



## *Small, Healthy and Competitive*

New Strategies for Improved Health in  
Small and Medium-Sized Enterprises

# *Report*

*on the Current Status of  
Workplace Health Promotion  
in Small and Medium-Sized Enterprises  
(SMEs)*





# Preface

The European Network for Workplace Health Promotion (ENWHP) is an association of state occupational health and safety institutions and public health service bodies from all Member States of the European Union and the European Economic Area. The Network is one of a number of health promotion initiatives backed by the European Commission as part of the 'Programme of Community Action on Health Promotion, Information, Education and Training' (645/96/EC).

With the passing of the 'Luxembourg Declaration on Workplace Health Promotion' at the end of 1997, the Network agreed on a common understanding of workplace health promotion (WHP). According to this Declaration, WHP is viewed as a comprehensive approach which necessitates a common strategy for all players inside and outside the enterprise.

In a two-year project carried out by ENWHP, models of good practice in workplace health promotion in (mainly) large companies were identified and publicised on the basis of jointly developed quality criteria for WHP throughout Europe. Early in 1999 the Network's second joint initiative was launched with 21 participating countries. For two years the project focused on workplace health promotion and occupational health and safety in small and medium-sized enterprises (SMEs):

- n The workplace health promotion situation in SMEs in participating countries was identified and assessed (see brochure: "Report on the Current Status of Workplace Health Promotion in Small and Medium-Sized Enterprises").
- n ENWHP members jointly developed criteria for good workplace health promotion practice in SMEs. On the basis of the criteria, appropriate models of good practice were identified and documented (see brochure: "Criteria and Models of Good Practice for Workplace Health Promotion in SMEs").
- n Under the umbrella of this project "Recommendations for Promoting Workplace Health Action" were also formulated and made available to the European Commission, other European Institutions and the offices responsible at national level.

This report is the result of an intensive discussion and co-ordination process lasting a number of years and involving many experts and decision-makers from both inside and outside participating companies. At this point special thanks should be extended to all those who participated, in particular those responsible at the European Commission, for their productive and successful co-operation.

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# Background

## Significance of SMEs in Europe's economy

Health and well-being at the workplace are important enablers for creating economic efficiency in businesses. Healthy working conditions can therefore have a positive impact on economic and social development in the Member States of the European Union. However, these are rarely rated as a top priority in corporate objectives where commercial criteria still predominate. This applies particularly to small and medium-sized enterprises (SMEs) and consequently affects the majority of employees in the EU.

**Figure 1: Definition of enterprise size categories according to the European Commission**

<b>Enterprise size category:</b>	<b>No. of employees:</b>
SMEs	< 250
Medium-sized enterprises	50 - 249
Small-scale enterprises	10 - 49
Micro enterprises	1 - 9

So far, little attention has been paid (especially in small enterprises), to questions of safety, occupational health and workplace health promotion. This not only applies to actual practice but corresponds equally to research and development. There are plenty of indications, however, that measures relating to workplace health promotion and occupational health and safety (OHS) can lead to a lasting improvement in the efficiency and competitiveness of SMEs.

In recent years increasing attention has been paid to SMEs at Community level and within the Member States in view of their economic and social significance. SMEs play a major part in solving Europe's unemployment problem. Interest is focused particularly on innovative SMEs who owe their flexibility and adaptability to their small or medium size.

## *Obstacles preventing better health*

The 'Council Directive of 12 June 1989 on the introduction of measures to encourage improvements in the health and safety of employees' ('Framework Directive', 89/391/EEC) and its transposition into national law have so far met with little acceptance from SMEs. This is probably due to inadequate orientation of European legislation to business processes. SMEs have great difficulty in putting these regulations into practice. Smaller businesses are often only motivated to fulfil statutory requirements by the threat of punitive action. Therefore, the political goal behind the Framework Directive, i. e. to promote preventative action in these enterprises, has hardly been achieved at all.

For occupational health and safety and for public health policy the question is therefore raised as to how economic development in the SME sector – including the creation of jobs – can be linked to the promotion of healthy working conditions and the implementation of reasonable social and protective standards.

As SMEs differ in many respects from large enterprises, the latter's experience cannot simply be transferred to smaller enterprises. Here, specific policies and strategies must be developed. The European Network for Workplace Health Promotion has therefore concentrated on small enterprises in its second joint initiative. Here in particular there is a great need for practicable approaches to improving health and well-being at the workplace.

## *Development stages of the project*

One of the aims of the project was to analyse and document the level of workplace health promotion in SMEs in participating countries. For this purpose guidelines were prepared prior to selected experts writing up analysis reports. Criteria were developed for the later selection and documentation of models of good practice. Experts from Austria, Germany, Greece, Ireland, Sweden and Switzerland helped to produce these guidelines and criteria.

In addition to preparing these analysis reports, another major task was to find and document three models of good practice in each participating country on the basis of the criteria. The aim was to obtain presentation material showing how exemplary workplace health promotion activities can be achieved.

The country reports and models of good practice were then discussed in detail in various committees attended by a variety of experts. Two questions were of particular interest: what strategies can be utilised to improve health and well-being at the workplace in the future? What criteria characterise and clarify exemplary practice in this area?

The results of this intensive discussion process were incorporated into the “Recommendations for Improving General Conditions for Workplace Health Promotion in SMEs” drawn up by a group of experts from the Network. These results were also used to refine the “good practice criteria”.

ENWHP's joint project on workplace health promotion in SMEs ended with the “ENWHP Second European Conference” in Lisbon (18-19 June 2001). Under the heading “Small, Healthy and Competitive – New Strategies for Improved Health in Small and Medium-Sized Enterprises”, the project and the results were presented for the first time to a broad international audience.

## *Report of the Current Status of WHP in SMEs: Objectives and focal points*

The aim of this report is to provide an overview of current practice in workplace health promotion and occupational health and safety in SMEs in the European Union. The following issues are discussed and assessed:

- general economic and health conditions (chapter 1).
- current procedures and regulations (chapter 2).
- conditions which inhibit or promote practice in both fields (chapter 3).

Finally, on the basis of this knowledge, recommendations are formulated for future strategies to promote workplace health promotion and occupational health and safety in SMEs.

For the most part, this report represents an assessment of workplace health promotion and occupational health and safety in SMEs from the point of view of the national reporters and experts. It compares the SME-specific situation with the overall situation in these two fields. It is neither intended nor feasible to conduct an international comparison of the member states. Instead, it focuses on the following questions: what are the characteristics of workplace health promotion/occupational health and safety in SMEs and what need for action still exists.

This report was prepared on the basis of the individual reports from the 19 countries involved\*, which you find summarised in the Annex, and supplemented by information from the relevant publications and databases at European level.

\* *Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein/Switzerland, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, UK*

# 1. *General conditions in workplace health promotion and occupational health and safety in SMEs*

## 1.1 *Definition and characteristics of SMEs*

It is difficult to accurately define an SME as the criteria used in individual countries in Europe differ owing to a very heterogeneous production structure. With the exception of Great Britain and Ireland, there is no clear-cut, officially recognised definition of SMEs in any country. In practical terms, most countries use the criterion “number of employees”, but the defining figure differs substantially from country to country.

The most common definition of an SME is an enterprise with fewer than 100 employees. This definition is used in Austria, Belgium, Denmark, Greece, the Netherlands, Norway and Spain. In other countries, the ‘number of employees’ criterion is higher: for example, in Luxembourg and Sweden the limit is 200 employees; in Finland, Ireland, Italy and Great Britain it is 249 employees and in France and in Germany 449 employees.

The definition of a small enterprise differs greatly too. Most countries – such as Denmark, Finland, Germany, Greece, Ireland, Spain, Sweden and Great Britain – group enterprises with up to 49 employees in this category. In Italy and Norway the limit is 19 employees and in the Netherlands 10 employees.

Furthermore, only a few countries differentiate between small and micro enterprises. The limit here ranges from 19 employees (France) to 9 (Finland, Germany, Greece, Italy, Portugal, Sweden) and 5 (Spain) to 4 employees (Norway).

In addition to this, the definitions in Denmark, Ireland, the Netherlands, Portugal and Great Britain also take the company's annual turnover figures into account. Here, too, figures vary from country to country.

In a recommendation by the EU Commission in 1996, an SME is defined on a combination of criteria: “number of employees”, “turnover”, “balance sheet volumes” and “independence”. According to this definition an enterprise is deemed to be an SME if it

# 1. General conditions

- n employs fewer than 250 people,
- n records an annual turnover of max. 40 million or has an annual balance sheet total of max. 27 million and
- n is owned by one or several large companies with a max. shareholding of 25%.

A further differentiation sub-divides SMEs into medium-sized enterprises, small and micro enterprises:

- n Medium-sized enterprises have 50 and more but fewer than 250 employees
- n Small enterprises are enterprises which employ fewer than 50 but at least 10 people
- n Micro enterprises have fewer than 10 employees.

In the case of small and micro enterprises, the criteria "turnover", "balance sheet total" and "economic independence" are merely examined as ancillary conditions.

## 1.2 Special features of SMEs

The working and production conditions in small enterprises differ in many respects from those in larger companies. Elements that affect occupational health and safety include: the role of the enterprise owner, the social relationships within the enterprise and the nature of the work.

### ***The role of the enterprise owner***

Small enterprises are frequently managed by the owner who exerts a dominant – positive or negative – influence on working conditions. The quality and significance of occupational health and safety are governed by his own experience and values. The owners of small enterprises regard themselves as independent and enjoy their personal autonomy and power to make decisions. Therefore, they are very sceptical about formal legal requirements.

If health-related strategies are implemented, they tend to be of a short-term nature and are constantly adapted to fit in with daily life on site. Longer-term strategic and conceptual programmes, such as those required for preventive action, are therefore less developed and/or are not promoted.

### ***Social relationships***

Many small enterprises have a strong family atmosphere. They tend to be family owned, sometimes going back several generations. Family members are involved in the work process. Their private and working lives partly merge as a result of this integration. The employees know about the home circumstances of their colleagues. Employees tend to feel a certain amount of trust and loyalty towards the owner and, similarly, the owner shows

consideration and understanding towards his staff. Against this backdrop, it is not surprising that institutionalised representatives – e.g. works councils – have little significance.

## ***Work requirements***

Small enterprises are, as a rule, characterised by simple organisational structures, fewer routine activities and a significant degree of direct communication. Ad-hoc decisions and improvisation are more common than rigid regulations laid down in writing. Seasonal fluctuations lead to very different levels of capacity utilisation. This kind of situation demands relatively highly qualified staff, capable of taking the initiative (and who are given reasonable latitude for doing so). For the employees this may involve a hectic work schedule, uncertainty, overtime and stress but also greater variety in their work and the freedom to be relatively independent.

Of course, not all SMEs conform to the above criteria. However, it is evident that the SME sector has special features which require the development of specific occupational health and safety policies and strategies.

## **1.3 General economic conditions**

### **1.3.1 Company and employee figures**

SMEs play a key role in the economic development of Europe. According to the latest data, almost 20 million companies within the 19 European states \* employ fewer than 250 people. That is more than 99% of all companies. 77 million people work in SMEs. SMEs therefore provide two thirds of all jobs. Moreover, SMEs account for more than half of Europe's turnover.

Within the SME sector, further differences can be seen which again highlight the significance of certain size categories. For example, 93% of all enterprises employ fewer than ten people. More employees find work in this sector than in large companies (with more than 500 employees). Roughly half of these micro enterprises, however, do not employ salaried staff and are therefore referred to as 'sole proprietorships'.

\* Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein/Switzerland, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden, UK

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**Table 1: Main indicators by enterprise size in the EU-19**

	<i>Micro</i>	<i>Small</i>	<i>Medium</i>	<i>Total</i>	<i>Large</i>	<i>Total</i>
Number of enterprises (1000)	18.465	1.175	170	19.810	40	19.850
Employment (1000)	39.330	22.140	15.640	77.100	39.860	116.970
<b>Average enterprise size:</b>						
– Employed persons per enterprise	2	20	90	4	1.010	6
– Turnover per enterprise (million euro)	0,2	3	23	0,5	215	1,0
Value added per occupied person (1000 euro)	30	50	90	45	90	60

*Source: European Network for SME Research (ENSR) (2000).*

Within a '19-state Europe', the five most prosperous and densely populated countries – France, Germany, Italy, Spain and Great Britain – are home to almost 80% of all SMEs. This percentage not only relates to the number of enterprises but also to the number of employees and the turnover.

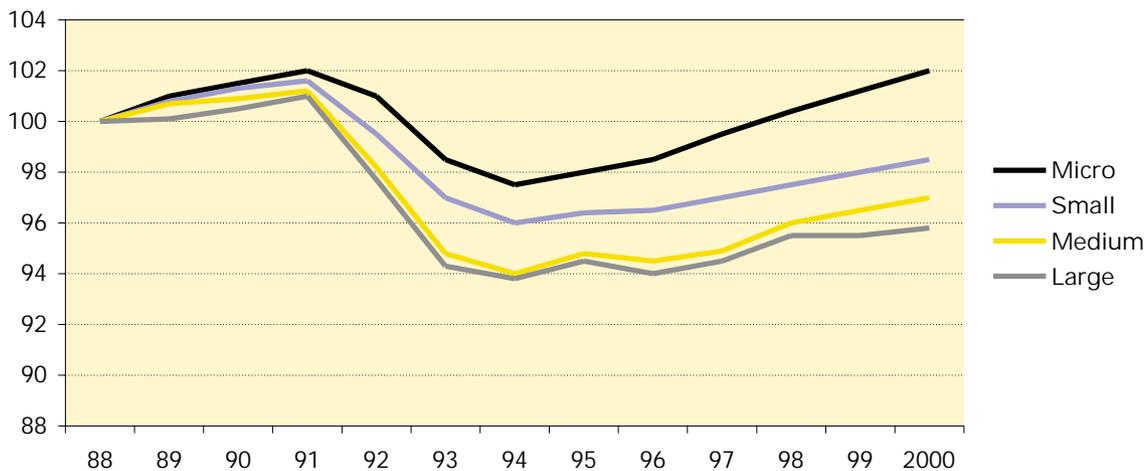
Germany occupies first place in terms of absolute figures. Germany has almost a quarter of all SME jobs (in 19-state Europe). Great Britain and Italy rank second and third.

Regarding turnover and productivity, defined as the value added per employee, there is a linear connection with the enterprise size: the larger the enterprise, the higher these two key indicators are. Within the SME sector, the medium-sized enterprises contribute the highest percentage to turnover and productivity.

An overview of the development of SMEs over the last 12 years highlights the economic significance of this sector (cf. Fig. 2)

# 1. General conditions

**Figure 2:** *Development of employment in enterprises in the EU-19, 1988 - 2000 (index: 1988 = 100)*



Source: *European Network for SME Research (ENSR) (2000)*.

The period 1988 - 2000 was dominated by fluctuating employment levels. The growth period between 1988 and 1990 was followed by a drop in employment during the 1990 - 1994 recession. After that, employment rose again. However, it is noticeable that SMEs – in particular micro enterprises – were less hard hit in this respect than large companies. And when the employment situation recovered again in the mid-90s, it was the micro enterprises that lead the way in terms of employment growth. Employment in the other companies did not rise appreciably again until 1997.

The following trends have been defined as the reasons for employment growth in SMEs in recent times:

- n The expansion of the service sector;
- n The outsourcing of activities which no longer belong to the core business and
- n The dynamism of certain sectors, e.g. information technologies, where SMEs lead the field.

# 1. General conditions

However, a more detailed examination shows that the significance of SMEs for the national economies of the countries involved varies (cf. Table 2).

**Table 2: Percentage of employment according to size of enterprise and countries in the EU-19, 1998, %**

	<i>Micro</i> (1-9 empl.)	<i>Small</i> (10-49 empl.)	<i>Medium</i> (50-249 empl.)	<i>All SMEs</i>	<i>Large</i> (over 250 empl.)
Austria	27	21	21	69	31
Belgium	32	20	12	64	36
Denmark	28	23	18	69	31
Finland	26	17	16	59	41
France	34	19	14	67	33
Germany	29	20	11	60	40
Greece	47	17	14	78	22
Iceland	34	22	21	77	23
Ireland	18	16	15	49	51
Italy	48	21	11	80	20
Liechtenstein/ Switzerland	23	22	22	67	33
Luxembourg	19	24	28	71	29
Netherlands	23	18	19	61	39
Norway	32	21	18	71	29
Portugal	39	23	18	80	20
Spain	46	20	13	79	21
Sweden	32	17	15	63	37
United Kingdom	29	15	12	55	45
Total	34	19	13	66	34

Source: European Network for SME Research (ENSR) (2000).

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Whereas SMEs provide two thirds of the jobs in Europe, this percentage ranges from 49% in Ireland, 55% in Great Britain, 59% in Finland and 60% in Germany to 78% in Greece, 79% in Spain and 80% in Portugal and Italy. Viewed overall, there is a dividing line which runs between northern European and southern European countries. In general, in southern European countries a higher percentage of their workforce is employed in small enterprises. By contrast, northern European countries tend towards production and employment in larger companies – as the examples from Ireland, Great Britain, Finland and Germany show.

The varying significance of SMEs within a 19-state Europe is largely reflected in different industrial and cultural development patterns resulting in specific production structures and traditions. In southern European countries small, generally family-owned enterprises dominate the service sector. By contrast, in northern Europe large chains have grown up in this sector – especially in the hotel and restaurant business, finance and insurance sector and in company services. The situation is similar although less obvious in the production sector. Here too, small enterprises are much more widespread in southern Europe than in the north. One reason for this may be the deep-rooted traditions of small businesses in traditional sectors such as the timber and furniture industry.

# 1. General conditions

**Table 3: Sectors with predominant shares of employment in SMEs in the EU-19**

<i>Sectors</i>	<i>Shares (%)</i>	<i>Predominant enterprise size</i>
<b>Manufacturing</b>		
Textiles	70	small/medium
Clothing	80	small/medium
Manufacture of wood and of products of wood and cork, except furniture; manufacture of articles of straw and plaiting materials	87	small/medium
Publishing/printing	69	small/medium
Manufacture of rubber and plastic products	58	small/medium
Manufacture of medical, precision and optical instruments, watches and clocks	43	small/medium
Manufacture of furniture; manufacturing n.e.c.	53	small/medium
Manufacture of other non-metallic mineral products	63	small/medium
Metal products	81	small/medium
Recycling	95	small/medium
Construction	88	micro
<b>Services</b>		
Sale, maintenance of motor vehicles	90	micro
Wholesale trade and commission trade, except of motor and motorcycles	84	micro
Retail trade, except of motor vehicles, motorcycles; repair of personal and household goods	73	micro
Hotels and restaurants	86	micro
Land transport; transport via pipelines	65	micro
Supporting and auxiliary transport activities; activities of travel agencies	66	small/medium
Activities auxiliary to financial intermediation	86	micro
Real estate activities	89	micro
Rental of machinery and equipment without operator and of personal and household goods	80	micro
Computer and related activities	76	small/medium
Health and social work	70	micro
Sewage and refuse disposal, sanitation and similar activities	58	small/medium
Recreational, cultural and sporting activities	76	micro
Other services' activities	94	micro

Source: *European Network for SME Research (ENSR) (2000).*  
*Rheinisch-Westfälisches Institut für Wirtschaftsforschung (2000).*

## 1.3.2 Sectors of the economy

A more detailed examination according to branches of industry shows that services predominate in the SME sector. This applies in particular to the trading and hotel and restaurant sectors (cf. Table 3).

Roughly 12% of all SME employees in Europe work in the retail trade. However, the service sector has the highest percentage of very small enterprises (fewer than 10 employees). More than half of the employees in companies with fewer than 10 people work in sales/ maintenance of motor vehicles, retail trade, hotels and restaurants, financial support services and real estate activities.

The percentage of SMEs in the individual sectors of the economy primarily depends on the required capital investment. In general, more capital is required in industrial production than in the service sector. This means that the percentage of employment in SMEs in the production sector is lower than in the service sector and below the European average (53% compared with 66%).

A similar trend can also be observed in the two sectors industry and services. The percentage of SMEs is low where high investment or high costs for distribution are required. This applies in the service sector, for example, in electricity/gas supply, air transport, post/telecommunications or financial services. The SME percentage, on the other hand, is high in the following sectors: hotel/restaurant, financial and business services, real estate, computer services, health/social work, and recreational and a variety of personal services.

However, some production sectors are characterised by a high percentage of employment in SMEs. These include, in particular, the textile and clothing industry, as well as production and processing of timber and metal products. The highest percentage of employment in SMEs is to be found in the recycling and construction industries.

Viewed overall, these trends, i.e. the concentration in the above-mentioned sectors of the economy, can be found in all member states even though certain variations are pronounced to a greater or lesser degree.

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## 1.4 Stakeholders

### ***Trade unions***

Few accurate details exist on the degree of trade union organisation in SMEs. In general, it is reported that the degree of organisation increases with the size of the enterprise. Exceptions to this trend can be found in Denmark, Sweden and to some extent in Italy where there is a relatively high percentage of trade union membership in SMEs.

### ***Employers' organisations***

Specific employers' organisations representing the interests of SMEs exist in most EU countries. This is the case in Belgium, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain and Great Britain. However, these organisations frequently play no role – or only a minor role – in the collective (wage) agreements with the trade unions.

In other countries – such as Austria, Denmark, Finland and Sweden – SMEs' interests are represented with those of major companies by central organisations.

The SME organisations and associations are characterised by their variety – e.g. representation of occupational, specialised, geographical or branch interests. However, that frequently involves a splitting-up of the organisations and poor co-ordination among them.

### ***Elected employee representatives***

Labour law or other statutory provisions in over half of the 19 European states exclude employees from collective representation of their interests in enterprises below a certain size. The lower limit for representation of interests in SMEs lies between 5 and 50 employees.

In Norway and Sweden workers have the right – regardless of the enterprise size – to represent their interests collectively.

However, in reality things are generally different. The following trend exists independent of statutory regulations: the smaller the enterprise, the less likelihood there is of effective representation of interests.

## 1.5 General health conditions

It is extremely difficult to obtain a clear picture of the present state of health and safety in Europe's SMEs on the basis of the information and statistics gained from each country's report. It is particularly difficult to differentiate between general health conditions in SMEs and those in large companies. One reason being that the documentation methods vary too much between countries – e.g. for accidents at work and occupational diseases. The rise or a comparatively high volume of such or other health risk indicators in a country can therefore – paradoxically – be the result of detailed and effective documentation rather than an indication of shortcomings. Furthermore, many countries have difficulty in obtaining relevant information on occupational health and safety at all. This problem is exacerbated when related to enterprise size.

Table 4 provides an overview of the health-relevant information from the country reports underlying this report which permit a differentiation according to enterprise size – irrespective of whether the figures are quantitative or qualitative.

Because of this deficient data situation, the following explanations of general health conditions include, wherever possible, existing results from European studies or data surveys.

# 1. General conditions

Table 4: Health-relevant information on SMEs

	Accidents at Work	Occupational diseases	Occupational sickness absence	Exposures			
				Physio-logical	Physical	Chemical	Psycho-social
Austria	4	4	0	0	0	0	4
Belgium	0	0	0	0	0	0	0
Denmark	4	0	0	0	0	0	4
Finland	4	0	4	4	4	4	4
France	0	0	0	0	0	0	0
Germany	4	4	4	4	4	4	4
Greece	4	4	4	4	4	4	4
Iceland	0	0	0	4	0	0	0
Ireland	0	0	0	0	0	0	0
Italy	4	4	0	0	0	0	0
Liechtenstein/ Switzerland	0	0	0	0	0	0	0
Luxembourg	4	0	0	0	4	4	0
Netherlands	0	0	4	4	4	0	4
Norway	4	0	4	0	4	0	4
Portugal	0	0	4	0	4	4	4
Spain	4	4	4	4	4	4	4
Sweden	4	0	4	4	4	4	4
United Kingdom	4	0	0	0	4	0	0

4 Information is contained in the country report

0 Information is not contained in the country report

Source: The national country reports

## Accidents at work

Nearly every country reports that accidents at work have decreased in recent years. However, this general trend is not reflected to the same extent in all enterprises. For example, there are frequently substantial differences between companies of different sizes and between the sectors of the economy. Regarding enterprise size, the current European situation can be best summarised and illustrated on the basis of the Eurostat data (cf. Table 5).

**Table 5: Accidents at work in the European Union in 1996**

Company size	Accidents with more than 3-days absence		Fatal accidents (excluding Norway)	
	%	per 100.000 employees	%	per 100.000 employees
1 - 9	32,3	4.241	45,1	6,8
10 - 49	27,4	5.195	27,0	6,3
50 - 249	22,5	4.043	15,4	3,4
250 or more	17,8	2.943	12,5	2,7
total	100,0	4.229	100,0	5,3

Source: European Agency for Safety and Health at Work (2000).

According to this table, the risk of suffering an accident is much higher in SMEs than in large companies. An even clearer trend can be seen in fatal occupational accidents: these are twice as likely in enterprises with fewer than 50 employees than in companies with more than 250 employees.

The fact that the accident risk rises as the enterprise size decreases cannot be confirmed by the reporters in Austria, Denmark and Sweden. In these countries, the figures for accidents at work (excluding fatal accidents) show that they increase with the size of the company. However, this may be due to the fact – and the Swedish report emphasises this – that minor accidents in medium-sized and large enterprises are more rigorously documented and this is reflected in the figures.

In addition to the size of the company, the sector of the economy also plays a major role in the accident situation: most accidents occur in the building industry. Working in industrial production processes, e.g. in the metal-working and wood processing industries and in agriculture, is almost as dangerous. Accident risk is traditionally lowest in the service sectors.

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## ***Occupational diseases***

Only sparse information regarding company size and occupational diseases is available – generally where a reliable connection between the work activity and a pension for those affected is established. This applies equally to the information and data in the country reports and to the relevant publications available from the “European Foundation for the Improvement of Living and Working Conditions” in Dublin, the “European Agency for Health and Safety at Work” in Bilbao and from the Eurostat data.

Only the country reports from Austria, Italy and Spain contain quantitative data on occupational disease according to company size. All the data indicate a higher risk for employees in large companies than for those in SMEs. Qualitative estimates from Germany and Greece confirm this trend.

Differing results, on the other hand, have been observed in the pilot study “The State of Occupational Health and Safety” run by the Bilbao Agency. According to this study, qualitative estimates from four European countries indicate a higher risk for employees in the SME sector.

Most occupational diseases (according to the results of the country reports and the pilot study mentioned above) are reported throughout Europe by companies in the building industry, the metal-working sector, health services and agriculture.

## ***Occupational sickness absence***

The level of sickness absence in European companies – like the accident situation – is probably connected to the enterprise size. However, the sickness rates in European companies tend to indicate an opposite trend. As the enterprise size increases, the number of days lost due to occupational sickness increases too.

Information (and to some extent detailed statistics) confirm this in the reports from Finland, Germany, the Netherlands, Spain and Sweden.

Norway reports that there are practically no health differences between SMEs and large companies and only in Greece do figures indicate a higher risk in small enterprises.

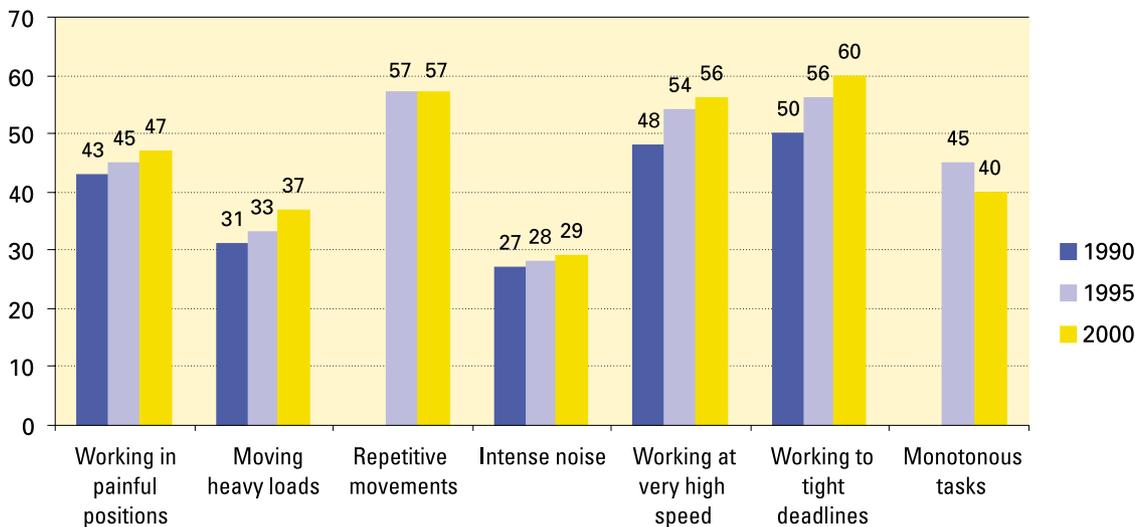
There is also a connection between the sickness rate and the type of industry: high sickness rates are often reported in the public sector, the building industry, the transport sector as well as certain private services (health service and education).

All in all, a downward trend has been observed in recent years – as with accidents. The most prevalent type of sickness (measured by percentage time lost due to sickness) is that of muscular-skeletal complaints.

## Strain at work

The results of three employee surveys conducted in the European Union in 1990, 1995 and 2000, by the European Foundation, clearly show that improved working conditions have not led to a long-term decrease in strain at work (cf. European Foundation 2000). Many workers are still at risk from major stress factors (cf. Fig. 3):

Figure 3: Development of major sources of working strains in Europe, %



Source: European Foundation for the Improvement of Living and Working Conditions (2000).

Whether it is a case of physical strain, e.g. moving heavy loads, physical environmental conditions (noise, heat, cold) or psychosocial demands at the workplace, e.g. working at high speed or repetitive work, it is clear that the problems identified 10 years ago remain, and in some cases, may even have increased. Furthermore, the surveys indicate that an increasing percentage of employees believe that their health is suffering due to strains at the workplace. The most frequently mentioned work-associated health problems relate to the muscular-skeletal system (in particular back, neck and shoulder pains) as well as stress. There are also close links between stress, working at high speed, repetitive activities and muscular-skeletal disorders.

# 1. General conditions

Structural changes in the economy and technical and organisational changes at work, have resulted in a relative reduction in physical strain factors but a significant increase in mental/nervous stress factors. This change is not universal and should be understood as a trend which does not exclude deviations specific to activities, type of company and company size as well as counter-trends. The surveys carried out by the European Foundation confirm this development. They also permit differentiation according to company size categories (cf. Table 6).

The following statistics on the sources of work strains are based – regarding differentiation according to company size categories – on the latest results from the second European survey on working conditions and on the information from the country reports.

**Table 6: Company size and sources of working strains**

<i>Exposure</i>	<i>Size of company</i>				
	<i>1-9</i>	<i>10-49</i>	<i>50-99</i>	<i>100-499</i>	<i>≥ 500</i>
Working in painful positions	51%	42%	43%	42%	41%
Moving heavy loads	40%	34%	33%	31%	27%
Repetitive movements	60%	56%	57%	57%	54%
Noise	25%	29%	37%	32%	28%
Vibration	25%	24%	33%	27%	19%
Handling dangerous substances	15%	11%	20%	15%	15%
Working at very high speed	54%	57%	58%	59%	55%
Working to tight deadlines	52%	63%	60%	61%	60%
Monotonous tasks	42%	45%	45%	45%	49%
Stress	26%	26%	25%	29%	31%

*Source: European Foundation for the Improvement of Living and Working Conditions (1997a).*

## ***Physical work strains***

In the case of physical strains, major discrepancies exist between micro enterprises and larger companies. There is a clear trend for physical strains to be greater, the fewer employees there are in a company. With the exception of the Netherlands and Sweden, this trend is confirmed by the other reporters.

The building sector, the processing industry and agriculture are the sectors where workers are most frequently exposed to working in painful positions, moving heavy loads or repetitive movements.

## ***Environmental work strains***

The environmental strains are also concentrated in the above-mentioned industries. However, it is harder to find a concentration dependent on enterprise size rather than on physical requirements. The 2nd Working Conditions Survey and the pilot study carried out by the European Agency in Bilbao, underline that traditional risks, e.g. noise and vibration, are most prevalent in enterprises with up to 100 employees. This result cannot be readily substantiated by information from the country reports. For example, Finland, Germany, the Netherlands, Norway and Sweden report a reverse trend or that no connection can be established.

## ***Exposure to chemicals***

The connection between chemical exposure and enterprise size appears to be just as contradictory. Whereas in Finland, Greece, Luxembourg and Sweden figures suggest greater exposure in small enterprises, German and Spanish studies show no connection or the reverse trend, i.e. exposure to chemicals occurs predominantly in larger companies. The results of the studies conducted by the European Foundation and European Agency in Bilbao do not allow for any well substantiated conclusions.

## ***Psychosocial working stress***

Both the results of the above-mentioned European studies and the information from the country reports provide a varied picture for connecting work stress and enterprise size. Some areas of stress are greater in SMEs, for example, having to work at very high speed, but monotony is more prevalent in large companies. One possible explanation for this (apparently) contradictory situation is that employees have greater scope for action and decision-making in SMEs and – as results of the stress theory confirm – have a stress-reducing effect as a moderator variable. However, it remains questionable whether the positive health potential created by greater latitude for decision-making in SMEs can compensate for or even outweigh the hazardous psychosocial factors.

# 1. General conditions

Summarising, it is clear that there are a number of arguments for boosting workplace health promotion and occupational health and safety in SMEs. The reasons and arguments are listed as follows:

- High prevention potential owing to a large number of employees
- Relatively high accident rates compared with large companies
- Relatively greater strain in specific work situations.

However, action is not justified simply on enterprise size. The higher accident rates and specific working strains in the SME sector are also attributable to the fact that a number of high-risk work processes are traditionally organised in small enterprises. This is backed up by the fact that the well above-average health risks are concentrated in only a few sectors of the economy. As a result, a branch-specific need for prevention can be justified but not a more general, size-specific need.

## 2. *Structures and practice in workplace health promotion and occupational health and safety in SMEs*

This chapter summarises the main results on the current status of workplace health promotion and occupational health and safety in SMEs. The information provided for this purpose from the individual country reports differs in many respects – this is not surprising owing to different problems as well as historical, political and cultural peculiarities – but there is a common pool of views and elements which is important for all occupational health and safety systems in Europe. This includes:

- n Legislative framework
- n Labour inspection
- n Occupational health services
- n Employee representation
- n Workplace health promotion.

### 2.1 *Legislative framework*

The regulations and directives issued by the EU do not have a direct effect in the individual states but must be transposed by laws and ordinances into national legislation. The following play a role for occupational health and safety:

- n Directives according to Section 100a of the EEC Treaty
- n Directives according to Section 118a of the EEC Treaty.

The differences in the directives can be seen from the following illustration.

## 2. Structures and practice in WHP

Figure 4: Important EU directives on occupational health and safety

	<u>Harmonisation objective</u>	<u>Subject matter of regulation</u>
<i>Section 100a of the EEC Treaty</i>	Complete statutory assimilation to eliminate technical trade barriers	Property requirements (construction + equipment) for machinery, equipment building products, etc.
<i>Section 118a of the EEC Treaty</i>	Minimum regulations on the gradual improvement in the level of occupational health and safety	Occupational health and safety; basic obligations and rights of employers and employees

Source: Strothotte, G.; Ziegenfuß, B. G. (1977).

EU directives according to Section 100a of the EEC Treaty serve to break down trade barriers and must be transposed into national legislation without any deviations. The different technical requirements placed on products are thus standardised throughout the entire European economic area.

Directives according to Section 118a of the EEC Treaty are socio-political and relate to an internal market that has no trade barriers. They are aimed at improving the occupational health and safety of employees. These directives outline minimum regulations which have to be fulfilled, but which permit the member states to develop higher protection standards.

The Framework Directive 89/391/EEC on the "Implementation of Measures to Improve the Health and Safety of Employees at Work" forms the basis of the directives according to Section 118a of the EEC Treaty, and are of particular importance in this context.

Important general conditions for occupational health and safety have changed with this framework directive and the resultant changes in national law. The definition of occupational health and safety and in particular health has become more comprehensive and geared to prevention. The focus is now on preventive and cause-oriented risk avoidance, adaptation of the working conditions to people (not vice versa) and on the development of a comprehensive occupational health and safety policy which is not solely aimed at preventing accidents at work and paying compensation. Moreover, the responsibility of the employer has been redefined and, according to this, jobs have to be assessed for any risks and appropriate action taken. Furthermore, fundamental provisions on reporting, participation, consultancy and training of employees as regards occupational health and safety issues have been regulated in a different way.

## 2. Structures and practice in WHP

On the basis of the EU framework directive, a series of further individual directives on occupational health and safety at EU level were issued between 1989 and 1992. These can be divided into three main categories:

- n Directives which extend occupational health and safety beyond the prevention of accidents at work and compensation (e.g. VDU work or lifting and moving heavy loads)
- n Directives which outline how new risks and demands should be dealt with (e.g. more systematic supervision for carcinogens and biological agents as well as provision for temporary workers in the building industry)
- n Directives aimed at a number working conditions affecting a large number of employees (e.g. minimum requirements placed on jobs, work equipment and working clothes).

The adaptation of the EU directives to national legislation has led all the countries involved here to a broad discussion on the principles of a preventive occupational health and safety policy and its effective implementation at the workplace. In all countries the process of transposition and integration of the EU provisions into national legislation has been concluded, apart from a few exceptions (individual provisions).

In a number of countries such as Austria, Germany, the Netherlands, Italy, Spain and Portugal, the adaptation process was linked to a more comprehensive legal reform project which resulted in major changes in existing occupational health and safety regulations. In other countries, such as the United Kingdom and France, the transposition of the EU directives only produced marginal changes because they were interpreted restrictively and only minimum requirements were fulfilled.

In the Scandinavian countries, the effects of the EU framework legislation were also minimal. However, the reasons for this can be explained, as existing national occupational health and safety provisions were generally of a high standard and already satisfied a large number of the EU directive requirements.

Regarding the SME sector, the EU framework legislation also resulted in important amendments and changes to most of the national occupational health and safety regulations. In many countries no generally applicable occupational health and safety regulations existed for all enterprises. For example, some regulations exempted employees in enterprises below a certain size or in the public sector from providing occupational health services or from representation regarding occupational health and safety issues.

Implementing these EU directives led to broad-based standardisation in the sense that major national occupational health and safety regulations regarding labour inspection, occupational health services, risk assessment at the workplace and employee representation now covers more or less all enterprises, regardless of size and sector. Major differences, however, still exist between countries where enforcement and practical implementation of statutory requirements at workplace level is concerned. There is sometimes a large gap between objectives and reality.

## 2. Structures and practice in WHP

### 2.2 Labour inspection

The reports available from the individual countries once again confirm that, despite different structures, qualifications, skills and responsibilities of the labour inspectors, their occupational health and safety strategies show more and more similarities (cf. also Piotet 1996; Walters 1997). All countries have a statutory mandate which goes beyond the traditional tasks of labour inspection. In addition to monitoring the observance and application of statutory occupational health and safety regulations, inspectors' duties have generally been expanded in two directions.

For instance, what is to be inspected and monitored has changed. Now inspectors have to look beyond working conditions which may lead to accidents and occupational diseases and look at work organisation, work content, psychosocial stress etc.

The inspection and monitoring mandate has also been extended to include consultancy and information. The employers, who are ultimately responsible in all countries for occupational health and safety, are to be advised and informed by the inspectors as to how they should carry out their obligations.

This redefinition of labour inspection based on a comprehensive and preventive understanding of health is attributable to changes resulting from the European framework legislation. Furthermore, work processes, work equipment and agents have changed to such an extent that the traditional methods of occupational health and safety have reached their limits.

Although inspection and monitoring, linked with action in the case of blatant infringements of occupational health and safety regulations, are still relevant, a new, revised understanding of a labour inspector's role can be seen from all the reports. The aim is no longer a short-term, one-off elimination of all acute deficiencies, but the detection of underlying (frequently organisational) shortcomings. Advice and encouragement on problem-solving is another major factor. In short, the labour inspector sees himself more as a mediator and advisor on occupational health and safety issues and less as an inspector.

However, elementary practical difficulties stand in the way of the implementation of this new mandate.

First of all, labour inspection is generally subject to restrictions in terms of resources. Almost all national reporters mention the problem of too few staff and insufficient funds to discharge their duties, especially where SMEs are concerned. In addition to this, there are often qualification shortcomings where the new strategies are concerned.

## 2. Structures and practice in WHP

**Table 7: Inspector resources in 19-state EU**

<i>Country</i>	<i>Number of employees per inspector *</i>	<i>Number of enterprises per inspector *</i>	<i>Shares of employment in SMEs **</i>
Austria	9.831	911	69%
Belgium	18.857	3.029	64%
Denmark	8.438	469	69%
Finland	5.443	600	59%
France	13.796	1.435	67%
Germany	3.632	357	60%
Greece	24.288	3.875	78%
Iceland	no figures	no figures	77%
Ireland	22.071	1.214	49%
Italy	5.550	985	80%
Liechtenstein/ Switzerland	no figures	no figures	67%
Luxembourg	11.045	682	71%
Netherlands	18.732	1.402	61%
Norway	no figures	no figures	71%
Portugal	14.170	2.300	80%
Spain	18.973	3.606	79%
Sweden	10.000	1.100	63%
United Kingdom	3.406	463	55%

\* *Source: Our own calculations to European Agency for Safety and Health at Work (2000).*

\*\* *numbers from table 2*

## 2. Structures and practice in WHP

The Swedish reporter's description is typical of the situation in SMEs: "The labour inspectorate visits 15,000 of the 160,000 private and independent enterprises with fewer than 10 employees annually. More than 75% of all visits were made to small enterprises. However, the largest companies are contacted on average almost three times a year while the smallest enterprises see a labour inspector roughly once in ten years."

By measuring the personnel capacities of the labour inspectorate in the individual countries shown in table 7, it is to be assumed that the situation in Belgium, France, Greece, Ireland, the Netherlands, Portugal and Spain is even more unfavourable. In the southern European countries the high proportion of SMEs exacerbates the situation.

The Swedish example clearly shows that the size of the enterprise limits the effect of any supervisory or consultancy activity. The smaller the enterprise, the less the likelihood of an inspection. The cost and effect ratio remains much more unfavourable in SMEs than in large enterprises too, even with adequate resources for labour inspection.

The size of the enterprise also has a bearing on the acceptance of and communication between SMEs and state occupational health and safety bodies. The reporters from Denmark, Germany, the Netherlands and Norway make particular reference to this:

A difference in perspective exists between the supra-company, formalised procedures of occupational health and safety (based more on rules and regulations than on practicality) and the pragmatic thinking of small entrepreneurs, which is geared towards the running of their firms. Labour inspectorate activities are therefore perceived by SMEs as being costly and time-consuming and that the regulations imposed by the authorities severely limit their entrepreneurial autonomy. In small enterprises, structures are less hierarchical, areas of responsibility have evolved in an informal manner and a lot of things work through oral communication. In other words: bureaucratic structures are less pronounced than in large companies. Therefore, the formalised statutory procedures for occupational health and safety represent a major hurdle with their need for documentation, identification, self-monitoring, etc. Regulatory preventive work is therefore seen as being altogether unsuitable for small enterprises.

Due to limited quantitative and qualitative resources, labour inspection is concentrated on high-risk work sites in most countries. However, Denmark, Finland, Germany, the Netherlands and Sweden have programmes and campaigns targeted specifically at the SME sector. This includes publicising and promoting the new statutory position and alerting people to its implementation.

A number of countries, primarily the industrialised northern European countries, with their long tradition of state occupational health and safety systems, are adopting new approaches. These are aimed at achieving the co-operation of all those involved at company and supra-company level. The state is responsible for system monitoring and quality assurance in occupational health and safety.

## 2. Structures and practice in WHP

Together with other occupational health and safety facilities (e.g. OHS services) specific key problems have to be identified and appropriate action programmes developed and co-ordinated. Nationwide monitoring on a case-to-case basis is therefore refined to become a strategy of co-ordinated intervention and consultancy geared to key issues. Corresponding practice, however, is still in its infancy.

### 2.3 Occupational health and safety services

In most of the countries involved, the employers are legally obliged to provide health care for their employees through occupational health and safety services. In Ireland and the United Kingdom employers traditionally have a wide latitude in terms of setting up OHS services and company health care provision for employees is voluntary. In Sweden, occupational safety and medical care (apart from certain high risk areas where the establishment of services can be obligatory) is also regulated on a voluntary basis but, in practice, is negotiated between employers' organisations and trade unions with a binding effect. The infrastructure for good health care is therefore in place.

Relatively good care is found in Denmark (70%), Finland (90%), Germany (50-70%), the Netherlands (65%), Norway (50%) and Sweden (72%) (pretty much countries with a strong statutory commitment to providing preventive care for employees). However, statutory pressure to establish occupational health and safety services does not necessarily guarantee good health care.

As for the size of the enterprise, the situation is more or less the same in all countries: the smaller the enterprise, the less favourable the situation is. This is obvious from the proportion of small businesses to have conducted a risk assessment. Although a risk assessment is obligatory in most countries following the implementation of the European framework legislation, it only takes place in 30 to 50% of small enterprises (< 50 employees) according to the survey results from Denmark, Germany, Ireland, the Netherlands, Norway and Sweden; whereas in larger companies (> 100 employees) the corresponding proportion is roughly 90%.

Only Finland provides reasonably satisfactory health care. In all other countries, there is a gap between (statutory) obligations and reality.

Different preventive services models operate in all the individual countries. Medical professionals have different powers, depending on the country, too. In France and in the southern European countries, medical professionals exert a great deal of influence. In northern Europe an interdisciplinary orientation predominates.

## 2. Structures and practice in WHP

Generally speaking, these two approaches result in different philosophies: in the case of a medically oriented service, emphasis is placed on employee health whereas, in the case of multi-disciplinary co-operation, the enterprise appears to be “the patient”. In the former, individual employee health is a priority, in the latter, the emphasis tends to be on structural elements, such as the assessment and adaptation of working conditions to the requirements of employees.

The provision of an occupational health and safety service in the Netherlands, for example, is only permitted or approved if at least four different disciplines are represented: occupational physician, safety specialist, occupational hygienist and a (psycho-socially oriented) work organisation expert. The enterprise must also be certified to ISO 9000 standard.

Another difference relevant to SMEs is the role of the employer regarding employee safety. In some countries, such as Austria (< 26 employees), Belgium (< 20 employees), Germany (< 50 employees), Portugal (< 10 employees) and Spain (< 6 employees), the employer in a small or micro enterprise can take on the responsibility for employee safety himself. In Austria and Germany pilot projects are underway – the ‘employer models’. The ‘employer model’ is based on the philosophy that the biggest obstacle to effective prevention is the small employer’s lack of knowledge and motivation where occupational health and safety issues are concerned. Therefore, this model focuses on training courses and seminars designed to inform and inspire.

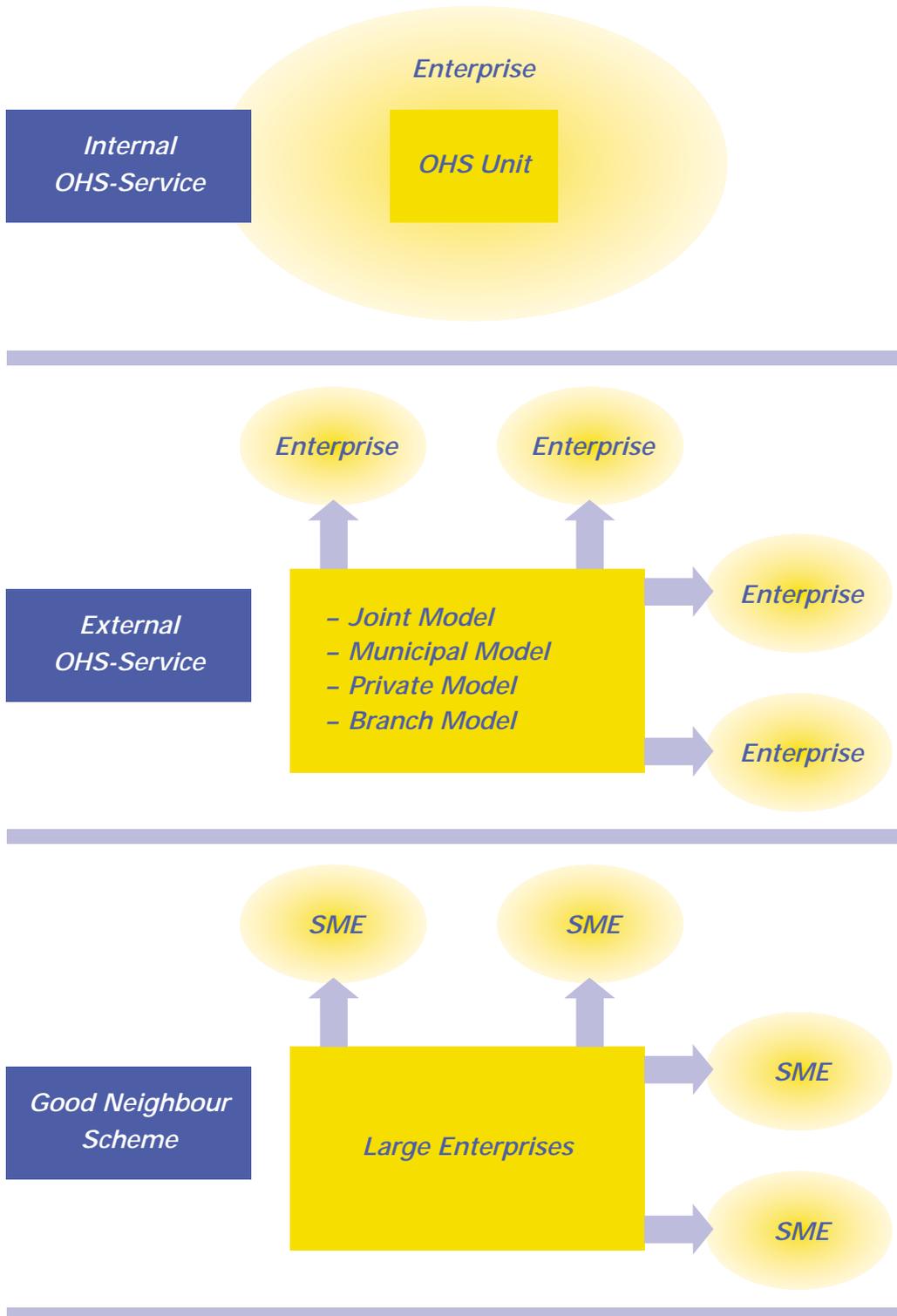
In Germany, employers learn about risk assessment, cost-efficiency, responsibility, organisation, hazardous substances, and the development of action programmes for occupational health and safety. The employer is also obliged to take part in regular further training programmes.

On the basis of these seminars, the employer then conducts a risk assessment on his own and identifies to what extent he needs the services of an external body. According to initial findings, the ‘employer model’ has had a positive response from small employers and acceptance of occupational health and safety issues has improved. Co-operation with the labour inspectorate is also better. The model appears to have a future because it is clearly tailored to the needs of SMEs.

Finally, occupational health and safety services can be differentiated according to their organisational and geographic scope. In principle, the question of whether they act within an enterprise or whether they are responsible externally for one or several enterprises plays a role here. The following diagram illustrates the various possibilities.

## 2. Structures and practice in WHP

Figure 5: Types of occupational health and safety services



Source: The national country reports

## 2. Structures and practice in WHP

The predominant preventive services model in Europe is traditionally the 'built-in' unit. This model is primarily found in large enterprises, which once again shows that occupational health and safety structures are geared to big companies.

However, more and more individual entrepreneurs (or groups of enterprises) are joining together to fund the services of an external body – usually for cost reasons. This can take place in various ways. The occupational health and safety units under the joint model are set up and financed by several enterprises working together. They generally offer their medical and safety services only to these member enterprises. Safety and health care can also be ensured by public service facilities or private companies. Branch-related services similar to the joint model can also be established.

In Sweden, for example, there are 700 preventive service units with 7,000 doctors, nurses, psychologists, ergonomists, and physiotherapists working in joint private and branch services (agriculture, forestry and the construction industry). The opportunity for enterprises to make use of public or municipal health services are very limited here.

In Finland, where there are also various preventive services models, the municipal model is the most important. 40% of all employees and 65% of all enterprises – of which 80% employ fewer than 10 employees - are looked after by this type of occupational health service.

The Netherlands established a very original service system in 1995 as part of their implementation of the European Framework Directive. The "Arbodienst" is made up exclusively of private suppliers. Every business, regardless of its size, is obliged to join a certified "Arbodienst". By 1998, 92% of all enterprises had signed a contract with an "Arbodienst"; and the difference between small businesses with fewer than 100 employees (91%) and large enterprises with more than 100 employees (96%) signing up was very small.

The "Good Neighbour Scheme" is a programme initiated by the Irish Health and Safety Authority, which aims to encourage SMEs to improve their occupational health and safety activities. The philosophy of this programme is for large enterprises with a good occupational health and safety infrastructure, to act as mentors for small enterprises in their region. In practice, this means that they help and advise local SMEs, support them with occupational health and safety services and make their vocational and further training amenities available to them. Since the programme was launched in 1995 it has proved to be very successful and is being used increasingly in the United Kingdom. More than 50 major enterprises in Ireland have now taken on the role of mentor. Perhaps the reason for its success is that it is a voluntary and on-going initiative. It is self-evident, for cost reasons alone, that the Good Neighbour Scheme is particularly well-suited to the specific occupational health and safety needs of SMEs.

## 2. Structures and practice in WHP

Until 1992, OHS services in Sweden were subsidised by the state. Since subsidies were cut, the number of occupational health and safety units has fallen from 900 to 700 and the level of employee care has dropped from more than 80% to about 70%.

In Finland, the employer is not entirely responsible for financing preventive services. Up to 50% of the costs can be reimbursed if certain criteria are fulfilled.

The situation in Sweden clearly shows that the medical and safety care of employees is compromised if this service is left exclusively to the free will of market forces. Furthermore, it is those employed in SMEs who are most at risk, because small enterprises tend to cut costs, i.e. by signing contracts with the cheapest service providers. In spite of these major problems, the situation in Denmark, Finland and the Netherlands illustrate that it is possible to achieve effective and reasonably priced care for all enterprises, including SMEs.

### 2.4 Health and safety committees and representatives

The establishment of enterprise occupational health and safety committees and the nomination of health and safety officers from the ranks of the employees have a long tradition in the older industrial countries, however corresponding practices in countries such as Greece, Ireland and Portugal are still in their infancy.

Health and safety representatives are frequently closely linked to the trade unions. They are either nominated directly by the trade unions, as in the United Kingdom, or approved by the trade unions following an election by the workforce (Denmark). They are often active trade union members. In countries where trade union membership has declined sharply, in France or the United Kingdom, for instance, the connection between enterprise occupational health and safety representatives and the trade unions is weaker. Generally speaking, the greater the direct influence of the trade union in the company, the greater the potential for employee participation on occupational health and safety and workplace health promotion issues.

## 2. Structures and practice in WHP

**Table 8: Limits to the creation of health and safety committees and representatives**

<i>Country</i>	<i>Committee</i>	<i>Delegates</i>
Austria	> 100	> 10
Belgium	> 50	no figures
Denmark	> 20	> 5 > 20 (safety groups)
Finland	> 20	< 10 (employer or employee) > 10
France	> 50	> 10
Germany	> 20	> 20
Greece	> 50	< 50
Iceland	> 50	< 10 (shop steward) > 10
Ireland	> 20	> 20
Italy	no figures	< 15 (shop steward) > 15 (responsible for several companies)
Switzerland/ Liechtenstein	no figures	> 5
Luxembourg	> 150	> 15
The Netherlands	> 35	> 10
Norway	> 50	> 10
Portugal	Obligations for specific high-risk sectors	> 10
Spain	> 50	> 6
Sweden	> 50	< 5 (regional safety committee) > 5
United Kingdom	Regardless of the size of the enterprise depending on the nomination by a recognised union	

Source: *The national country reports*

## 2. Structures and practice in WHP

The size of the enterprise is particularly relevant where participation in occupational health and safety is concerned. This means that, in a number of countries, employees in small enterprises are completely excluded from co-determination and participation possibilities (cf. Table 8).

In terms of employee participation in workplace health promotion and occupational health and safety, there is a distinction between collective representation in health and safety committees and individual representation by health and safety delegates.

In the Netherlands, the works council carries out the work of the health and safety committee. In Portugal, only the construction, mining and quarrying sectors are obliged to set up committees, whereas in the United Kingdom, committees only exist in companies where trade unions are recognised by the company.

In spite of the differences in their composition, one characteristic of these committees is that, by and large, they present a forum for employers' and employees' delegates to discuss occupational health and safety issues and work together to find solutions. Traditionally, the emphasis is on industrial accidents and safety issues. The committees, however, also play an important role in monitoring and holding training courses and information events for employees.

The establishment of health and safety committees is only obligatory for businesses of a certain size upwards. The limit is between 20 and 50 employees, depending on the country. Some countries have endeavoured to find answers to this problem.

In Denmark, for example, companies with fewer than 20 and more than 5 employees must appoint an OHS representative from amongst the staff. He works with a supervisor in a so-called safety group. The establishment of safety groups is also obligatory for each department within an enterprise.

Similar regulations also exist in Finland and Iceland. In Finland the employer in enterprises with fewer than 20 employees must appoint a head of occupational safety who is supported by two representatives elected by the workforce. In an enterprise with fewer than 10 employees, only one person is responsible for health and safety. The employer can perform this role himself or appoint someone else to do so.

In Iceland one employer's delegate and one elected employee representative are responsible for occupational health and safety in enterprises of between 10 and 50 employees. In micro enterprises (fewer than 10 employees), the shop steward performs this task in co-operation with a superior or the employer.

In Italy and Sweden, regional health and safety committees or delegates look after the interests of very small enterprises.

## 2. Structures and practice in WHP

In most other countries, such as Austria, France, Germany, Ireland, the Netherlands, Norway and Spain, there is a lower limit for employee representation, that is, companies employing between 5 and 20 employees. In other words, in many countries not all employees have the right to assert their rights in occupational health and safety. Indeed, employees in enterprises below a certain size are actually excluded by law from this right.

However, the lack of a statutory basis does not necessarily mean that small businesses do nothing about this. Survey results from Denmark, Germany and Spain are impressive. In Denmark, for instance, roughly 30% of all enterprises with fewer than 10 employees have established a safety organisation, although this is not always obligatory.

According to a representative study for Germany, occupational health and safety committees exist in 60 - 68% of all companies. Broken down, this shows that in the processing sector the proportion (about 70%) is higher than in service enterprises where it is only about 60%. If you examine the enterprise size category with 50 to 199 employees, about 50% of the companies in the processing sector and about 30% in the services sector have established occupational health and safety committees (Gröben, F.; Bös, K.: 1999).

In roughly 25% of all Spanish enterprises with fewer than 10 employees, health and safety delegates have been elected and in about 25% of all enterprises with up to 50 employees appropriate committees have been established although the law does not require it. On the other hand, 100% implementation of the statutory provisions regarding representation in occupational health and safety issues is still a long way off. This applies in principle to all countries, in particular to the public sector.

### 2.5 *Workplace health promotion*

Health promotion (according to the criteria set out in the WHO's Ottawa Charter and the Luxembourg Declaration on Workplace Health Promotion in the European Union) clearly goes above and beyond traditional, regulated occupational health and safety. Workplace health promotion includes issues such as job satisfaction, personal autonomy and social relationships. Health-promoting measures must be geared to the enterprise as a whole and should include its technical, organisational, social and communicative dimensions. The key requirements are the direct participation of the employees and the implementation, where needed, of measures relating to healthy working conditions and to a healthy lifestyle. This is additional to minimum OHS requirements (cf. also the quality criteria for workplace health promotion).

## 2. Structures and practice in WHP

The most advanced approaches in workplace health promotion have mainly been developed in northern European countries such as Finland, Sweden, Denmark, the Netherlands, Germany and Austria. They are characterised by the following elements, in spite of various differences in detail:

### n **Analysis**

Health promotion measures are developed on the basis of information and data about the health situation in the enterprise and the stresses/strains within it. This includes, among other things, preparing company health reports on the basis of data on sickness absence and/or staff surveys.

### n **Planning and project control**

The interpretation of health problems, decisions on key measures and the planning and control of health promotion activities take place discursively and in a co-operative manner with the participation of all relevant experts and decision-makers in the company. These are mainly: plant or company management, human resources and departmental management, employee representatives and professional occupational health and safety officers. Central steering committees are set up for this purpose.

### n **Developing measures**

Specific indications of stress/strain problems at the workplace, as well as areas where change and improvement are needed are worked out “on the shop floor” and are based on the perceptions, experiences and skills of the workforce. Health circles have been used successfully in Finland, as well as in Germany and Austria (as part of the workplace health promotion concepts of the health insurance funds). Improvements have to take place in the physical working environment as well as in the psycho-social one.

Ideally the focus should concentrate on “structural” measures (improvement in the working conditions). Lifestyle related prevention measures (e.g. exercise, nutrition, smoking) are not implemented in isolation but linked to measures to improve conditions and, as far as possible, work-related.

### n **Implementation of measures and evaluation**

Finally, the proposed measures are implemented and their effects assessed, e.g. through repeated data evaluation or another staff survey.

### n **Project management and organisational development**

Workplace health promotion should be geared to improving the skills of key players within the company. They should be able to identify and solve problems themselves and to encourage collective change (integration and organisational development).

## 2. Structures and practice in WHP

The implementation of such projects is, however, relatively costly and not very widespread, according to the few empirical surveys available in the individual countries. Results from company surveys on the level of dissemination of workplace health promotion measures are only available from Finland, Germany, the Netherlands and Portugal. The trend is, with the exception of Finland, the same in the above-mentioned countries: roughly 20 to 25% of the companies surveyed conduct workplace health promotion programmes. The more people who are employed in a company, the greater the likelihood of implementing WHP measures and the more comprehensive and demanding these measures are likely to be. Whereas in 10 to 20% of micro enterprises, workplace health promotion is on the agenda, the corresponding proportion is more than 70% in large companies.

The measures primarily relate to behavioural prevention (lifestyle), and are largely centred around exercise, nutrition, relaxation and stress reduction programmes, as well as projects relating to addiction (tobacco, alcohol, drugs).

Finland differs in a unique way from this pretty much typical European picture. A representative survey showed that more than 90% of Finnish enterprises are familiar with workplace health promotion measures. This percentage decreases in line with the company size to roughly 50% for micro enterprises, but such a widespread implementation of workplace health promotion programmes, particularly at a high level, appears to be unique in Europe.

## 3. *Summarising evaluation of workplace health promotion and occupational health and safety in SMEs*

### 3.1 *Occupational health and safety and workplace health promotion in SMEs: positive elements*

Occupational health and safety has undoubtedly gained in significance in SMEs through the implementation of European directives into national law. In many European countries a uniform legal basis was created for the first time for all companies and administrations – i.e. also for SMEs and the public sector. This is an important step towards unity and the elimination of fragmented occupational health and safety in Europe.

The implementation of the European directives has led to major changes in occupational health and safety.

For example, provision of care via occupational health and safety services and the implementation of risk assessments for all companies including SMEs became obligatory. This laid an important foundation for a systematic occupational health and safety policy in companies. In the wake of the implementation of European directives, many state occupational health and safety organisations and labour inspectorates began to adopt new concepts.

Elements of this new strategy include:

- n greater focus on management tasks in occupational health and safety
- n advice and system monitoring – instead of detecting and eliminating individual shortcomings
- n close co-operation with all those involved
- n a modern understanding of state action in occupational health and safety: fewer statutory regulations – more quality assurance and mediation.

These changes play an important role in creating a better occupational health and safety situation in SMEs and pave the way for better support for small enterprises.

Traditional prevention of industrial accidents and occupational illnesses was expanded to include prevention of work-related health risks, whether they be of a physical, chemical or psycho-social nature. In view of the predominant illnesses in the working population, this is an overdue addition to the occupational health and safety system.

## 3. Summarising evaluation

Workplace health promotion concepts, in their most advanced forms, can contribute towards attaining WHO health targets. Workplace health promotion concepts tried out initially in large enterprises have been adapted and refined to suit the specific needs of small enterprises. In this way, a series of impressive models of good practice were developed and implemented in the SME sector (cf. Models of Good Practice).

### 3.2 *Occupational health and safety and workplace health promotion in SMEs: weaknesses*

The practical implementation of the extended, and in some cases redefined, occupational health and safety tasks, face a series of quantitative and qualitative problems in the SME sector.

First of all, including a large number of SMEs into the occupational health and safety system is not feasible, as the labour inspectorate and OHS services resources are insufficient for this.

Furthermore, statutory provisions cannot be discharged in a purely formal manner, as illustrated by the cost debate in many companies. As a rule, SMEs have very little financial latitude, and tend to use the cheapest OHS services on offer, resulting in below standard care. In many countries appropriate regulatory instruments and comparable quality standards are missing or, are at best, voluntary.

Most small enterprises do not have an occupational health and safety infrastructure (works councils, health and safety committees and delegates etc.) and therefore lack fundamental skills and qualifications. There is a large gap between the formalised occupational health and safety systems found at supra-company level and the pragmatic thinking of the small entrepreneur which is geared to the running of the business.

Small entrepreneurs have a negative perception of occupational health requirements. Labour inspectors are not perceived as providing advice and support to the business, but as imposing expensive and time-consuming formal requirements. One example is the bureaucratic procedure involved in risk assessment, with its volumes of documentation. Bureaucratic requirements such as this are seen as a major stumbling-block.

The basic philosophy behind statutory regulations is not in question, only its lack of suitability for small businesses. Acceptance by SMEs is therefore largely dependent on practicable models and solutions which can be integrated into the workflow without any major cost.

## 3. Summarising evaluation

Another weakness is inadequate co-operation. This relates both to co-operation between labour inspectors and preventive services as well as to a lack of co-ordination within the preventive services themselves. There is not enough pooling of resources to make occupational health and safety efficient in SMEs, and to avoid duplication, detect shortcomings more quickly and to improve the acceptance of preventive measures.

Vocational and further training concepts have yet to be adapted to the current standards of legislation and practicality. Because of obsolete concepts and course content almost all occupational health and safety professionals are inadequately prepared for their role.

With a view to achieving more widespread use of the principles of health promotion in SMEs, the reporters from many countries also mention the following limitations and weaknesses:

- n Health promotion projects frequently remain isolated from other projects in the company. Routine incorporation and integration into company decision-making and management structures succeed only in rare cases.
- n The majority of health promotion projects are one-sided, relating only to behavioural and lifestyle issues and ignoring hazardous working conditions.
- n They also tend to be geared less to health and social needs than to immediate demands. For example, those targeted tend to be young, healthy people suffering from temporary health disorders, rather than those who are habitually exposed to the greatest hazards in the workplace.

### 3.3 Consequences and need for action

The following future challenges were identified from the aforementioned survey of workplace health promotion and occupational health and safety practice:

#### 3.3.1 Awareness-raising, marketing and communication

Traditional occupational health and safety, with its formality and bureaucracy, is clearly not suited to SMEs. The implementation of workplace health promotion programmes and occupational health and safety measures in SMEs must be focused more on motivation, co-operation and consultancy as well as on interest and acceptance. There is a need for

## 3. Summarising evaluation

positive and pragmatic occupational health and safety and workplace health promotion philosophies which are geared to everyday life in small enterprises and are motivating and trend-setting.

In order to achieve this, public relations work is essential to highlight workplace health promotion successes and to encourage acceptance among SMEs.

### 3.3.2 *Setting up infrastructures (building supportive environments)*

The optimisation of workplace health promotion and occupational health and safety in SMEs can only be achieved collectively, with the co-operation of all those involved.

At a political level this means developing new policies and integrating existing ones. Examples of this might include setting up WHP institutes, establishing dialogue between interested parties, making political commitments to WHP targets, developing policy documents, providing subsidies to organisations undertaking WHP or employing WHP professionals.

At the implementation and intervention level, networking and partnership-building models are in demand. This means the development and maintenance of enterprise and expert networks which ensure the sharing of experience and knowledge. On the other hand, the establishment and expansion of sectoral and regional co-operation models and supra-company networks are required (sectoral organisations, trade associations, employers' organisations, trade unions). Furthermore, it is necessary to improve and adapt vocational and further training concepts in occupational health and safety in order to be equipped to meet new targets.

### 3.3.3 *WHP service management*

There is a need to develop tailor-made, quality-assured preventive services for SMEs. This relates both to the integration of health promotion principles and measures into existing occupational health and safety services and to the question of how these services can reach considerably more SMEs than is the case at present.

That means the services and measures must:

- n be closely related in terms of content to the practical problems and experiences of SMEs, in order that they become part of everyday working life (integration)
- n be readily accessible, i.e. as local as possible.

## 4. *Annex: Summaries of the national country reports\**

### *Austria*

The Austrian economy is characterised by a high number of small and medium-sized enterprises. About 83% of companies in manufacturing and the service industries employ fewer than 10 people, a further 14% have fewer than 50 employees. Agriculture and forestry are also dominated by very small companies. Health promotion projects are generally aimed at large enterprises and employees in small and medium-sized companies are more or less neglected. However, some encouraging progress is being made as the models of good practice illustrate.

Health data on sickness and accident rates show that differences exist in specific sectors but not necessarily according to company size. The building and construction sector has the highest sickness rate per thousand workers, and also has a disproportionately high number of occupational accidents. Physical problems are also higher than average in both the construction industry and the metal industry – almost 60% of occupational diseases are distributed over 40% of the workforce in companies with more than 250 employees.

Employees in large companies are also at greater risk from exposure to chemicals, particularly in some of the manufacturing industries. High stress levels tend to affect the social services and health sector, administration and areas of transport and telecommunications currently undergoing great technical changes.

However, it cannot be assumed that employees in small companies enjoy healthier working conditions. The more accountable nature of small firms means that fewer days are lost to sickness. However, one can also see extremes of standards within small businesses – from caring places that operate like a family to enterprises where not even minimum health and safety standards are met. The reasons for inadequate social and health care measures for employees in small enterprises include a lower than average rate of union organisation and limited economic resources.

#### ***Current industrial safety and health promotion practices in SMEs***

The legal requirements for technical industrial safety are set out in the Industrial Safety Act (AschG). The implementation of EU guidelines has brought about considerable change:

- The ethos of prevention is central to the law: all workplaces and the working practices within them are evaluated with a view to minimising risk.
- An employer's responsibility has been redefined and is now more comprehensive in character with greater emphasis on evaluation and documentation.

\* No national country reports have been submitted by the national contact offices (NCOs) for Belgium and France. Although the NCOs for Luxembourg and Portugal compiled country reports, which have been included in this publication, they did not provide the necessary summaries.

## 4. Annex: AUSTRIA

- n Assessment of potential risk factors in every workplace plus implementation of measures for improvement form the basis of new industrial safety laws.
- n Small and medium-sized companies will have to use the services of preventive personnel after an interim phase of adjustment. There will also be a need to have input from safety officers and occupational doctors.

In-house industrial safety is complemented by a wider structure. The Workers Compensation Board (AUVA) and the Factory Inspectorate have a central role in providing advice on health and safety issues and supervising the implementation of legal requirements. Their involvement with other partners in health promotion projects is also increasing. Industrial safety and health promotion are important issues for the unions and they lead the way in the arena of political discussion.

New legislation has seen minimum standards being introduced for small and medium-sized companies which will have positive effects on the health and safety of their employees. A steady decrease in accidents at work since the amendment to the Industrial Safety Act in 1995 shows that the basic concept of prevention has a beneficial impact. Concessions were made to small and medium-sized companies in terms of financial support and less complex requirements. It is clear that inappropriate bureaucracy, no distinction being made between different types of industry, an avalanche of information and paperwork have caused hostility and resistance in small businesses.

Health promotion measures that go beyond minimum statutory requirements are the exception rather than the rule in small and medium-sized enterprises. Complex health promotion models used in large companies simply cannot be transferred to small organisations. Because of limited economic and structural resources, health promotion projects in small businesses tend to revolve around one-off initiatives and lifestyle measures. A lack of in-house employee representation also means that industrial safety and health promotion cannot be discussed in an open arena.

The social insurance institutes and employer and employee representatives are not the only players within industrial safety and health promotion, the number of private organisations taking part is also increasing. A wide range of services are now offered by prevention centres, research institutes, sport scientists, management consultants, dieticians, etc.

### ***What the future holds: conclusions and strategic approaches for SMEs***

Discussion on the amendments to the Industrial Safety Act has led to a more sensitive attitude towards health. Consequently the need for a preventive approach is, on the whole, viewed positively by both employers and employees.

Acceptance of measures to improve health depends on their being practical to implement and not overly bureaucratic. This is also true for the evaluation process and the use of preventive services. One method of simplifying things for SMEs could be a system that combines safety management with quality control.

Communication and participation are key factors for acceptance and success too, both for the implementation of statutory regulations and for health promotion. The regulatory

approach specifies that safeguarding health should be an integral part of corporate culture. Small businesses can also bring the issue of health into their corporate philosophy. It should also be possible for them to organise successful projects at little expense if the excessively bureaucratic elements are taken out.

The health and well-being of employees is affected by personal behaviour as well as by workplace conditions. The most effective measures, therefore, are those which take both these elements into account. The introduction of management systems can also provide an opportunity for detecting health risk factors in different areas of work.

By co-operating with regional or national networks, small and medium-sized companies can access practical help despite their limited resources. Information and education are basic requirements for health-conscious behaviour and improved working conditions. Well prepared information material can be just as important to a small enterprise as the quality of training provided for staff involved in preventive practices.

Health promotion measures must always be looked at from an economic viewpoint. This is particularly true for small organisations, because of their limited financial scope. As better employee health only pays off in the long term, it is necessary to identify incentives that make this type of investment appear attractive to business owners. If the measures create not only a better company image and improved employee motivation, but also lead to higher quality and productivity, then both sides are in a win-win situation.

### *Denmark*

In Denmark, working environment initiatives directed towards small and medium-sized enterprises (SMEs), have focused primarily on occupational health and safety. There are no examples of lifestyle or workplace health promotion initiatives directed at SMEs. Our report therefore focuses on occupational health and safety within small enterprises, particularly those with fewer than 20 employees.

Small enterprises dominate industry in Denmark and over the last decade the occupational health and safety system has placed increasing emphasis on them. One important measure to have been brought in is the tightening up of statutory requirements for setting up a safety organisation – small enterprises with 5-19 employees must now set up a safety group that includes a safety representative and a top level manager (or the owner if only one level of management exists).

Another important measure to have been introduced is the requirement for a workplace assessment. This should have been carried out before the end of 1997 but micro enterprises (with fewer than 5 employees) have been given an extended deadline until the end of 2000. All enterprises with high health risk factors must now liaise with an occupational health service, regardless of size. The occupational health service unit can give advice and provide consultancy services on occupational health and safety issues.

These legal requirements have been met with scepticism by many small enterprises, and are seen as being bureaucratic and out of touch with the practical problems facing SMEs.

## 4. Annex: DENMARK

A study by Tybjerg et al. 1999, indicates that, generally speaking, it is small enterprises who have yet to complete the workplace assessment. This study also confirms earlier findings that small enterprise are reluctant to use occupational health services (Hasle and Limborg, 1996).

### *Lessons for the future*

Our experiences here in Denmark suggest that it is important to take into account the way in which small enterprises perceive occupational health and safety and how they carry out their daily activities. In small businesses, health and safety activities tend to be informal, focusing in general on specific problems relating to the everyday functioning of the organisation. This contrasts heavily with legislative demands where the emphasis is on systematic assessment and management of occupational health and safety problems.

A number of pilot projects carried out in Denmark have proved that it is necessary to develop methods tailored to the specific needs of small enterprises. The most important factor is to develop a personal contact with the owner, who is the key to every aspect of the organisation. Improvements in health and safety and health promotion will not be successful without dialogue and trust between the owner and the occupational health professional.

In Denmark the occupational health service is an important contributor to health and safety and two examples of successful initiatives are outlined below:

- n The occupational health service in north-eastern Zealand has developed a new service model for small enterprises. Its most important features are: personal contact with each business, access to immediate advice and, pooling of resources for small enterprises.
- n The occupational health service in Sorø works in collaboration with a private consultant and offers a method of integrated workplace assessment. This approach brings preventive practices into areas such as quality and productivity. Emphasis is placed on encouraging businesses to see that creating a healthy working environment isn't an unnecessary expense, but an effective means of saving time and money. The integrated workplace assessment was developed and adapted specifically for small enterprises, and respects the individual culture within them and the owner's understanding of his or her particular working environment.

### *Conclusion*

Future strategies relating to workplace health promotion must respect the individuality of small enterprises. It is also important to be sensitive when criticising the way in which these companies operate as the owner will often take this personally.

Taking a positive approach and integrating workplace health promotion with other management goals such as quality and productivity are vital to success. Professionals will have to be trained in dealing with small organisations and their individual methods of operating. They must also learn how to establish and maintain a relationship with owners of small enterprises built on dialogue and mutual trust. Gaining a working knowledge of small

business management is also crucial. Denmark has a strong tradition of good interaction between management and employees both at work level and within society as a whole. It is therefore essential that workplace health promotion activities include these two parties.

Another important element to consider is that owners of SMEs rarely take notice of written material unless it is vitally important because they are already inundated with post, newsletters, junk mail, etc. Workplace health promotion campaigns in written form therefore seldom achieve their purpose. We believe that it is possible to develop successful strategies for workplace health promotion in small enterprises based on the above considerations. But, in such enterprises the daily fight for survival takes priority and it will take time to convince them that workplace health promotion helps and supports this goal.

### *Finland*

The Finnish work force totals about 2.4 million employees. Around 530.000 of these (44%) work in SMEs in the private sector. SMEs account for about 33% of the Gross Domestic Product.

#### ***Statistics on absenteeism and accidents***

According to a survey conducted by the Confederation of Finnish Industry and Employers (TT) absence due to sickness and accidents is lowest in SMEs (4.0 - 4.8% of regular working time). In larger companies absence rates range from 5.3% to 5.7%.

Accident risk is estimated according to the accident insurance premiums paid by companies. In every sector SMEs pay higher premiums than bigger companies. Physiological risks, particularly from lifting and moving heavy loads, are greater in SMEs than in larger enterprises too. However problems such as noise, vibration and uncomfortable temperatures, are equally common in small and large enterprises. Noise levels are at their most disruptive in the largest companies (i.e. in industry).

#### ***Health and safety legislation***

Four main laws form the basis of occupational health and safety: Labour Protection Act, Occupational Health Services Act, Labour Administration Act and Supervision of Labour Protection Act.

Every enterprise is required by law to devise an action plan for occupational safety and for occupational health provision. These action plans should also contain a maintenance of work ability/workplace health promotion (MWA/WHP) policy.

#### ***Occupational health services in SMEs***

The employer is obliged to arrange occupational health services for employees and these costs are refunded (to a maximum of 50%) by the Social Insurance Institution of Finland (KELA). 1.6 million employees are covered by occupational health services.

## 4. Annex: FINLAND

However, servicing remote rural areas of Finland can be difficult. Small businesses have to rely on municipal health care centres which often have limited resources. Despite the obligation to serve all companies in the region, waiting times can be very long.

### ***Occupational health and safety in SMEs***

The occupational safety administration takes care of regional inspection and guidance on occupational safety. During 1997 the regional labour inspection offices carried out about 36.000 workplace inspections. About 24.000 of these (around 66%) focused on workplaces with fewer than 10 employees.

Within the Finnish system two separate authorities oversee occupational health and safety. Better co-operation is needed between the two.

The Labour Protection Act requires that every workplace make the following arrangements:

- The employer must nominate a person as a head of occupational safety if he does not himself act as such.
- If ten or more people are employed at the workplace an occupational safety representative and two deputies have to be appointed from the ranks of the employees.
- When 20 or more people are employed an occupational safety committee has to be established.

Subcontractors have proved to be difficult to access where occupational safety is concerned. Safety inspections of short term work sites, for example where building demolition is being carried out, is not easy. Problems also exist with temporary and part-time workers, as well as in seemingly risk-free environments such as high technology enterprises – jobs in these businesses can often involve long working hours resulting in stress and burn-out.

However, the flexibility enjoyed by small companies means that they are often better placed than large companies to make changes. When a small business decides to adopt preventive OHS practices these are implemented swiftly and comprehensively.

### ***Workplace health promotion in SMEs***

MWA/WHP activities are based on an agreement devised between the central labour market parties in 1989. As the tripartite labour market parties were, in fact, the founders of the Finnish MWA/WHP policy they are very strongly supportive of strengthening and improving it.

Encouraging small enterprises to take health promotion on board is very important as SMEs are so numerous and they employ a large number of people. The main point to get across is that improving the well-being of employees will ultimately save the employer money. Workplace health promotion is more than simply good health or lack of illness, it encompasses motivation, work skills and productivity.

Unfortunately, the response of small or micro entrepreneurs to occupational health has not been positive. Many employers see it as an expense to their company with no appreciable benefits.

The Central Organisation of Finnish Trade Unions (SAK) has been active in generating initiatives in governmental policy. The action programme for well-being at work was started in 2000. A major challenge for the future, from the point-of-view of trade unions, is to generate greater equality in working life, i.e. all employees should receive the same services and treatment regardless of where they live, in which sector they work and what kind of employment relationship they have.

The European Social Fund highlighted MWA/WHP issues in Finland in the programmes it ran between 1995-1999. The Finnish SME programme also established a positive link between MWA/WHP and enhanced productivity, improved motivation and a better attitude towards work.

Workplace health promotion was publicised widely in a national campaign during the 1990s. The occupational health and safety authority took a proactive stance in informing SMEs about WHP with promising results.

Two big problems face the acceptance of WHP in SMEs: attitudes in such companies tend to be more paternalistic and conservative than in larger organisations and WHP is seen an unnecessary waste of time and resources. SMEs also suffer from a lack of understanding of their specific needs in health and safety matters. Furthermore the compensation system for occupational health services does not allow for extra costs of services in SMEs.

### *Needs for action*

Occupational health services need to improve their WHP methods and the accessibility of WHP provision. New legislation on occupational health services is likely to improve the situation by creating an arena where there can be better consultation on WHP matters between occupational health services and their client enterprises.

Economic incentives should also encourage SMEs to implement WHP activities. Health risks should be managed at a reasonable cost to individual businesses and investment in health promotion needs to reap positive benefits.

WHP for self-employed workers should become a fundamental human right which is (at least partly) supported by public funds.

### *Germany*

The proportion of employees and enterprises in the SME sector in Germany is slightly lower than the European average. Roughly 60% of employees in Germany work in SMEs (Europe: 67%) and 99,4% of companies (Europe: 99,8%) are included in this size category.

Crafts account for a very high percentage in the SME segment. 97% of the good 6 million employees in the craft sector belong to the SME category. In former western Germany almost 32% more employees now work in craft enterprises than 20 years ago. Roughly 38% of all trainees and apprentices worked in craft enterprises in 1998. For this reason, the

## 4. Annex: GERMANY

craft sector is also termed the “trainer of the nation”. In addition, trading, construction, hotels and catering, banking and insurance as well as transport and telecommunications, with a more than 50% proportion of its employees in SMEs, play a major role.

The degree of organisation in collective bargaining associations of employees and employers is lower in SMEs than in larger companies. For the representation, promotion and safeguarding of their interests, the SMEs are organised in a branched chamber system, which is frequently subject to self-administration and which can play an important role as regards occupational safety and health and its prospects.

Health conditions in the SME sector are different. On the one handside the sick leave rate is much lower than the average, especially in companies with fewer than 10 employees. On the other handside in the SME sector there are much higher accidents. Over 60% of industrial accidents occurred at enterprises with up to 200 employees. Accidents resulting in death are almost three times more frequent at enterprises with fewer than 20 employees than at concerns with more than 1,000 employees. Specific health hazards related to physiological, physical, chemical or psycho-social working conditions are also higher than in larger companies. However, there is some doubt as to whether these risks are actually related to the size of the enterprise. The higher accident rates and (specific) work stresses can equally be attributable to the fact that a number of hazardous work processes are traditionally performed in small enterprises, in particular, in the crafts sector.

### *The current situation of OHS and WHP in SMEs*

The occupational safety and health system is dominated by the dualism of the state and statutory accident insurance funds (Berufsgenossenschaften).

The state monitoring and consultancy functions are performed by the state authorities responsible, the state offices for occupational safety and health. Beside, the bodies of the statutory accident insurance system, the Berufsgenossenschaften (BGs), issue regulations with the force of law to the member companies (accident prevention regulations) and monitor their observance.

Since 1996 the BGs have also had the mandate to co-operate in the prevention of work-related health hazards with the statutory health insurance system, i.e. the health insurance funds. In turn, these funds have the statutory authority to participate in the prevention of work-related health hazards and to co-operate with the accident insurance bodies. Above and beyond the legally regulated occupational safety and health system, they themselves can define and provide services aimed at maintaining and promoting the health of the employees. The health insurance funds therefore have equally broad latitude for establishing and defining the need for health-promoting services, in particular at company level.

As part of the transposition of European provisions into German law, particular rules and possibilities for preventive care, i.e. in terms of safety and occupational medicine, have been introduced in the SME sector. The so-called entrepreneur model has proved to be an interesting and promising alternative to the former practice of standard care according to prescribed deployment times. The entrepreneur model is based on the philosophy that the

small entrepreneur is to qualify in matters of occupational safety and health. Appropriate qualifications and information would then result in the entrepreneur seeing himself the extend of external expert advice of occupational safety and health measures.

Both preventive care as well as the supervisory and consultancy activities of the state occupational safety and health offices and the BGs are not readily feasible for SMEs throughout the country. According to a representative study on the state of company occupational safety and health in two German states (Hesse and Thuringia), there is the smaller the enterprise, the lower the degree of safety and in particular occupational health service. The lowest level of preventive care by a works physician (50%) and as regards the occupational safety service (75%) is found at enterprises with fewer than 200 employees in the services sector.

In Germany, the main players in workplace health promotion, as defined beyond traditional, statutory regulated occupational safety and health, are the statutory health insurance funds which were given their own statutory mandate in 1989 in the field of prevention and health promotion. The trend is also very clear here. Results of a representative study show that the majority of health promotion programmes were sponsored by the health insurance funds at major companies. The programmes therefore mainly relate to the sector of lifestyle prevention, primarily programmes on exercise and relaxation as well as addiction prevention.

Only roughly 10% of the enterprises with fewer than 200 employees carry out health promotion measures. However, in spite of the commitment of the health insurance funds, a lasting and widespread effect has not been achieved.

### ***Strengths and weaknesses of OHS and WHP in SMEs***

Owing to the transposition of European directives into German law occupational safety and health in SMEs has gained in significance. For the first time in Germany, a uniform legal basis was created for all enterprises and administrations. Moreover, the preventive task of the accident insurance system above and beyond industrial accidents and occupational illnesses was extended to the prevention of all work-related health hazards. The statutory labor inspection, accident insurance bodies and health insurance funds have been obliged to work closely together and to promote the exchange of experience. These were important steps towards eliminating the fragmentation, shortcomings and fragmentary limitation in German occupational safety and health legislation.

With the health reform law of 1989, the health insurance funds were given a comprehensive health promotion mandate which also covered enterprises and workplaces. From that time on, the health insurance funds rapidly extended their commitment in the field of health promotion and developed workplace health promotion concepts which, in their most advanced forms, can be understood as a contribution towards the implementation of the WHO health policy. The activities of the health insurance funds created and still develop important momentum which the other institutions of occupational safety and health can no longer ignore and by which they are measured.

## 4. Annex: GREECE

Statutory labor inspection like Berufsgenossenschaften have a common core of problems in communications with SMEs which relate to their sovereign functions and statutory legitimisation. Their commitment and advice is perceived less as further consultancy but rather as a formal requirement with which a small entrepreneur is much more difficult to convince than the executive in a large company. Owing to the low sickness rate, the infrequency of accidents in the individual enterprise and the unfavourable cost/benefit ratio of structural measures there is only a weak foundation for formal occupational safety and health demands in SMEs.

Another weakness is the (still) minimum co-operation of all those concerned. There is (still) absolutely no pooling of resources to make occupational safety and health effective in SMEs, to avoid overlapping, to detect shortcomings more quickly and, in particular, to improve the acceptance of these measures.

Finally, there is (at present still) no quality assurance, in particular of preventive health care, and a lack of suitable vocational and further training concepts and their practical implementation.

### ***Consequences and need for action***

- n Development of new approaches to occupational safety and health in SMEs
- n Development of viable models of co-operation involving the self-administration bodies and other relevant intermediaries for SMEs (formation of network structures)
- n Tailor-made and quality-assured support programmes
- n Changes in vocational and further training for players in occupational safety and health.

### ***Greece***

Most companies in Greece are small and medium-sized enterprises (SMEs) and the majority of the country's workforce is employed by this type of organisation. According to figures provided by the National Statistics Department, companies with a workforce of fewer than 50 people employ approximately 1,790,000 people. From a sample of 534,760 Greek companies 490,386 (91%) employ no more than ten people. The majority of these companies are involved in the wholesale and retail trade.

The Greek Occupational Health and Safety (OHS) system comes under the jurisdiction of the Ministry of Labour and Social Affairs and, more specifically, under the General Directorate of Occupational Health and Working Conditions. The Centre for Occupational Health and Safety, and the Directorate of Working Conditions operate within this.

The main responsibilities of the General Directorate are:

- n Legislation (changing and passing laws, presidential decrees, implementing EU Directives, participation in EU services e.t.c.)
- n Organisational responsibilities (such as detailing technical instructions, guidelines, e.t.c.)
- n Information, education, training; and

- n Research (surveys and programmes relating to Occupational Health and Safety in collaboration with EU Universities and other institutions).

Other organisations involved in OHS are the Hellenic Institute for Occupational Health & Safety (ELINYAE), the Greek General Confederation of Labour (GSEE) and the National Insurance Fund (IKA).

The Ministry of Labour and Social Affairs has a very rich legal and constitutional framework relating to health and safety. A legal framework on hygiene and safety at work issues has been implemented for all companies including SMEs. Over the last decade, emphasis has been placed on supporting institutions that contribute to the improvement of working conditions at national, regional and company level.

Important recent changes to OHS legislation include the extension of services relating to preventive practices and safeguarding health in every company without exception. Employees are given the opportunity to choose health and safety services supplied by members of the company or from an external source, another option is the External Service for Safeguarding Health and Preventive Practices, an initiative established recently by the Ministry of Labour and Social Affairs. All companies in Greece regardless of size and sector must have an elected employee committee responsible for OHS and a trained safety officer. Companies employing more than 50 people need to employ an occupational doctor too.

Statutory health and safety legislation has contributed to a decrease in occupational diseases, occupational accidents and occupational sick leave in the last three to five years.

The Centre for Occupational Health and Safety is very interested in improving health and safety in SMEs. This has led to the adoption of the Cardiff Memorandum. Further efforts to promote WHP in SMEs have been implemented through seminars, projects, information leaflets and a website on the Internet ([www.osh.gr](http://www.osh.gr)). The need to develop effective WHP strategies and activities in SMEs in the future is particularly important because of the large number of small businesses in Greece.

### ***What stands in the way of WHP?***

Greek companies tend to focus more on occupational safety than on health promotion. The reasons for this stem primarily from a lack of economic resources along with insufficient information on WHP. Other reasons for the difficulties SMEs have in implementing not only WHP but also statutory OHS legislation derive from:

- n Economic difficulties
- n Lack of commitment from management
- n Poor information about OHS legislation
- n Traditional organisational structures
- n Poor condition of equipment and installations
- n Poor technological communication
- n Large number of isolated SMEs in rural Greece
- n Lack of available statistics to draw employer's attention to the relationship between low productivity and poor occupational health and safety conditions at the workplace
- n Low union participation among employees in SMEs.

## 4. Annex: ICELAND

### *Looking to the future*

In order to enhance OHS and WHP in SMEs in Greece the Ministry of Labour and Social Affairs has identified the need to:

- Provide support for the recently established services aimed at enhancing preventive practices and improving workplace health in Greece
- Improve upon the dissemination of information to SMEs through seminars, leaflets, events and the EU Network
- Continue the positive collaboration between the social partners and experts and to ensure the dissemination of all relevant information
- Support research programmes on WHP and award Models of Good Practice at national level
- Systematically monitor SME workplaces (through the Labour Inspectorate).

### *Iceland*

Little attention has been paid to occupational safety and WHP issues in small and medium-sized enterprises in Iceland. Legislation here makes no distinction between SMEs and larger companies. All employers are required to ensure good working conditions, healthy surroundings and safety in the workplace, and to work closely with employees and the safety manager/shop steward.

Employers must make it clear to their employees if there is any risk of accident or disease associated with the job and see to it that they receive adequate information and training to perform their tasks without endangering themselves. According to the law, employees should also contribute towards creating satisfactory working conditions. For instance, if an employee detects any shortcomings that could jeopardise health, which he himself cannot rectify, he should notify a superior immediately.

### *WHP in SMEs*

Trying to find models of good practice wasn't easy given that workplace health promotion in SMEs is not a legal requirement in Iceland. However some companies are in fact working on small projects which come under the banner of WHP as outlined by the Luxembourg Declaration, but without the companies defining them as such.

Some organisations do offer some kind of occupational health service to their employees but this applies mostly to larger companies. A few healthcare centres also offer this service.

The survey carried out in connection with this SME project illustrated very clearly why it is difficult for small and medium-sized enterprises to carry out WHP activities. Larger companies have access to resources that make it easier for them to implement health promotion

at the workplace. Small enterprises cannot afford to employ a paid representative, therefore motivation for implementing WHP projects often depends on the enthusiasm of one person or a few individuals. Consequently, if that particular person quits his job, the entire project is likely to fall apart. The work load is often great in SMEs and it can be difficult to shoulder the burden of extra responsibility.

Awareness of WHP issues tends to fluctuate as those responsible for this kind of activity have other tasks to perform and cannot devote their entire working day to organising and promoting health related activities.

Furthermore, managers have generally become aware of the benefits of quality management, but health promotion is rarely seen as being part of that. As the benefits of WHP only become apparent in the long-term, it can be hard for management to understand its importance to the company. In selecting and documenting models of good practice in SMEs, it became obvious that if management fails to ensure that WHP is part of company policy then it will never develop beyond a few short term projects.

The fact that Icelandic companies do not systematically record accidents in the workplace, work-related illnesses or stress-related factors in the working environment defining 'good' and 'bad' practice and identifying improvements or worsening situations can be difficult.

### *Current legislation*

Laws relating to the workplace (no. 46. 1980) are intended to ensure that employees enjoy a safe and healthy working environment. The focus has very much been on safety measures, with the emphasis on the workplace rather than on the individuals within it. The organisation and content of the work, social relations, atmosphere at work, communication, management/employee relations and other psycho-social factors that affect the general wellbeing of employees have not been given due consideration. Lifestyle issues are not dealt with either in rules and regulations or within the framework of the law.

Employing a safety manager working in co-operation with the AOSH, is a legal requirement for all companies with 10 or more employees. In smaller enterprises a shop steward, elected under trade union rules, deals with safety issues. Employers also have to ensure that the safety manager attends courses on workplace health and safety run by the AOSH.

Even though the system officially applies to SMEs, it is clear that it functions better in larger companies. It is also taken more seriously in an environment where there is an inherent risk element.

Even though health promotion at the workplace is not a legal requirement in this country, some workplaces are taking it on board, partly because of EU/89/301, and partly because there is an increasing awareness that the workplace is a very appropriate place for carrying out health promoting activities.

## 4. Annex: IRELAND

### *What the future holds*

Workplace health promotion is an important issue and the National Contact Office in Iceland faces a major task in devising practical ways of bringing it to SMEs and creating ways in which it can be established on a long-term basis. As there are plans to formally establish occupational health services for employees in the near future, new channels will be opening up to develop workplace health promotion and to enhance its standing in the business community.

### *Ireland*

Just like in other European countries, SMEs are considered valuable in terms of their contribution to the overall competitiveness, flexibility and resilience of the economy. However, less attention has been given to the state of employee health in SMEs, and this area needs to be addressed in the future. However, in order to do this effectively, one has to take on board some of the relevant characteristics of SMEs.

The majority of Irish enterprises are SMEs and from many points of view are the most important parts of the economy. Traditionally they have been the focus of industrial policy because of their potential for job creation. Indeed, the fact that out of 50.000 new jobs created in 1996, 43.000 were in SMEs (86%) is proof enough. (Annual Competitiveness Report ([www.forfas.ie](http://www.forfas.ie)) and all recent indicators regarding job creation fall in line with this).

### *Distinctive SME characteristics*

SMEs are generally more vulnerable than large firms, they usually lack financial and human resources, especially for planning and analysis, and they also lag behind in terms of benefiting from what is now known as e-business. There is a high probability that SMEs will have deficiencies in management resources, which is rather significant, given that 70% of employees in the private sector work in companies managed by owners. (Owner-managed companies are almost 100% SMEs and the majority are small enterprises with fewer than 50 workers).

SMEs are also more affected by financial problems (the second most frequently cited cause of failure in SMEs), often the result of a small firm's inability to raise finance. They are also disadvantaged in terms of market power, are more labour intensive and relatively less productive than large-scale enterprises (LSEs). Linked to this is their lower share of the national wage packet. Finally, SMEs in a small open economy (such as that of Ireland) face even more difficulties, being more susceptible (than LSEs) to exchange rate fluctuations and bank lending policies<sup>1</sup>.

Company profitability was found to be by and large independent of its size, (i.e. in general, LSEs were not more profitable as a group), while anecdotal evidence suggests that there is

<sup>1</sup> Admittedly, bank lending policy is very favourable at the moment, while exchange rate developments have also been largely favourable, apart for those businesses affected by high exchange rate for sterling.

a very profit-driven mentality in SMEs, which is thought to compensate for lower labour productivity. As a result, SMEs could be susceptible to shortcut-taking in health and safety and workplace health promotion initiatives.

There is also a worry that SMEs, particularly micro enterprises, are at an information disadvantage compared to LSEs. Only 2% of micro enterprises (fewer than 10 workers) make use of the Internet (The Irish Independent, June, 26th 2000). This fact has some important implications for the development of WHP in these enterprises (lack of information regarding up-to-date research, initiatives, etc.), as well as for the way in which these companies can be targeted by future WHP campaigns.

These difficulties often lead to new businesses starting up without adequate resources (in a wide sense), with significant repercussions for OHS and WHP.

SMEs in Ireland are also characterised by a high proportion of apprenticeships, but a lower prevalence of on-the-job training. With regard to trades union membership, SMEs are generally less unionised and generally not covered by collective bargaining agreements<sup>2</sup>. Although this fact has certain adverse implications for OHS and WHP, many observers will also point out that informal but nevertheless effective consultations within SMEs have the potential to compensate for this.

SMEs tend to subscribe to national level agreements between the government, national employers' and trades union organisations (another characteristic of Irish SMEs is a very low rate of membership to employers' organisations). Consultations regarding organisational changes are generally lower in SMEs. This, combined with a general lack of awareness on the advantages of better health in business terms, tends to indicate that Irish SMEs may well be failing to integrate WHP into their overall business strategy.

### ***The part played by health and safety legislation***

As expected, it was found that implementation of occupational health and safety in SMEs was hugely dependent on legislation and statutory requirements. Thus the 1989 Health and Safety at Work Act (HSAW) brought about much needed change by seeking to encourage both diffusion of stipulated health and safety practices, as well as more proactive employer involvement. One of the main methods used to achieve this is an obligation placed on employers to produce an annual Safety Statement, in which all relevant threats to health and measures to counteract them are detailed.

However, although the body of legislation is seen as broadly supportive of workplace health promotion, there is very little evidence that it has played any role in promoting activities that go beyond statutory responsibilities. Furthermore, there is some evidence to suggest that even 'traditional' health and safety activities are not applied universally, and this is particularly the case for the SME sector. In general, compliance with legislative requirements (regarding the Safety Statement) is generally lower in the SME sector too. This is particularly true of the smaller companies. Some differences have also been noted between SMEs depending on the business sector they operate in. True, the delivery of health and

<sup>2</sup> However, the picture is not so simple here since multinational (MNC) branches that have located in Ireland and represent a substantial proportion of LSEs are not unionised.

## 4. Annex: IRELAND

safety to smaller enterprises has been enhanced by some state-sponsored schemes (such as the 'Good Neighbour Scheme') but this gap has yet to be fully bridged.

Although there are some legislative shortcomings regarding WHP it would nevertheless seem unfair to blame a lack of statutory requirements for slow progress. Indeed, the nature of WHP development, which was rather ad hoc, could be the cause. True, lack of legislation is responsible for the fact that WHP activities in general lag behind traditional health and safety initiatives, but it is really the lack of a coherent perspective on WHP and subsequently, the lack of a universal model that is largely to blame. However, some positive initiatives have been launched recently at national level, such as a national plan for health promotion and (well targeted) state-sponsored research into the health promotion needs of SMEs, illustrating a rapidly developing national policy on WHP, and an increasing commitment to it.

### *Stakeholders: how they influence WHP in SMEs*

With regard to major national stakeholders and their activities in the area of OHS and WHP, the picture is rather diverse. The national health and safety authority (HSA) is largely pre-occupied with traditional, mainstream activities and is thought to lack the specific strategy required to effectively target SMEs. This is attributed to a resources constraint (mainly staff) and the need to prioritise high-risk sectors (construction and agriculture) instead. The other statutory agency responsible for public health is the Health Promotion Unit of the Ministry of Health and Children (HPU), which has only recently been active in the workplace. However, the HPU has adopted the right approach, taking a coherent, national route towards workplace health promotion and paying particular attention to the SME sector.

Other stakeholders include the employers' association and trades unions, both of which are predominantly concerned with traditional health and safety issues. However, they both lack a coherent strategy regarding SMEs in this area. The same is pretty much true in relation to WHP. However, there are signs that trades unions are starting to take a more proactive role in WHP. It is also worth noting that the employers' association is broadly supportive of WHP and that some members of the association are very active individually.

### *Conclusion*

It should be noted that there is a sound legislative basis (legislation is consistent with European Directives) for OHS activity in Ireland. This coupled with an increasing commitment to health and safety by Government Agencies and a strong commitment to employee training in health and safety, represents a major strength in the Irish system. Inevitably, the system has some weaknesses, the most notable being a lack of reliable data on occupational accidents and diseases, (and subsequently, relatively little attention paid to work-related diseases), inadequate enforcement procedures and lack of development and usage of OHS services.

With regard to WHP, a number of positive developments should be noted, particularly a growing commitment by State Agencies (including increased resource backing). However, there are some considerable obstacles to be surmounted, mainly too few professionals in

this field and inadequate levels of awareness regarding WHP amongst enterprises (particularly relevant for SMEs). Furthermore, a coherent, universal model relevant to the Irish context is missing. The models in use are heavily influenced by the US approach, focusing on the individual and/or single issue(s).

In terms of action regarding WHP and OHS, one of the priorities would be to develop a knowledge base regarding the needs, risks and preferences of SMEs, which would in turn form a basis for formulating a national policy and strategy in this area.

### *Italy*

The Italian labour system is made up of small businesses. Data from the Interim Census on Industry and Services carried out in 1996 by ISTAT (Central Statistics Institute), confirms that these enterprises are of major importance to the Italian economy.

SMEs in Italy employ 11.025.755 people. From a total of 3.521.416 businesses registered in Italy, 3.518.783 (99,925%) have fewer than 250 employees, and 95% of these have fewer than 10 employees.

In the agrindustry group 92,9% of businesses employ only family members, most service industries only employ 2,9 people each.

Manufacturing industries tend to have a larger workforce, with 90%, employing more than 250 people.

In terms of economic growth, the first nine months of 1999 were poor, but recent figures look more positive, with 42,1% of small businesses and 22,8% of medium-sized enterprises, in almost all economic areas (97%), showing an upward trend.

40% of employees working in medium-sized enterprises are represented by a trade union. For small and micro enterprises the percentage is much lower, around 20%. In 1997, the total number of workers belonging to one of the three leading trades unions (CGIL, CISL and UIL), was 10.659.892.

The exact number of SMEs belonging to an employers' association isn't known, but it is thought to be around one in six.

### ***Accidents and sicknesses***

All accidents at work and occupational illnesses of any kind should be reported to INAIL (National Board for Insurance against Industrial Accidents).

Registered data on accidents in the workplace over the last five years shows quite a linear trend. At the end of 1995 the number of accidents registered was 890.436, at the end of 1996: 873.022, 1997: 844.963, 1998: 866.052, 1999: 872.092 and for the first six months of 2000 a 5% rise on the same period in 1999 was recorded.

## 4. Annex: ITALY

According to the official data on occupational illnesses the situation seems better. In fact, since 1995 the number of cases reported has dropped consistently.

The incidence of temporary disability per 1.000 employees, (among craftspeople) from 1996 to 1998, was higher in companies with 1-15 employees, than in those with over 30 staff, 79,62 and 38,73 respectively. The overall data shows that the Agricultural-industrial sector had the highest injury rate with 103,3 per 1000 while services had the lowest with 12,8 per 1000.

The incidence of temporary disability per 1.000 employees (from 1996-1998) is substantially higher overall in companies with fewer than 250 employees.

### *Occupational health in practice*

Current occupational health practice in SMEs is regulated by the Legislative Decree 626/94, (a collection of general regulations and guidelines for preventive practice in the workplace).

This Legislative Decree outlines two levels of prevention:

A) Level One: the employer's obligation to guarantee the health and safety of employees. Risks must be identified and evaluated and preventive measures implemented by the "Company Prevention and Protection Services". In the case of small enterprises, the employer can take charge of all this himself. The employer is also obliged to inform workers about the risks inherent in their jobs and provide training on safety practices. The Occupational and Environmental Medicine Doctor, who can be a company employee, a freelance or employed by a private or government body, works alongside employers to safeguard health.

Employee participation, and workable preventive practices are overseen by an employee representative for 'Preventive Practices and Safety' (ERPS). For a company with fewer than 15 employees the ERPS can work for several companies in the same region or the same economic sector.

The minimum number of ERPS required per company runs as follows:

- n One per company where fewer than 200 people are employed
- n Three for those with between 201 and 1.000 employees
- n Six for all other companies.

The ERPS is expected to take a proactive approach. He or she needs to forge a productive relationship with the people involved in health and safety within the company as well as motivate the workers; encouraging them to take a keen interest in complying with safety regulations.

B) Level Two: the Public Health Local Services Unit (L.H.U.). This department is responsible for keeping a check on companies to ensure that they are meeting their health and safety obligations.

They also consult with businesses and provide help and information, particularly for small and medium-sized enterprises.

## 4. Annex: *LIECHTENSTEIN/SWITZERLAND*

### *Drawing conclusions*

Over the last five years health and safety professionals have discovered that many problems face both public and private companies.

These include:

- n Inconsistencies in the law
- n The fact that the law makes no distinction between large enterprises and SMEs
- n Lack of co-ordination between the national, regional and local organisations involved
- n Incomplete collation of data.

In order to tackle some of these issues, the Ministry of Health dedicated a chapter to injuries and occupational illness in the National Health Plan 1998-2000. At the same time, the Ministry of Health and the Ministry of Labour asked all stakeholders for their thoughts and called in experts nation-wide to provide an overview.

The action plan put together by these individuals was presented by the government at the National Conference on Workplace Safety (Genova 3-4-5/12/99) under the name: "Charter 2000: Safety in the Workplace". The document features legal requirements that need to be set in place, outlines ways in which the various parties can pull together to achieve a common goal and highlights changes that need to be made by organisations, trades unions, employers and employees if a brighter future is to be created. The document can be found on website [www.minlavoro.it](http://www.minlavoro.it).

### *Liechtenstein/Switzerland*

In Switzerland and Liechtenstein there is no actual statutory basis for health promotion in the broader sense. However the first confederate factory legislation passed in 1877 was a progressive piece of industrial legislation which included regulations on occupational safety and health protection. Until now, occupational health and safety has been interpreted rather narrowly and WHP measures have met with opposition. Companies implementing WHP measures have done so on a voluntary basis.

At present, health and safety at work in Switzerland and Liechtenstein is regulated mainly by two legislative bodies. The accident insurance legislation (UVG) regulates occupational safety (the prevention of accidents at work and occupational illnesses) and the employment legislation (ArG) regulates occupational health in general, work and rest period regulations and special protection for young people and women. The responsibility for safety and the protection of health within a company lies with the employer.

Workplace health promotion is beginning to play a more important role in Switzerland and Liechtenstein and management departments in both private and public enterprises are beginning to place greater emphasis on it. Companies are gradually recognising their responsibility for employee health and modern management systems are starting to open the door to acceptance of workplace health promotion.

## 4. Annex: *LIECHTENSTEIN/SWITZERLAND*

Technological advances over the past ten years have led to a change in the way work is structured and consequently to a considerable increase in stress factors. Although ergonomic and physical strains and the adverse effects of chemicals have improved, psycho-social factors such as monotony, heavy work load and time pressure, complexity of job requirements, adapting to new conditions, conflict and disruption etc., are on the increase. Rapid changes in production methods, an increased fear of job loss, career breaks, the need for greater mobility and a general loss of control relating to the working and domestic situation also add tremendous pressure. In spite of these fundamental changes, occupational safety and occupational medicine are still largely concerned with the prevention of illness and accidents.

In economic terms, industrial and occupational illnesses in Switzerland cost ten billion francs per year which is approximately 3% of the total gross national product.

There are many reasons why the workplace is an ideal setting for preventive and health promotion activities: in Switzerland and in Liechtenstein, 80% of 15 to 65 year olds are employed. Those in full time employment spend more than one third of their waking hours at the workplace. Attitudes to health and behavioural habits are therefore strongly influenced by experiences at work and the situation there. In many case work has a significant influence on lifestyle.

In accordance with the aims of the World Health Organisation's European strategy for Health 2000, the aim of the occupational safety authorities in Switzerland and Liechtenstein is to protect the employee against occupational hazards. The Confederate Commission for Occupational Safety (EKAS) co-ordinates the work carried out on accident prevention by the occupational safety authorities such as the Swiss National Accident Insurance Fund (SNAIF), the State Office for Industry and Commerce (SECO), the canton Inspectorates and various expert organisations.

Every day company processes as well as the advice and control procedures are laid down in a book of regulations. The EKAS guidelines and regulations determine how machines, installations and systems are to be built and used to meet safety standards. Instead of having to understand the detailed regulations, the companies are given targets to meet. They can decide on whether to take advantage of the solutions that have been suggested or to use those of equivalent value they have developed themselves. Sanctions can be taken if the regulations are severely disregarded and the company fails to take steps in improving the situation. However, because the emphasis is placed on improving motivation and self responsibility, repressive measures are an exception.

Occupational safety is an ideal basis for co-operation between the social partners. Employers and employees should be encouraged to support the interests of occupational safety in the companies. Some forms of co-operation between the social partners have been developed in the field of occupational safety which have resulted in the successful development of branch-specific solutions in the guidelines for enterprises and SMEs, drawn up in consultation with occupational doctors and occupational safety specialists (ASA guidelines).

The results of the RIGA study (research on measures in health promotion at the workplace), show that there are many activities geared towards changing employee behaviour but only a few that focus on the working environment and the demands of every day life.

## 4. Annex: THE NETHERLANDS

There are too few projects dealing with organisational development. The projects which are carried out tend not to be sustainable as most are of a one-off or short-term nature. This suggests a lack of commitment to integrating health groups into the structure of a company.

Employee participation is essential to the success of WHP. The only WHP projects that can hope to achieve a lasting effect are those planned, implemented and evaluated on an involvement basis. However, WHP is something which needs to be anchored into company and management policy first.

Without the enthusiastic participation of everyone concerned, a project risks failure. Workplace health promotion needs to be part of the company culture. At present, projects lack planning and are not systematic enough and the companies lack support and expertise. The transfer of knowledge from university institutes and expert institutions is still inadequate.

Many companies appear to be willing to promote health, but cannot do so effectively because of a lack of professional expertise. There is also an overriding perception of WHP as mere window dressing – a means to improve the company image or as something to satisfy and reward the employees.

If the implementation of the ASA guidelines could be used as a form of management system in the companies and SMEs and integrated into the company organisation and if the continual improvements could be integrated into the processes, the ASA guidelines will have created a basis for the successful implementation of workplace health promotion.

In this combination, the ASA guidelines and workplace health promotion can become a determining economic factor and quality characteristic in companies as well as SMEs.

### *The Netherlands*

In 1998, SMEs employed 2.3 million people, some 60% of the working population. Of all private enterprises 98% were SMEs. Within this sector, there were 188.000 businesses with 1-10 employees and 40.000 businesses with 10-100 staff. Almost 239.000 enterprises had no employees at all. The boom in SMEs over the past few years, however, seems to have come to a halt.

“FNV Bondgenoten”, (by far the largest union in The Netherlands), looks after the interests of most SMEs. It has approximately half a million members and 1.000 employees. The employers association, MKB-Nederland, services the majority of SMEs, representing 125.000 businesses, 115 sectoral organisations and 450 regional and local employers' confederations. There are no separate figures relating to collective bargaining and SMEs.

Sickness absence is lowest (2,4%) in companies with 1-9 employees and highest (6,5%) in large companies (more than 99 employees).

Research shows that nearly 30% of sickness absence is caused by work-related health disorders. Sickness absence rates are higher in companies where employees have to carry out heavy physical work or where stress levels are high. This is also true of shift work and monotonous jobs.

## 4. Annex: *THE NETHERLANDS*

There are no separate figures on accidents at work in SMEs. However, those who work with chemicals in SMEs are at greatest risk of serious health damage. Absenteeism is also highest in this sector.

The cost of absenteeism, disability and health care has been estimated at 12 billion DFL, which is almost 2% of the total gross domestic product.

The Dutch government brought the European directive into the Working Conditions Act in 1995, it was then reformed in 1999. The Working Conditions Act is called the Arbo-wet and all companies including SMEs have to be affiliated with a certified Arbodienst (Occupational Health and Safety Service) which are private occupational health consultancy agencies. This requirement is part of the implementation of the European Framework Directive on Health and Work in The Netherlands. By law all companies are obliged to:

- carry out a risk-inventory and risk-evaluation (RIE),
- have a structured policy on preventing absenteeism,
- have a periodical health and work investigation (PAGO),
- offer employees the opportunity of a consultation with the occupational health service doctors and set up company medical support.

People tend to assume that workplace health promotion is taken care of under the Working Conditions Act. However a closer look at it reveals that WHP is not specifically mentioned.

It is clear that the larger the company the better it complies with the Working Conditions Act. Research shows that in 1999 11% of companies had not yet carried out the risk inventory and risk evaluation and that these were mainly SMEs. The Labour Inspectorate will now be focusing its attention in this direction. However, research also shows that only one third of SMEs thinks that Occupational Health and Safety Services help prevent sickness absence.

Since the reform of the Sickness Benefits Act employers are usually responsible for paying an employee's wages during the first year of sickness. This act has not taken the size of the company into account, so the costs can be prohibitive for small businesses. No written policy governs rehabilitation of sick workers, however, there is evidence to suggest that this is often taken care of on an informal basis.

SMEs perceive occupational health care as something they are obliged to do but which has few benefits for them. Employers are reluctant to pay for additional services that are not required by law. The majority of employers in SMEs indicate that they do not pay a great deal of attention to occupational health and safety regulations. This is because employers in small companies are too busy meeting the demands of daily life.

As the opportunities for SMEs to develop single-company policies are limited it has been suggested that it might be worthwhile exploring the possibility of sector activities in this field.

Many SMEs have taken steps to improve working conditions and reduce the physical and mental work load. Small businesses are keen to improve staff morale, create a better working atmosphere and to encourage employee involvement. Measures taken by SMEs that go beyond statutory occupational health and safety requirements have also increased in recent years but there is still much room for improvement. Awareness of workplace

health promotion has increased over the years too and is highest (20%) in small companies (1-4 employees) but has decreased in medium-sized (10-100 employees) companies.

Those companies wishing to start on WHP projects in the near future are primarily interested in stress issues (43%). Almost a third of employers also believe that it is important to tackle the problem of smoking. Companies of different sizes have different priorities: companies with more than 50 employees tend to focus on exercise programmes, closely followed by stress related programmes. The smallest companies (1-4 employees) are more interested in alcohol programmes. Compared to previous years, however, it is clear that the demand for practically all types of WHP activities is increasing.

SMEs tend to know very little about the benefits of WHP. More effort should be made to clarify the benefits through evaluation studies and cost-benefit analyses. Emphasis also needs to be placed on the advantages of good working relationships and good work organisation if SMEs are to take more interest in WHP. Companies which are well informed about the benefits of WHP are certainly more active in this field.

Workplace health promotion should become a standard part of the occupational health and safety policy and occupational health services should offer greater support for health promotion activities and policies

Research shows that small companies do a lot to make work safer, healthier and more attractive. Small companies are also characterised by a pragmatic approach that deals with problem-solving in a direct and effective manner. Risky situations are dealt with in a similar vein. A caring attitude at work, albeit an informal one, is far more important than formal arrangements such as plans, procedures, rules and consultation. These worthwhile characteristics need to be recognised and valued.

Certain factors, such as economic growth and consequently fewer employees to choose from, are putting pressure on employers to make work more attractive and to create a better, more health promoting environment. Therefore, in the future, employers may prove to be more receptive to workplace health promotion projects.

### *Norway*

A significant part of Norwegian business and industry is made up of small and medium-sized enterprises. According to the Norwegian Register of Companies and Enterprises, 99.8% of registered companies have fewer than 250 employees. As many as 97% of the enterprises are small, employing fewer than 50 people, and as many as 80% are micro enterprises with fewer than 10 employees. These figures are based on the registration of approximately 440.000 businesses – those operated by a single individual have not been included.

Small enterprises represent almost 60% of total employment, while other enterprises have a rather smaller share, almost 17%.

## 4. Annex: *NORWAY*

Different sectors are dominated by different types of enterprise. Data shows that the building and construction industry is characterised by small businesses (98%), whereas in the oil and mining industries more than 45% of total employment is in large enterprises and only 21% in small enterprises.

### *Strengths and weaknesses of statutory legislation relating to SMEs*

Two contradictory elements exist here that create problems for enterprises and national authorities alike. The Working Environment Act stresses the importance of developing initiatives at individual workplaces. At the same time, comprehensive and detailed regulations have been developed by public authorities. These amount to approximately 60 laws and close to 1.000 regulations within health and safety.

This causes SMEs immense problems. Small organisations do not have the resources to meet the demands of such a complex system. The pressure to provide documentation breeds resentment towards legislation. As one company observed in a survey: "We are craftsmen, and paperwork is the worst thing we can think of."

The follow-up to these regulations proved that SMEs find it difficult to meet rigidly imposed requirements. The regulations came into force in 1992, and by 1999, 84% of enterprises employing more than 50 people had met these requirements, but only 32% of businesses employing fewer than 10 people had been able to do so.

The authorities are worried about this situation, and acknowledge that methods other than further regulation need to be developed. They are now reviewing current laws and regulations relating to SMEs to see what can be done to make running a small business in Norway easier.

The national authorities within HES (Health, Environment, Safety) are also showing a greater will to accept different solutions where SMEs are concerned, as in many cases these businesses are carrying out good HES work, even though their formal documentation is inadequate.

### *Strengths and Weaknesses of WHP*

Health promoting work in Norway has largely been carried out in the public health arena and has concentrated on the general population and lifestyle issues. The Ministry of Health and Social Affairs oversees this work.

Workplace health is dealt with by the Ministry of Local Government and Regional Development. Here, health promotion is not a familiar term. However, there was a positive reaction to finding a Norwegian representative for the European Network for Workplace Health Promotion, and the National Institute of Occupational Health, Norway, was set up as a contact office.

Nevertheless, there is still insufficient commitment to workplace health promotion and the department is unsure of its place within the business community. Lack of commitment

characterises other executive authorities such as the Norwegian Labour Inspection Authority and other partners within HES work, such as managers, employees and OHS professionals. They claim that this is not their field and are reluctant to enter into discussions on WHP.

However, there are inspiring activities going on in enterprises every day. Many people realise that there is more to health than preventing diseases and accidents and have worked hard to create good workplaces. These people are keen to identify elements that will trigger development, energy and health, and they have therefore moved into the health promoting arena.

There are also good examples of health promoting work in SMEs. The potential for getting more of these organisations on board is immense given that managers and employees in this group are often closely connected. There are also great opportunities for creating effective processes that will bring about health promoting solutions. SMEs are not very bureaucratic and have a tremendous ability to make fast and bold decisions as well as being flexible enough to create individual solutions for individual employees.

### ***Initiatives needed***

A large proportion of business in Norway belongs to the SMEs group, creating a diversity that is a fundamental part of modern society. However, the authorities and OHS have paid too little attention to the individuality of this sector and the special needs created by such diversity. This has slowed down the implementation of preventive and particularly health promoting work.

In order to create a healthy working environment within SMEs, the authorities, occupational health professionals and the Social Partners must change their approach.

The authorities must:

- n Be bold enough to open up to individual solutions and greater flexibility towards existing legislation and regulation. This applies to the development of obligatory HES systems and the nature and level of written documentation.
- n Avoid new laws and regulations, but help SMEs push good practice forward in other ways
- n Be more open to focusing on the positive aspects of the enterprise
- n Internal co-ordination and co-operation between ministries and public services is essential in order to develop positive interaction between public health, primary health and local authorities and health promotion at the workplace.

The Occupational Health Services must:

- n Develop and organise services within health promotion that are relevant to the needs of SMEs and to their financial status
- n Make sure that management and employees are active participants. OHS should not walk in claiming to have all the right answers, alienating the organisation in the process. In a business, it is the employees who really know what needs to be done to improve the

## 4. Annex: *NORWAY*

situation for them, but they need help to develop processes that bring about appropriate solutions. "Empowerment" is a crucial term in this context.

- Be open to solutions where individual needs outside the enterprise are taken into consideration

SMEs must:

- Become acquainted with and give priority to preventive and health promoting work
- Create a local network and help one another
- Get help from their trade associations and establish a connection with OHS in order to develop the best possible health promoting working environment. This will also help attract highly skilled individuals to the enterprise – and keep them there.

WHP should be an important element in the future development of enterprises within the SME sector. It can be a launching pad for creative solutions that meet the needs of employees both in and out of the work environment. WHP needs to be taken into consideration in all aspects of the organisation, but SMEs efforts in this direction must be encouraged and supported. Organisations need to feel inspired to stimulate good health rather than simply preventing illness.

### *Sweden*

In this report the term Small and Medium-Sized Enterprise (SME) refers to enterprises with fewer than 250 employees and Small-Scale Enterprise (SSE) to an organisation employing fewer than 50 people. This report is restricted to enterprises with 1-49 employees.

SMEs play a very important role in the Swedish economy. More than 99% of Sweden's 790.000 private enterprises (including enterprises within the agricultural sector) are SMEs.

One fifth of the total export value was generated by smaller enterprises, which make up 98% of all export companies. Furthermore, many small enterprises are suppliers to export companies. SMEs account for 32% of investment in tangible assets.

In 1998 the total Swedish workforce amounted to 4.255.000 employees, including 570.000 self-employed people (sole traders). Approximately 1.300.000 people are employed in public organisations. About 2.100.000 people are employed in SSEs, accounting for 72% of all employees in the business sector and 48% of the total workforce, including the public sector.

#### ***SMEs and trades unions***

74% of white-collar workers and 85% of blue-collar workers are union members. Union membership is lower in small enterprises, about 50% in enterprises with 1-9 employees and about 75% in enterprises with 11-50 employees.

The Swedish Employers' Association organises almost all of the country's large private enterprises but only deals with 15% of enterprises with fewer than 50 employees. In all, 360.000 employees work in subscribing companies.

The employers' associations negotiate collective bargaining agreements, principally in areas like pay and general conditions of employment. Many small enterprises apply the same agreements as SAF members. About 15% of SSEs (and SMEs) are covered by collective bargaining agreements in one form or another.

### ***Absenteeism due to sickness in SMEs***

There is no general statistical information available on sick leave rates relating to the size of the workplace. However, the typical sick leave rate in SSEs is around 5% and there appears to be no major difference between small and large companies. Sole traders have the lowest sickness rates of all – around half the average rate.

### ***Work related accidents in SMEs***

Definitions of work related accidents have not been standardised, but accident rates are highest in agriculture, construction, industry and transport and lowest in the service sector. It is hard to assess available figures accurately because medium and large companies are more likely to report accidents – even minor ones. Overall, however, it is probably more dangerous to work in a small company than in a larger one.

### ***Common hazards in SMEs***

In general, the ergonomic conditions are more favourable in small enterprises because there is a greater scope for variety within the work and a higher level of personal decision making. Nevertheless there are physical strains associated with particular types of work. Heavy lifting is widespread in industries such as farming, forestry and fishing. Strain to the neck and shoulders is common in hairdressers and dental technicians. Vibration from handheld tools is a problem in car repair, welding shops, forestry and among craftsmen, dentists and dental technicians. Exposure to excessive noise creates problems in joinery and mechanical workshops and in construction work. Sensitising chemicals cause problems to hairdressers, dentists, dental technicians, car sprayers, bakers and farmers. About 5-10% of workers in SSEs are exposed to organic solvents.

### ***Psycho-social working conditions in SME***

In general, the psycho-social conditions are better in SSEs than in larger companies due to the more informal atmosphere within them and the fact that they are less impersonal than big organisations. SSEs operate more like a family and employees are usually more empowered and have greater personal autonomy.

## 4. Annex: SWEDEN

### ***A brief summary of the occupational health and safety system***

There are three different types of OHS: traditional built-in units within a company, joint occupational health centres and branch services. The centres offer a non-profit making service to member companies and firms. Occupational health services cover about 70% of all employees and 10-20% of all enterprises. There are no community-based facilities for small businesses and a large proportion of small enterprises have no access whatsoever to OHS facilities.

### ***Statutory health and safety requirements in SMEs***

All enterprises employing five or more people should have a safety representative, but only one enterprise in four complies with this stipulation. There are no specific provisions for health and safety in SMEs.

### ***Public Health and Safety and Health Institutions***

The national health system offers very limited work related medical care to SSEs. However it is estimated that 11-16% of visits to primary care doctors are due to work-related disorders. Occupational medicine clinics at university hospitals have multidisciplinary skills and offer limited consulting and information services and mandatory check-ups for SMEs. The National Institute of Working Life runs a special multidisciplinary unit for Small-Scale Enterprises.

### ***Employers Associations and the trades unions***

The Swedish Employers' Association, SAF, operates a special committee for SME issues, although this focuses largely on economic matters. There is no special focus on SMEs in terms of occupational safety and health promotion.

The Swedish Trades Union Confederation has no particular SME programme either, but the affiliated trades unions appoint Regional Safety Representatives, whose main task is to oversee working conditions in small enterprises.

### ***Strengths and weaknesses of statutory health and safety requirements***

Swedish labour market legislation applies to all enterprises irrespective of size. Consequently, there are no specific regulations or provisions on work-related health and wellbeing in SMEs.

The Labour Inspectorate supervises the way in which smaller companies operate. Although allowances are made for the way in which small businesses are run, more than half of enterprises with fewer than 50 employees have yet to start meeting these health and safety requirements. Labour inspectorate officials focus less attention on small companies – while

the largest companies are inspected almost three times a year, the smallest ones might be visited about once every ten years.

### ***Strengths and weaknesses of workplace health promotion***

Generally speaking, owners of SSEs are anxious to improve the wellbeing of their employees because they understand that a healthy, motivated workforce contributes towards productivity, quality and profitability. The psycho-social environment at work is often acceptable and sometimes excellent and the job satisfaction high in SSEs.

The positive benefits of introducing health promotion include a healthy workforce, reduced health-related costs and increased productivity and quality. Customer satisfaction and a better public image are also important bonuses.

Negative aspects that stand in the way of WHP include the pressures involved in fulfilling further legal requirements and dealing with more visits from labour inspectors. Financial and organisational resources are limited, therefore bringing in WHP can be problematic. Usually there is little in-house knowledge on occupational health matters, and many employers take little interest in it beyond statutory requirements.

### ***Future action***

A holistic approach is needed if improvements are to be made in SSEs. External know-how needs to be linked with local practice. Personal contact, learning by doing, local training and participation by both – owners and employees – is vital. This requires trust, involvement, follow-up work, patience, and giving credit where it's due for improvements in the work environment.

At local level supportive structures are very important, particularly occupational health services, private consultants, occupational health clinics, the Labour Inspectorate, insurance companies, trades unions and employers' associations.

Local intermediaries need to be change-agents rather than problem-solvers. Local networking and co-operation is crucial if the needs of small workplaces are to be addressed. Attention should be drawn to local models of good practice to encourage other SSEs to follow suit.

At regional level skills centres should be organised with educators, trainers and insurers. Occupational health clinics can be useful in this context too.

At national level the government's standpoint needs to be outlined along with a work and health policy. Educational institutions and research institutes need to be supported.

## 4. Annex: SPAIN

### *Requirements for future research:*

- n There is a need for applied research, feasibility studies, well co-ordinated case studies, assessments of the cost of ill-health and analysis of the impact and effect of WHP interventions. It is important that new methods and models are evaluated with regard to their impact on health and their cost-effectiveness.
- n Standardisation of methods and definitions is crucial. Reliable data will be best obtained by use of standard methods as used in epidemiology.
- n Valid and relevant statistics will help detect problems, promote follow-up activities and make comparisons between countries possible. Concrete evidence of a disparity in health and accident rates between SSEs and larger companies and between SSEs in different countries is absent due to a lack of accurate data.

### *Spain*

An SME is classed as a company with fewer than 250 employees. Companies with no employees are not included in this report because of the lack of reliable information surrounding them. Nonetheless, they make up a substantial percentage of SMEs – approximately 55% (1.01.99)

In 1998, Spain's total working population was 13.204.900 (INE, Encuesta de Población Activa). Around 23% of these people were non salaried workers. This figure includes 1,876,200 self-employed people. 64% of salaried workers were to be found in SMEs, largely in the wholesale and retail trade and the building industry.

Among the 2.500.000 companies registered in 1998, 55% had no salaried workers; and almost all the companies with salaried workers were SMEs (99.6%).

SMEs were responsible for 44% of exports and 64% of sales. This sector is crucial to employment creation: having created 56% of all jobs during the last four years.

No data is available on how many SMEs belong to trades unions and employers' associations, however, it is fair to say, that the smaller the company the less likely it is to be unionised. SMEs are covered by collective bargaining in the same way as other companies (mainly at sectoral level), even though in smaller companies workers have less say.

Companies employing between 50 and 99 workers experience high rates of absenteeism, but the highest rates of all are experienced by companies employing between 100 and 499 people. Where occupational illness is concerned, the highest rates are to be found in the 10-49 employee and 50-249 employee categories. One major problem being repetitive strain injury (RSI).

Workers in SMEs are at greater risk from occupational accidents than workers in large companies. The highest rates occur in the 10-49 employee category. This category is also responsible for 38.9% of all accidents affecting temporary workers.

### ***Working conditions in SMEs***

RSI injuries and musculo-skeletal problems are common in workers who maintain the same posture for more than 50% of the working day. Environmental conditions and excessive noise cause major problems too. In the case of harmful chemicals, workers in SMEs are at greater risk than staff working in larger organisations. To balance up these negative elements, it is evident that psychosocial working conditions are generally better in companies with fewer employees. It seems that workers in SMEs are more autonomous and have greater freedom to make decisions.

### ***The limitations of occupational health and safety legislation***

The smaller the company the less likely it is to be controlled by the Labour Inspectorate or to receive any kind of external audit. Accidents tend not to be recorded either. Organisations with fewer than 50 employees are not obliged to have an OHS Committee. SMEs also have fewer preventive practices in place.

### ***The role of health at work within SMEs: the national stakeholders' perspective***

The big concern of all the stakeholders in Spain at the moment is the fight against the high industrial accident rate. A plan to reduce industrial accidents was drawn up with the primary objective of enforcing OHS legislation in companies (mainly focusing on SMEs). Moreover health authorities (both at national and regional level) include health at work in their programmes along with a number of specific initiatives. The main contribution from unions and employers' associations is to improve training.

### ***Strengths and weaknesses of statutory health and safety requirements***

OHS legislation provides a good framework which goes beyond basic safety and hygiene. One of its most productive elements is the National Committee for Health and Safety at Work, which brings all the stakeholders together to work jointly towards better health.

Weaknesses are linked to a lack of suitable methodologies in terms of cost, effectiveness and simplicity. Regulations are taken into account if their costs appear to be proportionate to the risks, benefits are visible in the short term and measures easy to put into practice.

### ***Strengths and weaknesses of workplace health promotion***

Health promotion is included under the umbrella of OHS legislation and health strategies, and the workplace is considered to be an ideal setting for interventions at national level. WHP weaknesses are linked to a lack of knowledge and understanding of potential benefits, bad previous experiences and the prevalence of OHS risks.

## 4. Annex: UNITED KINGDOM

### *The need for action*

The gap between theory and practice should be bridged by training, clearer guidelines, provision of financial facilities, advice and use of motivating factors to push employers from reactive to proactive interventions. The benefits of WHP need to be highlighted, for instance, the contribution it can make towards improving the sustainability of business. Attitudes need to change too: employers need to view the cost of health measures differently, but these measures also need to be easier to implement. All stakeholders need to take a good look at how health can be improved. Better training would also be helpful.

Health problems and their adverse impact on business should be made clear. Efforts also need to be made to encourage employers to give health measures the same emphasis as they do to other major issues such as meeting clients' expectations. The powers of labour and health inspectors could also be increased and positive measures introduced to encourage good practice.

### *United Kingdom*

The UK has a workforce of some 21.5 million people and 3.7 million businesses. Of these 99.1% or approximately 3.667 million businesses employ fewer than 50 employees and only 0.2% or 7.400 employ more than 250 employees.

Small and micro enterprises provide employment for almost 45% of the workforce and produce 38% of the total turnover in the country.

Within the small and micro enterprise sector, by far the largest group is that of 'sole traders', (some 2.4 million) followed at some distance, by businesses with 2-5 employees (just over 900.000).

Approximately 36% of the total UK workforce has union membership. In organisations with fewer than 25 employees this figure is 15%, but when private sector organisations are considered the figure for union membership in businesses with fewer than 25 employees is 9%. Only 10% of employees in organisations employing fewer than 25 employees are covered by collective bargaining arrangements, compared to 31% in organisations with 25 or more employees.

The main features emerging from the sources of workplace injury statistics are that the rates of fatal and amputation injury in small workplaces (fewer than 50 employees) are double those in large workplaces (200 or more employees); and that level of fatality has risen in small workplaces both in number and rate of injury. In contrast the level of fatality in larger workplaces has remained about the same.

A number of bodies have an interest in working on work-related health issues with SMEs, namely the Health and Safety Executive (HSE), the federation of Small Businesses and the

national and local providers of health promotion services. However it should be noted that there is no legal compulsion for organisations to undertake workplace health promotion.

### ***The major bodies with an interest in SMEs***

The HSE's Mission is 'to ensure that risks to people's health and safety from work activities are properly controlled'. To do this the HSE employs around 1.200 field inspectors (1 per 1.8000 of the working population) who seek to ensure that the legislation relating to workplace health and safety is adhered to.

The Law requires that employers look after the health and safety of their employees; and the self-employed look after their own safety; and all have a duty to take care of the health of others. The HSE has a number of functions – it can inspect workplaces, it investigates accidents and cases of ill-health, it enforces good standards by providing advice and guidance, ordering compliance and in extreme cases prosecuting companies. It also publishes advice and guidance, provides an information service and undertakes research.

The Federation of Small Businesses provides advice and guidance on a wide range of issues, particularly issues such as tax affairs, financial management, personnel management etc. It acts as a lobbying and advocacy body representing the interests of small businesses at a national level. It also provides training and networking opportunities for its members. Also involved in some of these activities are the various Chambers of Commerce and Trades Associations

The national and local health promotion agencies have a duty to promote the health and wellbeing of the population they serve. For all of them the workplace setting (including SMEs) is a major focus of activity as over a third of the population spend at least a third of their waking hours at work, and many of these individuals are in otherwise hard to reach groups. The health promotion agencies advise Government on the development of workplace health policy specific to SMEs; develop and implement innovative projects to promote health and well-being through the workplace, undertake research and provide advice and guidance on WHP.

### ***Current activity***

The Health and Safety Executive published a report in 1998 entitled 'Factors Motivating Proactive Health Risk Management in SMEs'. The report 'reviewed empirical research regarding what motivates managers, particularly SME management, to manage health and safety proactively, and whether management attitudes towards health, safety and business management are congruent.' Major findings in the report suggest that there are two main factors in the UK that motivate both SMEs and larger organisations to initiate health and safety improvements.

These are (i) fear of loss of corporate credibility and (ii) a belief that it is necessary and morally correct to comply with health and safety regulations. The HSE has also developed a long-term occupational health strategy, 'Securing Health Together', its aim being to bring

## 4. Annex: UNITED KINGDOM

occupational health services within reach of all employees. A review of the impact of the 1974 Health and Safety legislation has also been undertaken and proposals developed for future action. These proposals will reflect the changing nature of work and employment. The review was published in June 2000 under the title of 'Revitalising Health and Safety'.

The Federation of Small Businesses is a supporter of health promotion activity, but given its wide range of responsibilities is not actively involved in the delivery of health promotion to SMEs.

The national and local health promotion agencies have devolved responsibility that facilitates the targeting of effort to address issues and areas of need. They work independently of one another but with a high degree of cooperation.

Programmes, which will facilitate the achievement of the public health agenda, are being developed. Whenever possible the agencies seek to work in partnership with other appropriate bodies. Research is undertaken to identify needs, the factors influencing workplace health promotion programmes and the outcomes of these programmes. General advice and guidance is provided to those seeking to promote health in the workplace setting. The local health promotion providers are responsible for a much smaller geographical area, but will provide some or all of the above services to local companies.

### ***Barriers to working with SMEs***

Experience across the UK would indicate that there are a number of barriers that need to be overcome if the full potential of WHP in the SME sector is to be achieved. However there are no easy solutions to these problems, the most notable of which is the 'survival' mentality of many SMEs. The average life of an SME is estimated to be around 5 years, and for a lot of SMEs, surviving in the market place from one month to the next is the overriding priority. Any activity that does not contribute directly to the survival of the organisation is not given a high priority.

SMEs are also faced by a huge amount of paperwork, administration and bureaucracy. Owners and senior managers have a wide range of responsibilities, many of which involve considerable levels of administration, with some annual records having to be kept and maintained for up to six years.

Workplace health promotion is not perceived to be relevant to the needs of the SME or the people it employs. The links between work and health and the benefits of reducing risk factors are not being communicated well enough, thus their importance to the wellbeing of the company is not being recognised.

For the reasons set out previously, any activity that has a net cost may be dismissed because it is a drain on otherwise scarce resources. The notion that the promotion of employee health need not be costly is not well understood. The period between the promotion of health and health improvement, when the real benefits of reduced sickness absence etc. are achieved, is perceived to be lengthy and too long for many SMEs to see the benefit themselves. This is emphasised when high staff turnover rates are taken into consideration.

Owners/managers are also reluctant to become involved in health matters as they do not wish to be seen to be acting in an intrusive and paternalistic manner.

### *Opportunities for working with SMEs*

The Government's new public health agenda identifies the workplace as a key setting for health promotion activity. The Government is also seeking to improve access to occupational health services and to create a system in which all employees, regardless of the size of the company in which they work, can gain access to specialised advice on health matters.

Considerable attention is being given to the range of services provided to SMEs at start-up. The possibilities for including advice and guidance on work-related health issues should be investigated.

There is also considerable potential in the development of training initiatives for owners and managers of SMEs. In addition, the inclusion of workplace health topics in undergraduate and vocational training courses could be of great benefit in raising awareness of the important role that employee health plays in company wellbeing.

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