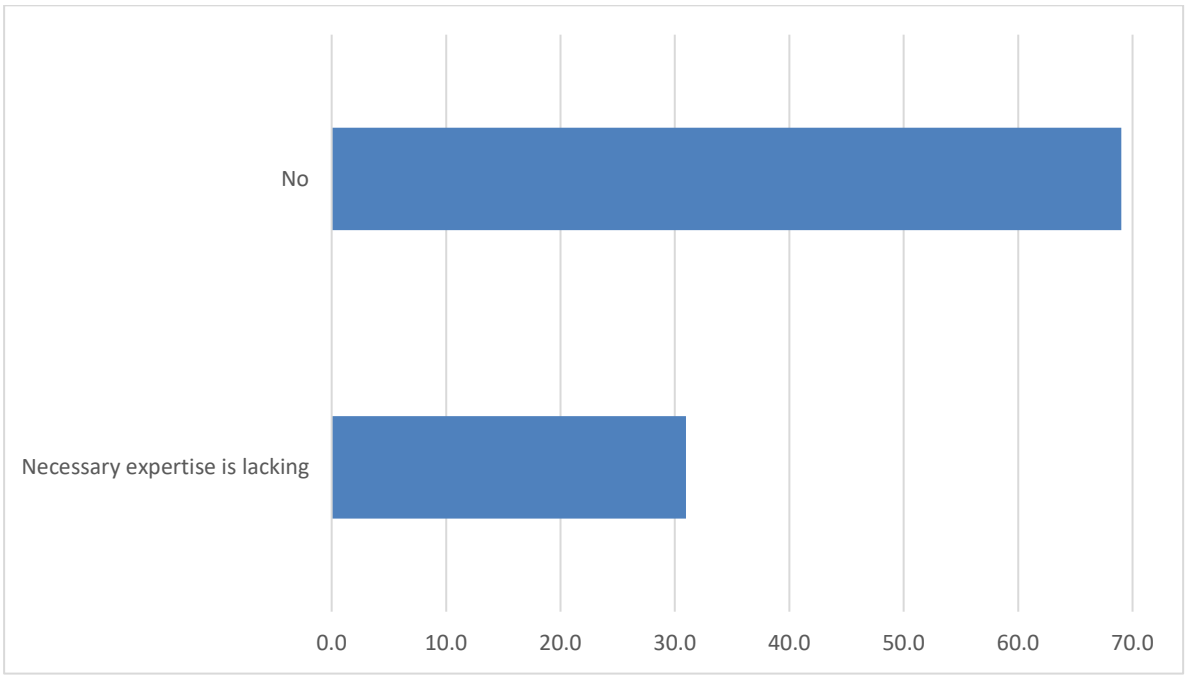
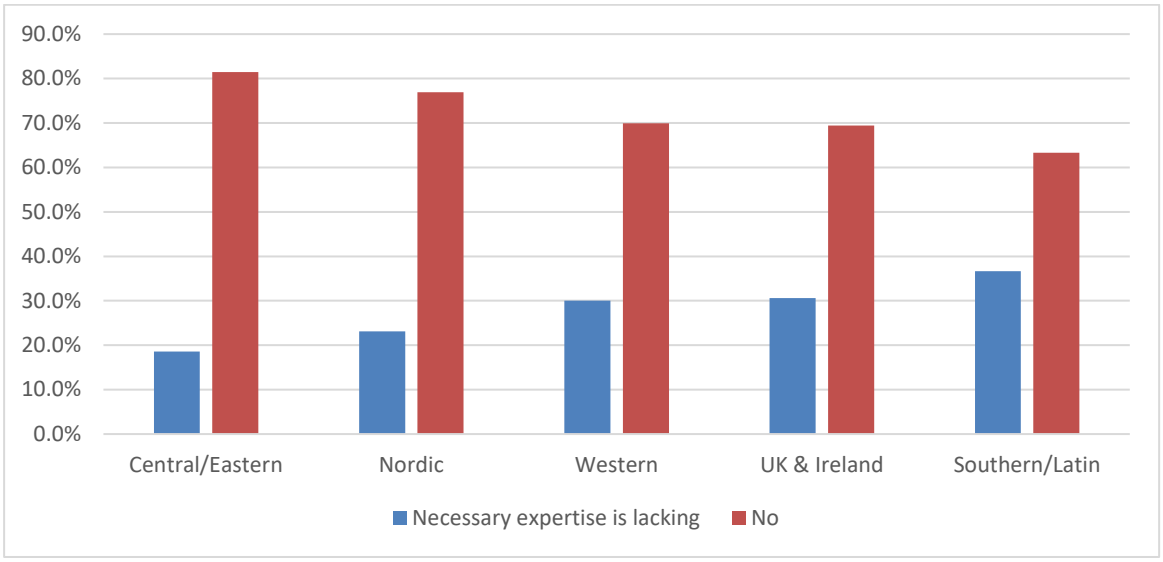


Figure 27: Proportion (%) of enterprises reporting that the necessary expertise is lacking as a reason risk assessments are not regularly carried out (Q260_4) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 28: Proportion (%) of enterprises reporting that the necessary expertise is lacking as a reason risk assessments are not regularly carried out (Q260_4) by enterprise size

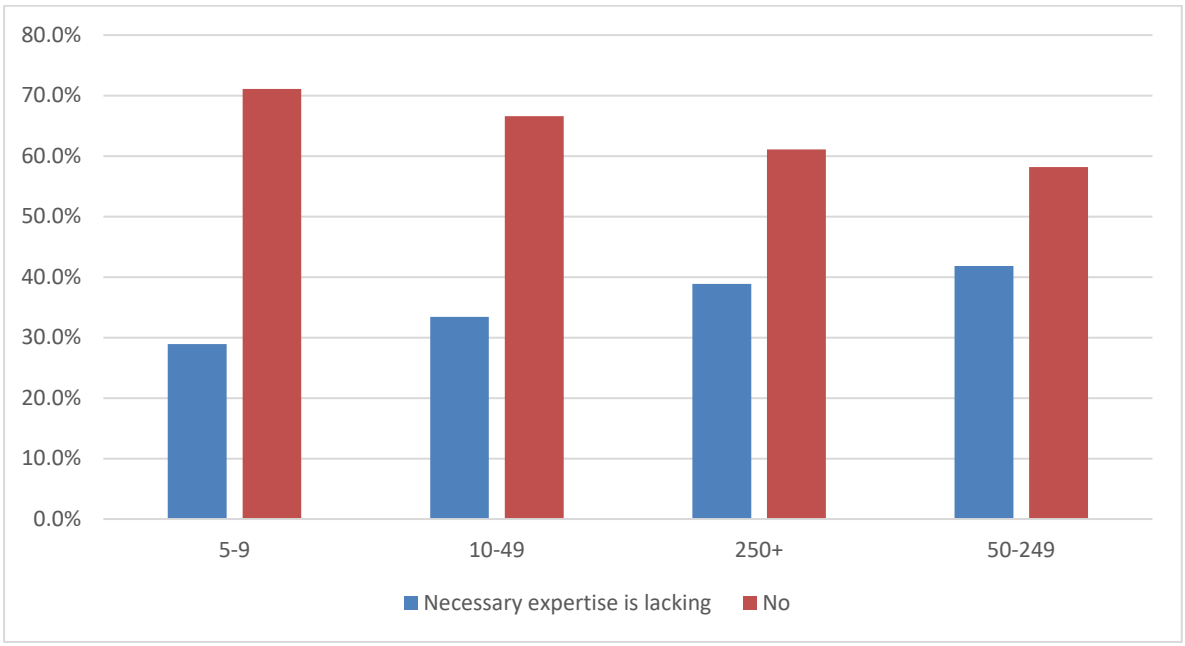


Figure 29: Proportion (%) of enterprises reporting that the necessary expertise is lacking as a reason risk assessments are not regularly carried out (Q260_4) by sector

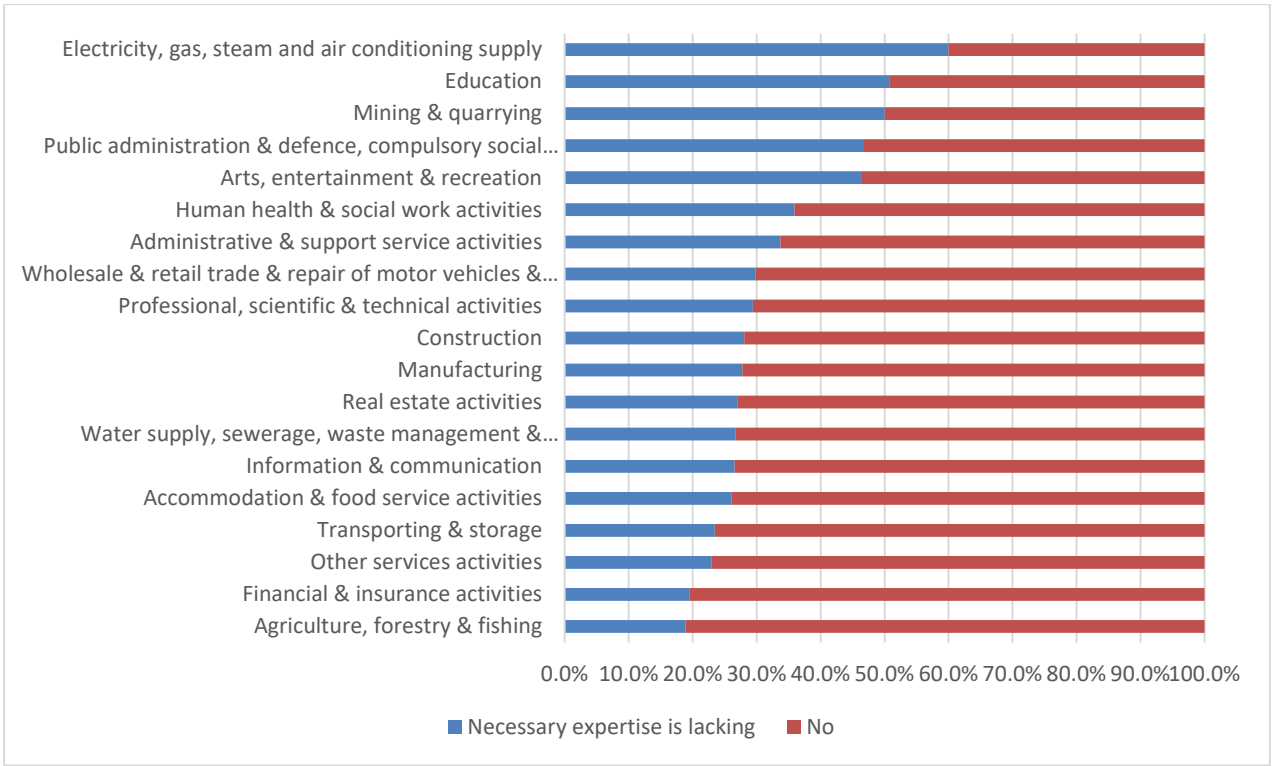
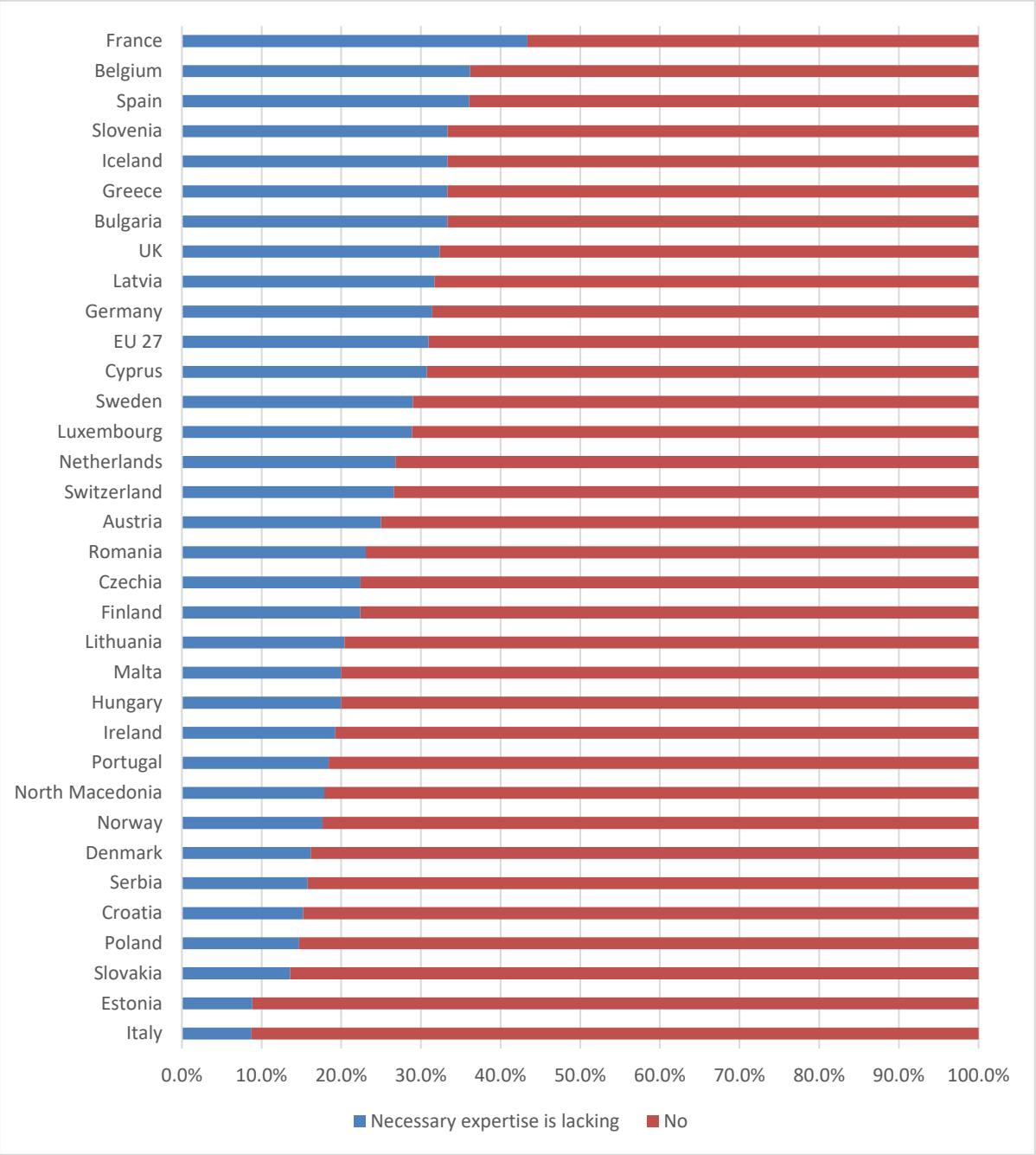


Figure 30: Proportion (%) of enterprises reporting that the necessary expertise is lacking as a reason risk assessments are not regularly carried out (Q260_4) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries

More generally, respondents were also asked 'what are the main difficulties in addressing health and safety in your establishment?'. Figure 31 shows that a little over 30% report that neither lack of time or staff nor lack of expertise or specialist support are a difficulty in addressing health and safety, while a third (33%) report that both are a major or minor difficulty. For those reporting only one of these areas as problematic, lack of expertise or specialist support is less commonly cited than lack of staff or time (7% and 29%). Again, some variation is apparent by enterprise size, sector and location (Figures 32 to 35).

Figure 31: Proportion (%) of enterprises reporting lack of time or staff and/or lack of expertise or specialist support as major or minor difficulties or not a difficulty at all in addressing health and safety (Q263_1 and Q263_5)

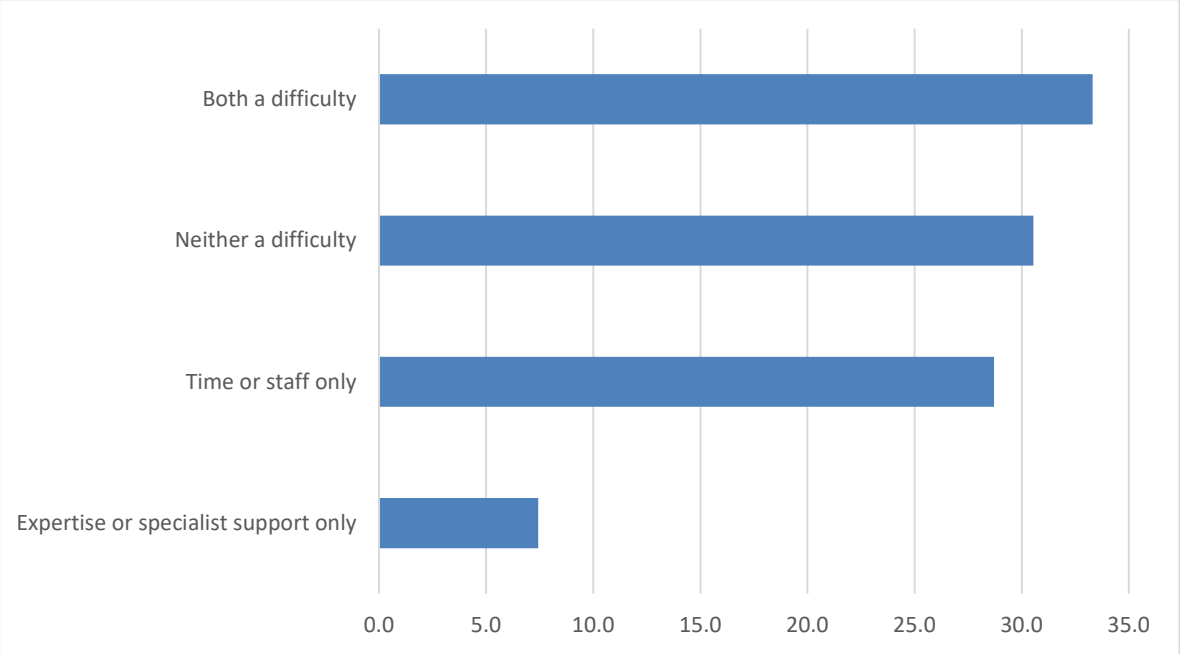
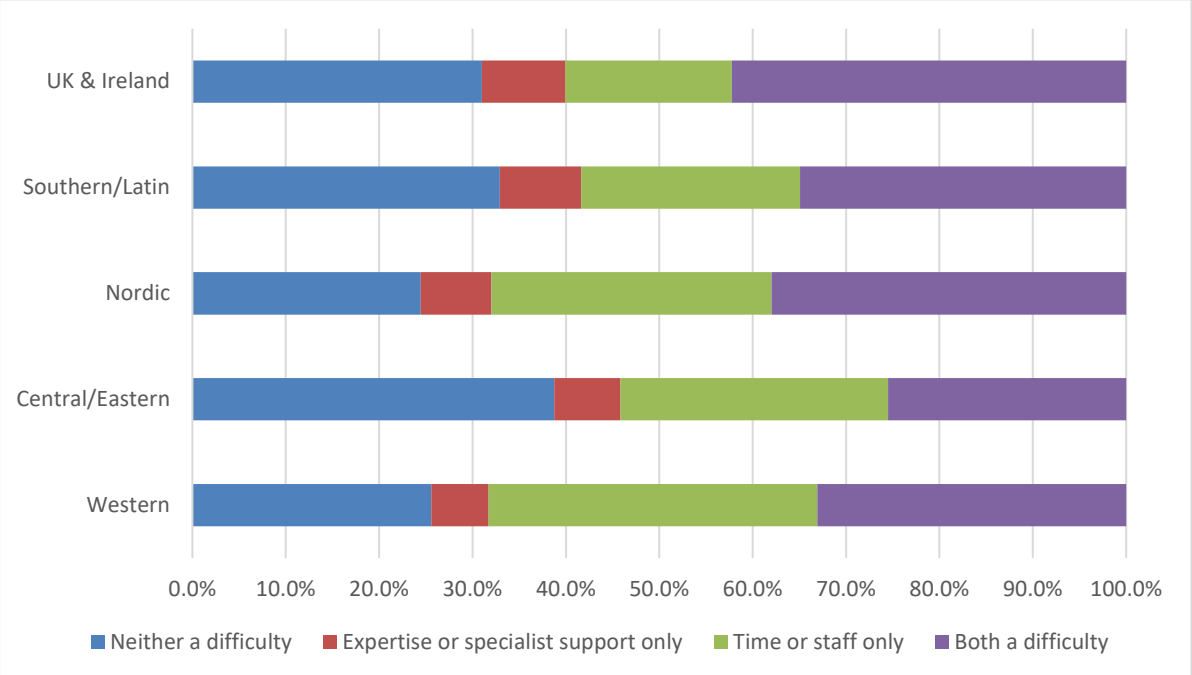


Figure 32: Proportion (%) of enterprises reporting lack of time or staff and/or lack of expertise or specialist support as major or minor difficulties or not a difficulty at all in addressing health and safety (Q263_1 and Q263_5) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Figure 33: Proportion (%) of enterprises reporting lack of time or staff and/or lack of expertise or specialist support as major or minor difficulties or not a difficulty at all in addressing health and safety (Q263_1 and Q263_5) by enterprise size

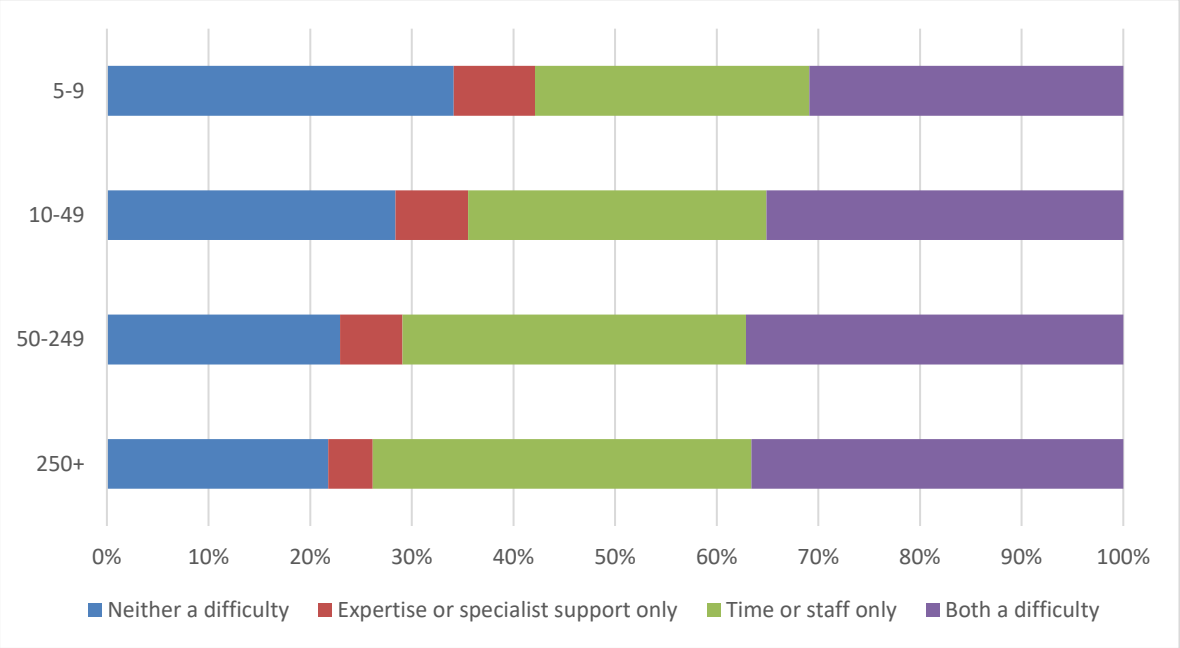


Figure 34: Proportion (%) of enterprises reporting lack of time or staff and/or lack of expertise or specialist support as major or minor difficulties or not a difficulty at all in addressing health and safety (Q263_1 and Q263_5) by sector

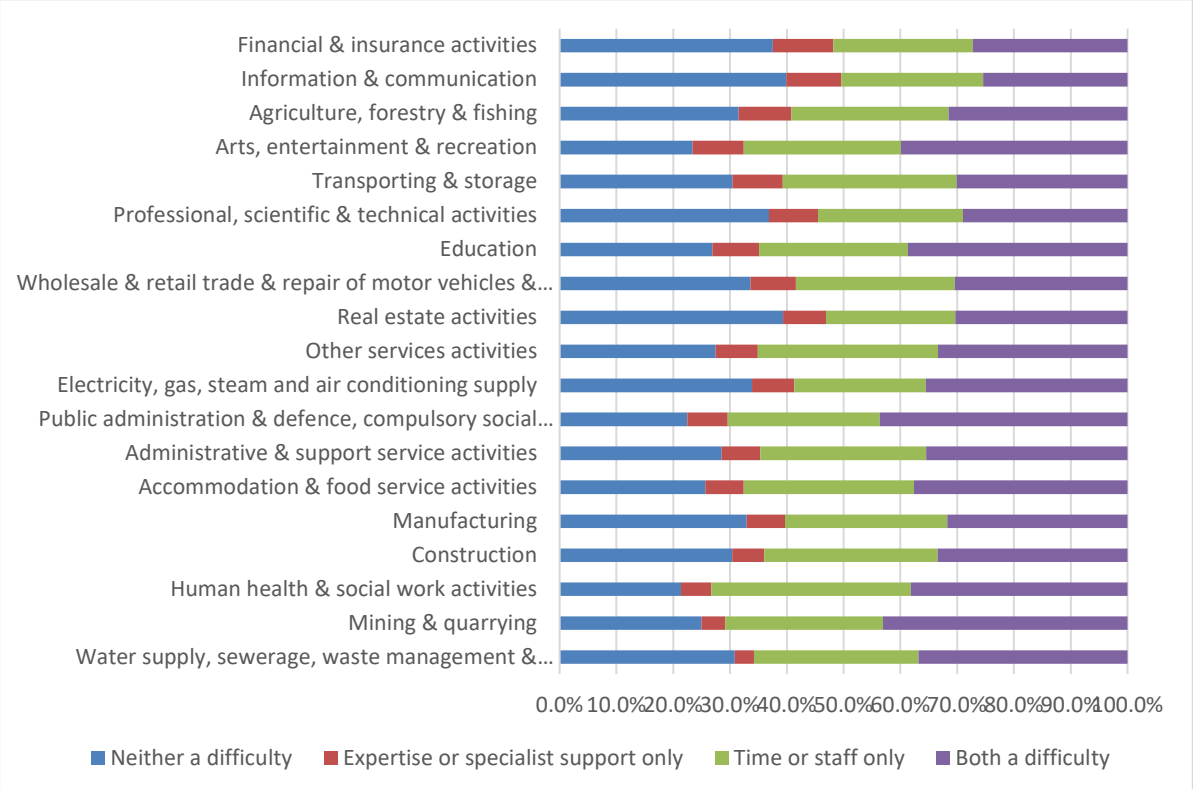
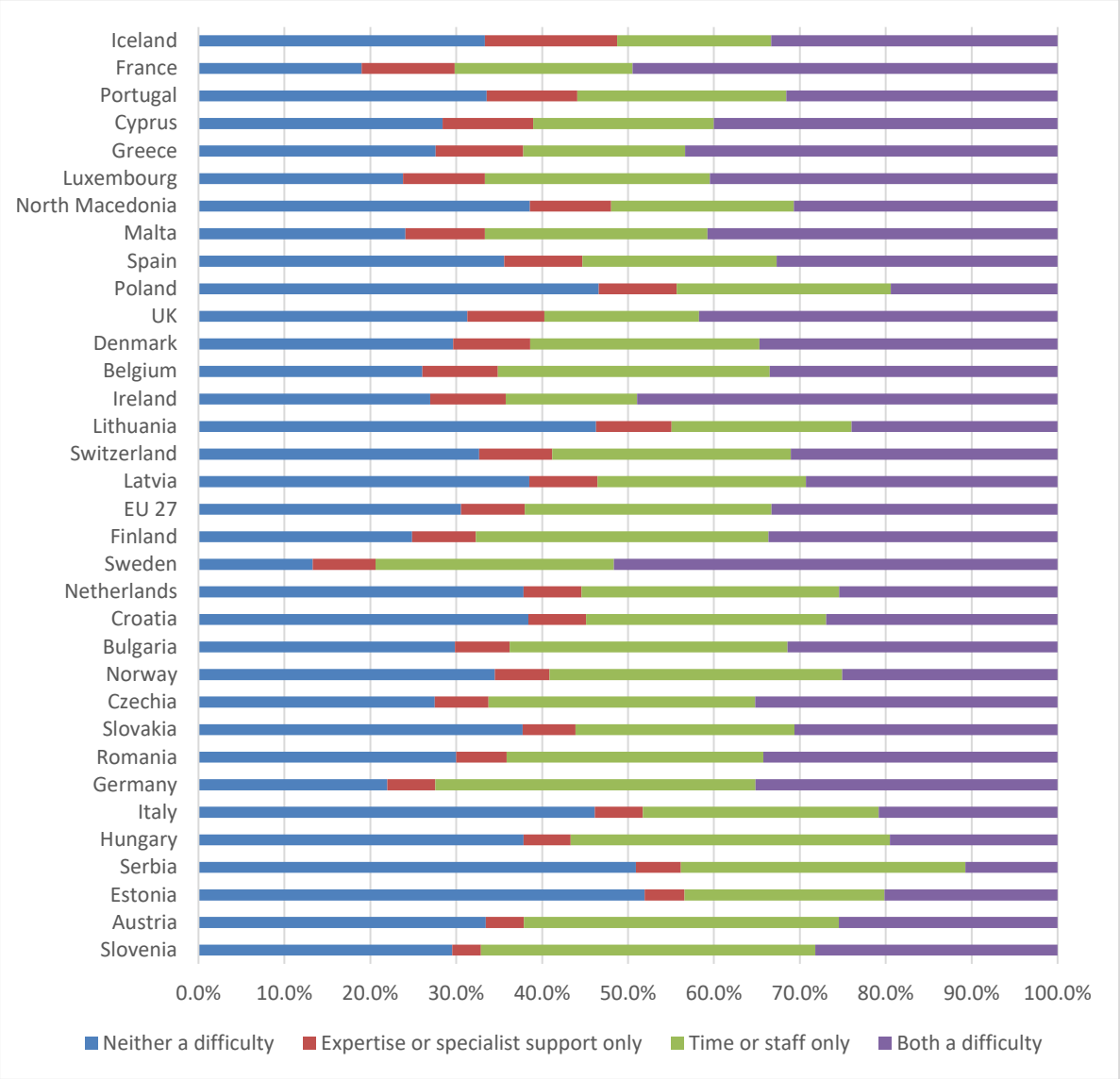


Figure 35: Proportion (%) of enterprises reporting lack of time or staff and/or lack of expertise or specialist support as major or minor difficulties or not a difficulty at all in addressing health and safety (Q263_1 and Q263_5) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries.

Respondents were asked a similar question in relation to 'What are the main obstacles to dealing with psychosocial risks in your establishment?' which identifies gives 'lack of expertise or specialist support' as one possible reason. Nearly half (46%) the respondents report that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Figure 36). Identifying this gap was most common in the UK & Ireland and Southern/Latin countries and in the mining & quarrying and public administration & defence, compulsory social security sectors, but there was less variation by enterprise size (Figures 37 to 40). Linking these findings with those reported previously concerning sector differences in the experience of respondents of competency on psychology among OSH prevention services may suggest a weakness in provision of support here, but the evidence is tentative.

Figure 36: Proportion (%) of enterprises reporting that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Q308_4)

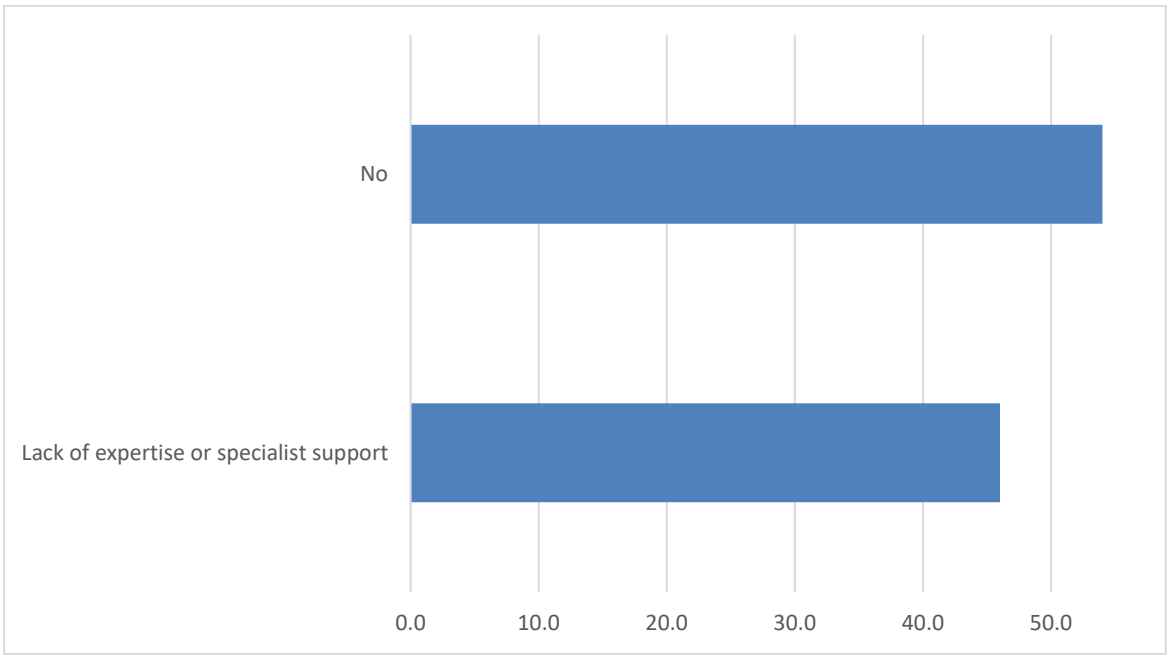
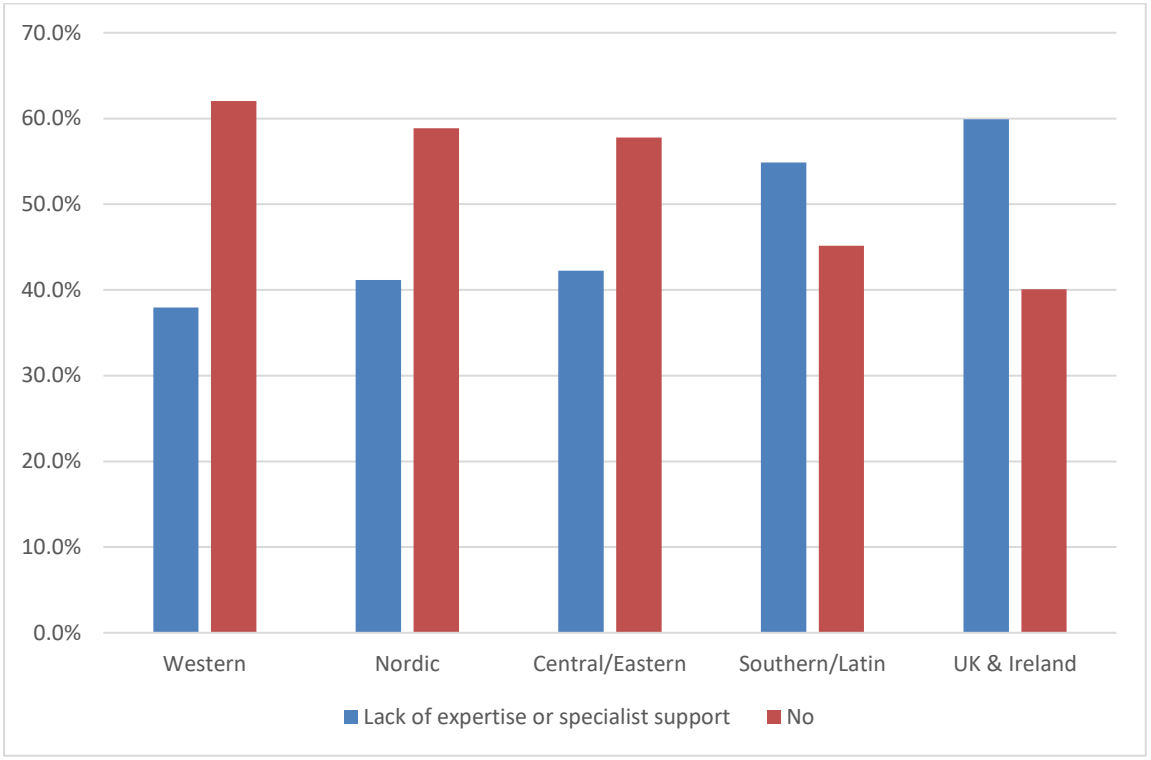


Figure 37: Proportion (%) of enterprises reporting that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Q308_4) by country group



Note: Based on respondents to the 2019 survey from all 33 participating countries

Figure 38: Proportion (%) of enterprises reporting that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Q308_4) by enterprise size

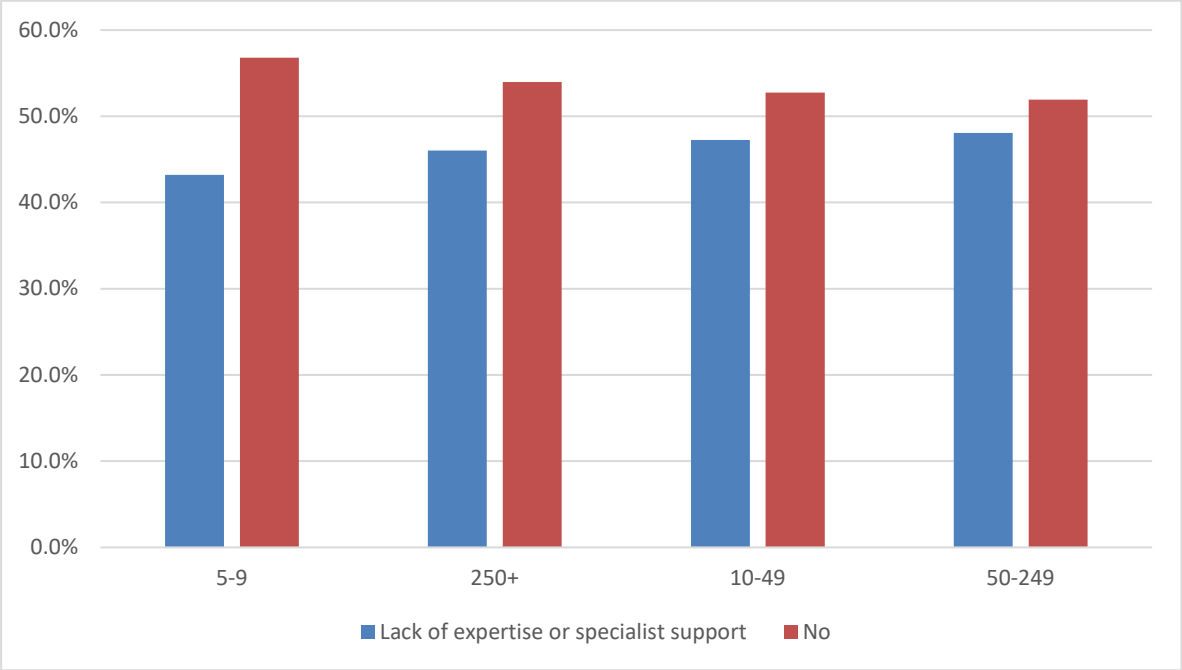


Figure 39: Proportion (%) of enterprises reporting that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Q308_4) by sector

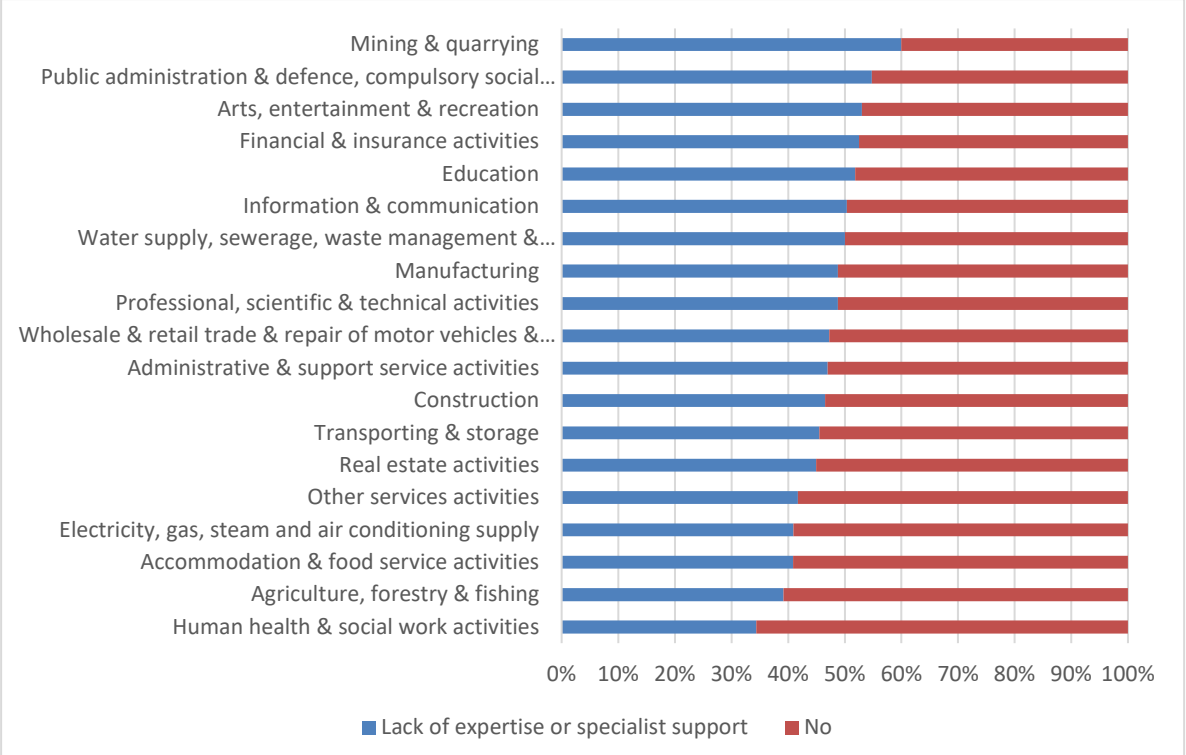
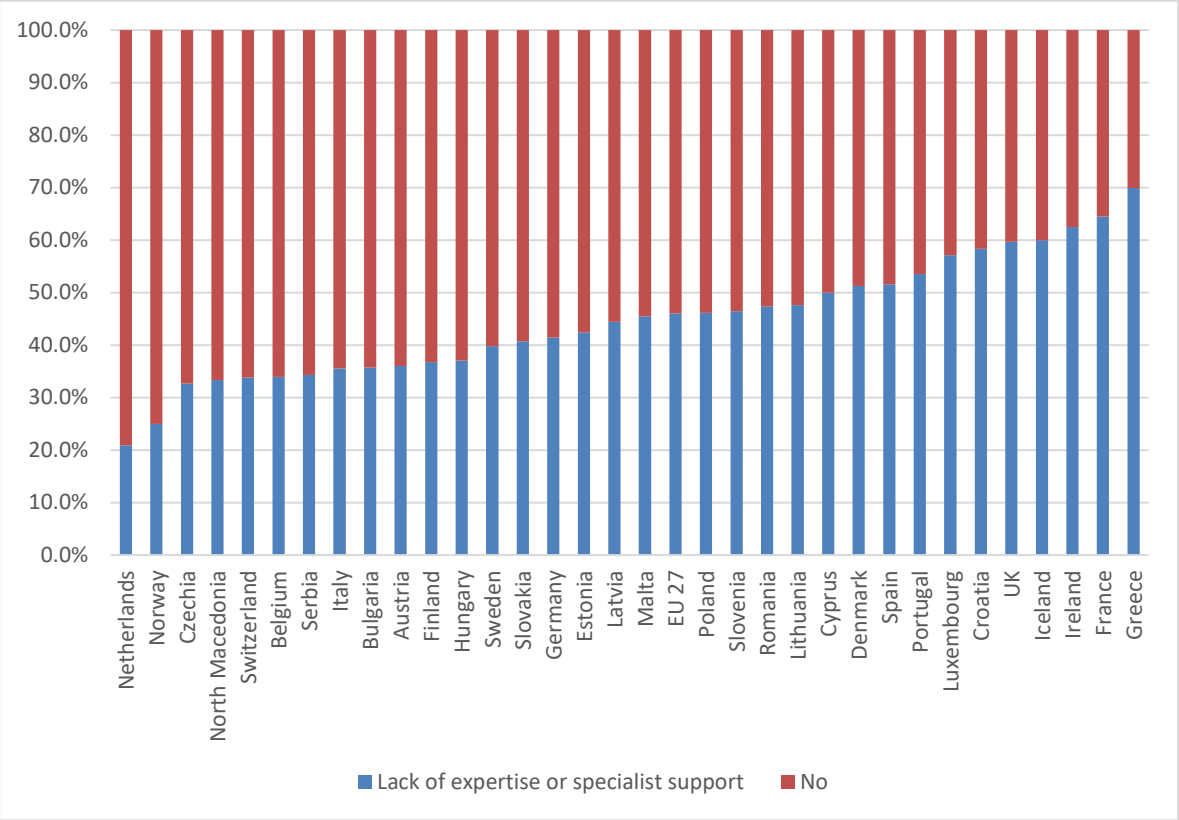


Figure 40: Proportion (%) of enterprises reporting that lack of expertise or specialist support is the main obstacle for dealing with psychosocial risks (Q308_4) by country



Note: Based on respondents to the 2019 survey from all 33 participating countries.

4 Comparison with ESENER 2014

Finally, in the descriptive analysis of the data it has been possible to make some limited comparison between ESESNER 2014 and ESENER 2019 where similar questions have allowed. As well as that concerning competencies already presented in Table 1, they were also possible in relation to who conducted risk assessments. Table 2 shows there was little difference in the overall responses to the two surveys.

Table 2: Differences in who conducted risk assessment: comparison between ESENER 2014 and 2019

	2014	2019
Contracted mainly to external providers	34%	35%
Conducted mainly by internal staff	31%	31%
No risk assessment or no answer	26%	25%
Both about equally	9%	8%

Note: Based on respondents from the EU 27 Member States within the 2014 and 2019 surveys.

However, Table 3 suggests some differences by Member States. For example, considering the use of mainly external providers for risk assessment, Serbia, Italy, Slovakia, Spain, Malta, Poland, Portugal and Hungary all saw increases of over 5% in 2019 compared with 2014 (ranging from 18.8% in Serbia to 8.9% in Hungary); while Lithuania and North Macedonia saw decreases of over 5% in 2019 compared with 2014 (from -13.2% and -7.3% respectively).

Table 3: Differences in who conducted risk assessment by country: Comparison between ESENER 2014 and 2019

	No risk assessment		Mainly internal		Mainly external		Both	
	2014	2019	2014	2019	2014	2019	2014	2019
Spain	8.1%	7.1%	14.4%	9.2%	65.7%	76.4%	11.7%	7.3%
Slovenia	3.8%	9.3%	10.2%	8.7%	78.3%	74.7%	7.7%	7.3%
Italy	3.7%	6.5%	20.3%	15.7%	52.6%	66.0%	23.4%	11.7%
Serbia	21.1%	15.2%	21.3%	13.7%	46.0%	64.8%	11.6%	6.3%
Hungary	17.0%	20.3%	18.4%	10.9%	55.2%	64.1%	9.4%	4.8%
Bulgaria	7.5%	8.1%	13.9%	20.2%	65.4%	61.9%	13.2%	9.8%
Croatia	16.5%	16.7%	7.2%	14.0%	63.0%	60.3%	13.3%	9.0%
Portugal	18.9%	23.4%	21.3%	11.8%	50.9%	59.9%	8.9%	4.9%
Poland	15.4%	21.5%	42.8%	28.3%	37.3%	47.4%	4.5%	2.9%

	No risk assessment		Mainly internal		Mainly external		Both	
Slovakia	34.0%	31.5%	24.5%	17.1%	31.9%	44.3%	9.5%	7.1%
Romania	9.8%	6.1%	41.9%	38.6%	43.0%	43.9%	5.3%	11.4%
Lithuania	23.5%	41.3%	22.0%	14.8%	47.6%	40.3%	6.9%	3.7%
Czech Rep.	17.9%	26.2%	24.8%	22.3%	39.8%	38.9%	17.5%	12.6%
Latvia	13.0%	18.1%	46.0%	39.1%	34.3%	38.7%	6.6%	4.2%
Malta	26.8%	29.1%	33.9%	29.1%	22.6%	32.7%	16.6%	9.1%
North Macedonia	33.3%	46.9%	17.7%	18.0%	45.2%	32.0%	3.8%	3.1%
EU 27	26.2%	24.7%	30.5%	31.4%	34.1%	30.5%	9.3%	9.2%
Greece	43.6%	45.8%	23.3%	21.8%	26.7%	24.6%	6.4%	7.8%
Belgium	26.6%	31.4%	32.8%	29.3%	22.0%	24.3%	18.6%	15.1%
Netherlands	20.6%	26.1%	42.6%	42.9%	22.9%	21.0%	13.9%	9.9%
Finland	21.4%	13.9%	50.6%	53.0%	17.5%	19.5%	10.5%	13.5%
Germany	23.9%	33.1%	43.0%	39.8%	22.9%	18.1%	10.2%	9.0%
Austria	34.4%	36.3%	34.0%	35.9%	18.1%	17.6%	13.5%	10.2%
Estonia	26.4%	28.2%	45.5%	48.1%	20.7%	17.6%	7.4%	6.1%
Ireland	20.7%	24.1%	53.5%	49.3%	10.7%	15.2%	15.0%	11.4%
Cyprus	40.7%	53.0%	26.4%	25.0%	16.3%	13.0%	16.6%	9.0%
Denmark	6.3%	11.0%	74.7%	71.2%	9.5%	11.3%	9.4%	6.6%
France	34.1%	44.7%	51.6%	40.2%	8.7%	9.5%	5.6%	5.5%
UK	5.8%	12.0%	72.3%	65.0%	7.3%	8.9%	14.6%	14.1%
Iceland	56.3%	52.5%	28.3%	30.0%	5.7%	7.5%	9.8%	10.0%
Luxembourg	57.3%	57.6%	28.5%	29.4%	6.0%	5.9%	8.2%	7.1%
Norway	16.2%	16.2%	62.5%	65.5%	4.8%	4.4%	16.4%	13.9%
Switzerland	44.7%	60.8%	35.8%	30.9%	4.3%	4.4%	15.2%	4.0%
Sweden	15.5%	15.1%	69.7%	72.4%	3.1%	3.2%	11.7%	9.3%

Note: Based on respondents from 33 countries which participated in the 2019 survey, within the 2014 and 2019 surveys.

While, as Table 4 indicates, there has been a slight rise in the overall proportion of respondents for whom lacking the necessary expertise was given as a reason for NOT conducting risk assessments. Considering this at the country level (Table 5) showed more variation, with Slovenia, Germany, Malta, Czech Rep., Luxembourg, Spain, Iceland, Cyprus, Switzerland, Austria and Sweden seeing increases of over 5% in 2019 compared with 2014 (from 19% in Slovenia to 6% in Sweden); while Romania, Serbia, Norway, Finland, Greece, Portugal, Italy, Ireland and North Macedonia saw decreases of over 5% in 2019 compared with 2014 (from -21% in Romania to -5% in North Macedonia).

Table 4: Comparison between ESENER 2014 and 2019 on reasons for not conducting risk assessments

	2014	2019
Risks are already known	84.3%	84.0%
No major problems	81.0%	80.3%
Necessary expertise is lacking	28.5%	31.0%
Procedure is too burdensome	24.5%	20.9%

Note: Based on respondents from the EU 27 Member States within the 2014 and 2019 surveys.

Table 5: Necessary expertise is lacking as a reason for not conducting risk assessments: comparison between ESENER 2014 and 2019 within each Member State

	2014	2019
France	47.5%	43.4%
Belgium	37.8%	36.2%
Spain	28.8%	36.1%
Slovenia	14.3%	33.3%
Iceland	26.1%	33.3%
Bulgaria	31.1%	33.3%
Greece	42.0%	33.3%
UK	30.4%	32.4%
Latvia	28.1%	31.7%
Germany	19.8%	31.4%
EU 27	28.5%	31.0%
Cyprus	23.7%	30.8%
Sweden	23.5%	29.0%
Luxembourg	20.4%	28.9%

	2014	2019
Netherlands	25.3%	26.8%
Switzerland	19.8%	26.6%
Austria	18.5%	25.0%
Romania	43.9%	23.1%
Czech Rep.	13.4%	22.4%
Finland	31.8%	22.4%
Lithuania	22.5%	20.4%
Malta	9.1%	20.0%
Hungary	18.8%	20.0%
Ireland	25.0%	19.3%
Portugal	26.9%	18.4%
North Macedonia	23.3%	17.9%
Norway	27.0%	17.6%
Denmark	20.8%	16.2%

	2014	2019
Serbia	25.9%	15.8%
Croatia	17.1%	15.2%
Poland	16.6%	14.7%

	2014	2019
Slovakia	12.8%	13.6%
Estonia	9.8%	8.8%
Italy	16.9%	8.7%

Note: Based on respondents from 33 countries which participated in the 2019 survey, within the 2014 and 2019 surveys.

There were also no substantial differences between the responses to questions about major difficulties in addressing OSH, in both ESENER 2014 and in ESENER 2019, 14% of respondents identified 'lack of expertise or specialist support' as a major difficulty — as shown in Table 6. Table 7 shows that while Slovakia, Luxembourg and Czech Rep. saw increases of over 5% in those identifying lack of expertise or specialist support as a major difficulty in 2019 compared with 2014 (from 7% in Slovakia to 6% in Czech Rep.), Ireland saw a decrease of over 5% (6%).

Table 6: Reasons for major difficulties with OSH

	2014	2019
Complexity of legal obligations	42.5%	42.0%
Time or staff	26.8%	33.4%
Paperwork	31.1%	31.0%
Money	24.3%	19.2%
Staff awareness	19.3%	18.9%
Expertise or specialist support	14.1%	14.2%
Management awareness	13.2%	12.3%

Note: Based on respondents from the EU 27 Member States within the 2014 and 2019 surveys.

Table 7: Expertise or specialist support is lacking as a major difficulty with OSH: comparison between ESENER 2014 and 2019 within each Member State

	2014	2019
France	24.5%	25.3%
Greece	23.6%	21.7%
Cyprus	17.0%	20.8%
Belgium	22.1%	20.2%

	2014	2019
Luxembourg	12.8%	19.3%
Spain	19.3%	18.6%
Netherlands	17.6%	15.7%
Poland	16.0%	15.4%

	2014	2019
Czech Rep.	8.9%	15.1%
Iceland	12.5%	15.0%
Italy	16.9%	14.5%
Bulgaria	13.1%	14.3%
EU 27	14.1%	14.2%
Slovakia	6.0%	12.9%
Portugal	13.1%	12.3%
Romania	15.6%	11.4%
Malta	9.7%	11.3%
Sweden	10.2%	11.0%
Ireland	17.2%	10.8%
UK	9.6%	10.5%
Denmark	10.1%	10.4%

	2014	2019
North Macedonia	10.6%	10.2%
Switzerland	6.1%	9.9%
Estonia	9.4%	9.2%
Germany	6.5%	8.7%
Lithuania	10.9%	8.7%
Latvia	5.4%	6.7%
Finland	5.8%	6.2%
Slovenia	2.0%	6.0%
Hungary	7.2%	6.0%
Austria	5.5%	5.9%
Serbia	9.3%	5.4%
Croatia	6.7%	5.0%
Norway	3.9%	1.9%

Note: Based on respondents from 33 countries which participated in the 2019 survey, within the 2014 and 2019 surveys.

5 Conclusions and ways forward

ESENER 2019 provides information on the experience of support from OSH prevention services in establishments in EU Member States. It indicates experience of different forms of specialist support provided through both internal and external services, and how helpful respondents have found it. It also provides some information on its involvement in supporting the processes of risk assessment in their establishments. Looking at their experience from a somewhat different angle, it further suggests something of the needs of respondents for such support and their perception of gaps in its provision in relation to particular processes and risks — such as in the case of help with risk assessment or in addressing psychosocial risks more effectively.

The results of the analysis show a much higher level of experience of support for OSH from specialists, most of which would appear to involve external services, than that which might be anticipated from previous studies. It is not entirely clear why this is so but there are a number of possible explanations most likely to do with the nature of the survey and its participants that may help to account for it (as they also account for other comparatively high levels of OSH arrangements reported by ESENER). Spokespersons for EU-OSHA have previously commented that for the same reasons, the ESENER data is not intended to be used as a comparative measure of regulatory compliance and advised that it is inappropriate to do so. Nevertheless, the analysis shows similar variations in use between size and sector as reported in other surveys —for example, experience of the use of services increases with establishment size and is more frequent in the public sector than in private services with that in manufacturing falling somewhere in between. There is also variation in the experience of OSH services

between Member States, which may to some extent may reflect differences both in the nature of the economies involved as well as in in the predominant historical models of service provision in different Member States. Sector differences are suggested by the greater use of support from the services of psychologists found in public services like health and education which may reflect a greater awareness of the frequency and challenges of managing psychosocial risks in these sectors. However, the findings do not distinguish further clear patterns in these respects and the data is not thought likely to support further detailed analysis.

Most respondents who have experience of using support for OSH indicate they have been happy with the support they have received. Particular issues focused on in the ESENER 2019 interviews concerned the role of support in procedures for risk assessment and here analysis indicates both internal and external forms of specialist OSH support to be used in this way by a large proportion of the firms responding to the survey. There is a suggestion that Nordic establishments and those in the UK and Ireland may have internalized these processes more than firms in other countries. This would support previous analyses of earlier ESENER data, which indicated that countries with longer experience of the kinds of principle and process-based regulation such as found in the Framework Directive 89/391 may have adopted these approaches to OSH management more widely than others where the change to this regulatory approach is somewhat more recent. But the evidence here is somewhat tenuous and again the data probably doesn't support further analysis.

Turning to the needs for support from OSH services that are identified by the analysis of the ESENER 2019 data, almost a third of the respondents who do not undertake regular risk assessments report a reason for not doing so being that they lack 'the necessary expertise'. While some 13 per cent of respondents indicated that lack of expertise and specialist support for OSH were among the difficulties they encountered in addressing OSH in their establishments. Nearly half of respondents reported that lack of expertise or specialist support was the main obstacle in dealing with psychosocial risks.

Overall therefore, the analysis of the ESENER 2019 data on the experience and use of prevention services by establishments in EU 27 Member States adds some useful information to what is already known. This is helpful in providing a point of departure for the Discussion Paper[4] on OSH Prevention Services in the EU, which, as noted in the Introduction to this Report, constituted the second deliverable of the project commissioned by EU-OSHA (see Walters D., Wadsworth E.,). At first sight, the present analysis would appear to contradict some of the conclusions on OSH prevention services found in the 'Overarching Review on Improving the Extent and Quality of Support for Securing Compliance (EU-OSHA 2021), that preceded and stimulated the present project. For example, based on a detailed review of the relevant literature the Overarching Review noted that:

- The reality for the majority of workers in the EU is that they will have only very limited experience of direct contact with an OSH preventive service.

And further concluded that:

- There are no systematic data that are comparable between EU Member States on the extent of the coverage of prevention services or their effectiveness at the present time. However, such data that do exist suggest both the coverage and the effectiveness of these services are quite limited and that these services are strongly biased towards the needs of large enterprises that can resource their activities.

Among the aims of the present report was to interrogate the relevant parts of the ESENER 2019 data set to explore how far they supported or contradicted these conclusions. As reported above, the analysis appears to contradict the first conclusion of the previous report, in as far as it suggests that a substantial

[4] https://osha.europa.eu/en/publications/occupational-safety-and-health-prevention-services-experts-europe

proportion of respondents, have some experience of using OSH prevention services. As we have already pointed out however, generous estimations are a feature of the ESENER data more generally and EU-OSHA has itself cautioned against using them as absolute measures of comparative compliance. In relation to the second conclusion, the analysis adds to the available systematic data on extent of cover of OSH prevention services in EU Member States and shows a similar bias in coverage in favour of larger enterprises to that seen in the literature.

The Review goes on to suggest several further conclusions. Namely:

- The presence and practice of these services is subject to a host of challenges resulting from changing national contexts, including changes in the structure and organisation of work and labour markets, as well as political changes that determine what constitutes the support they provide and how it is resourced.
- There is little in the current structural and organisational contexts of these services to encourage notions of their centrality in the economies of EU Member States.
- Nowadays, external prevention services are increasingly required to take responsibility for the economic survival of prevention services in a competitive market for their business. Understanding the current relationship between prevention services, securing compliance and achieving better OSH practice requires some acknowledgement of this.
- There are some OSH prevention services in all EU Member States that have succeeded in finding the means to secure their sustainability and to deliver advice and guidance on good practices to support securing compliance and better practice in different sectors
- Consequent to changes in the structure and organisation of work and labour markets are changes in the nature of risk and the strategies used to manage this risk and to protect workers from harm. It would be surprising, under such circumstances, if there were not also concomitant changes needed in the nature of knowledge and professional expertise to support managing such protection. For instance, the growth in the presence and significance of the 'generalist' OSH practitioner within professional support for OSH in recent decades. However, there has been very little serious study of the consequences of this for the balance of professionalism generally in OSH, for the nature of the support it may bring to improving compliance and better practice, or indeed for the results of such support. Further research is therefore recommended here too.
- In increasingly de-structured and market-orientated economies, in which work is organised and controlled in a host of ways that limit the effectiveness of direct forms of intervention, the future effectiveness of these services lies in them developing in other directions. Ways for these services to deliver support for compliance and better practice in the disaggregated, fractured, fissured and remote forms of work organisation characteristic of the current economic structure need to be found, along with means of ensuring their relevance and use by persons responsible for these undertakings. There are therefore research questions to be addressed in relation to the delivery of new ways forward for the contribution of prevention services to securing compliance that are both sustainable and transferable.

Unfortunately, the analysis of ESENER 2019 presented in this report does not throw much light on any of these conclusions, primarily because the data collection for ESENER 2019 does not address them. The survey does not attempt to examine national contexts, or the position of OSH prevention services with their infrastructures or policy frameworks on support for work and health. Nor is it able to add meaningfully to the discourse concerning the marketisation of these services or what supports their sustainability in different EU Member States. The analysis identifies the presence of general OSH practitioners among the various forms of professional service offered by both internal and external services and the survey suggests experience of their use to be significant, but there is no information either in ESENER 2019 or through its comparison with ESENER 2014 that is helpful in exploring change in the balance of professionalism need to support OSH within establishments. Since the analysis of

ESENER 2019 indicates that the experience of prevention services is related to establishment size, it might be inferred that they are failing to reach the 'disaggregated, fractured, fissured and remote forms of work organisation characteristic of the current economic structure' that are further identified in the above conclusions of the Review. But ESENER 2019 did not seek data to address this directly and by virtue of their hard to reach nature, it might be anticipated they would be anyway under-represented among the respondents to the survey had it done so.

Overall therefore, the present analysis offered some interesting insights into the cover and use of OSH prevention services, and served as a point of departure for the aims of the second deliverable (Discussion Paper). However, the analysis was only able to contribute in a limited way to the existing and current debates about:

- current practice in terms of forms and functions of prevention services (market demands, structures and professional capacities);
- efficiency in terms of quality and coverage of the existing models of prevention service provision in the EU;
- role to be played by preventive services in the context of a changing world of work (among others: reorganisation and restructuring of work);
- quality of the services they provide;
- marketisation of prevention services;
- changes in the nature of OSH professions, their orientations and practice.'

However in the Discussion Paper were considered other sources of information, and including in its framework, reference to a considerable number of further sources of information drawn, for example, from: recent scientific articles and reports, grey literature, as well as results of other EU or national surveys. The paper combines a review of historical perspectives and reference to empirical findings on the presence and functions of professional practice in support of OSH, with a discussion of what the literature suggests helps to determine this presence and influences its role in support of OSH. This in turn leads to the identification of a number of gaps in current provision, along with exploration of ways in which professional practice on OSH has responded to the contexts in which it is situated. A discussion of the consequences of this, forms a further focus for the paper and leads to the identification of some key challenges for future policy and research that the paper concludes need to be addressed if professional support for OSH is to fulfil the expectations that are held of it.

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