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Network regulation of the working environment

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“... a safe and healthy working environment
which shall at any time be in accordance
with the technical and social development of society ...”
The objective of the Danish working environment act

New challenges for working environment regulation

In recent years work environment in countries like Denmark has changed profoundly. Two important factors in this development are the growth of service economy and the introduction of new forms of organization and management of work. Therefore, psychosocial and ergonomic problems are of growing concern, while traditional problems, like chemicals and noise recede in the background. The outcome of this development is increased complexity, both in terms of the problems and the conditions for solving them. Thus the delimitations of the political field Occupational Health and Safety (OHS) in relation to other fields such as employment and health are constantly challenged.

But, also general societal trends influence the conception of health and safety at work and the means to improve it. General mistrust in rules and authorities as the best way of regulating societal matters as OHS and “empowered” employees expected to take care of themselves are examples of such trends, which constitute general political conditions for the improvement of health at work.

In most western OHS acts implemented in the 70ies, regulation is presumed to change, so that it matches the technological and social developments (quote above). They all include components of reflexive regulation, as a strategy to secure this adaptation (Frick & Wren 2000). The question however remains how these changes actually are brought about? What are the dynamics of change, how can we conceptualise them, and are there ways to improve their function?

In this paper we will argue that governance through networks may play a crucial role in the process of renewal of OHS regulation. We point out how network governance might act as a vehicle for innovation. Characteristically networks are not submitted to the same institutional strain as the traditional political institutions. They might be heterogeneous, in the sense that they include actors from different societal spheres (state, market, civil society), or that they include different levels of a hierarchy. But of course networks governance might fail. So we also look into the weaknesses of the networks, in order to discuss under which conditions networks might be successful.

We present two cases that illuminate the role of network governance in the renewal of the field of working environment and - regulation.

Network Governance – a theoretical framework

Within political science there has been increasing interest in network governance. One obvious reason is that these types of plural regulation are rapidly spreading in western societies. But another reason is that governance represents a kind of third way, which is not based purely on market or the state, but combines elements from both and even includes civil society.

Bob Jessop (2000) – British sociologist and a prominent figure within this debate – define governance as an *interactive way* of governing that is neither hierarchical as classical public regulation nor anarchic as market regulation. Characteristically actors belonging to different areas and levels contribute to the regulation through cooperation and deliberation.

Eventually network governance seems to be a promising way to address complex problems. In general, it is assumed that network governance – when it is well-functioning – has several advantages in comparison to traditional governance: The solutions are better, because they are adjusted to the specific context, and are more proactive. Moreover the solutions are more easily implemented because the stakeholders are part of the network. Subsequently, conflicts between different actors are solved, and a joint ownership to the solutions is accomplished.

Governance networks are generally understood as (see eg. Sørensen & Torfing 2005) a relatively stable interrelation between institutions, which are

- Operationally autonomic
- Interacting and affecting each other through negotiation
- Self-regulating – within the frames often set by public authorities
- Contributing in a broad sense to public government

The network metaphor draws our attention to the transformation of the state, as a centre for political government. But at the same time theories on network governance also delivers new understandings of the policy process. Traditionally the policy process is conceived of as a rational process based on technical bureaucratic principles. This conception has – as we also have seen it within organization theory – been subject to much criticism. Concepts like ‘bounded rationality’ (March and Simon 1958) or emergent perspectives like Lindbloms (1959) ‘muddling through’ or March & Olsen (1976) ‘garbage can model’, where problems and solutions are haphazardly coupled, offer new perspectives that are better able to grasp the complexity of the policy process.

But, while these approaches accounts for deviances from the rational model, and are attempts to explain the failures of governance and the problems connected to alignment of the policy process, the network governance approach look at non-hierarchical and polycentric features of the policy process as potentially productive. Policy, they claim, is not only developed centrally, but also in local negotiations between institutions within a network, and many studies of network governance is focussed on local development of policy. Another important point is that goals and visions are created and revised in the very process where they are realized. In this way the policy process and the process of implementation is tightly interwoven. (Kickert *et al.* 1997).

Within recent years, networks of institutions have become a research field within several disciplines: sociology, political science as well as organization theory. Consequently, different theoretical approaches to network governance have been developed.

In this paper we use a neo-institutionalist approach (e.g. Scott 1995), which gives attention to the development of political capabilities and identities, as a consequence of the participation in governance networks. This approach focuses at the network dynamics, in order to gain a deeper understanding of the political processes and the development of meaning and knowledge in networks. An important aspect of networks is their reflexivity and their capacity for learning. If networks should be able to create agile solutions and secure a regulation that adapts to changing conditions, reflexivity is a key feature (e.g. March & Olsen 1995)

Case 1. Working environment in the care sector

Introduction

In the late 80ies early retirement presented a massive problem among nurses, nurse aids and social workers in the the public health sector. These groups carried out care work in home care, rest homes, hospitals, kindergartens and special institutions for physically or mentally disabled people. To illustrate the extent of the problem, in 1991 the assurance company covering the nursing aids – PenSam - concluded that they had to reduce the normal pensions with 25%, because of the costs of early retirement. Analysis of data revealed that low-back injuries were the major cause for retirement (Kobæk 2006). Thus ergonomics in care work turned out to be at the heart of the matter.

This case study aims at showing how a network grown from below developed a new concept for regulation in a way that sought to encompass the complexity of this problem, and to transgress the limitations of a narrow conception of working environment. The case study is based on 9 semi-structured qualitative interviews with key persons from different institutions in the network. This is supplemented with analysis of the comprehensive amount of written material, comprising: action plans, campaign material, evaluation reports, research reports, articles in professional medias like Danish Physiotherapists etc. In the analysis we go through how institutions, who are identified as network members, interpret the problem, the conditions for solving them and their perception of adequate solutions.

Challenges for traditional regulation

Ergonomics constituted a major challenge for OHS regulation in the late 80ies. While traditional hazards like noise, dust and chemicals might be described through simple dose-response models that form the basis for traditional regulation: rules, inspection and control, ergonomics problems were often of greater complexity. In the early 90ies authorities from the Nordic countries made a joint effort to solve this problem, compiling models for assessment of expose and for inspection (Andersen & Bjurval 1994, 1997). However, these models primarily targeted manual handling in industrial work.

Thus, regulation was not successful in improving ergonomic problems in care work. Primarily because it did not take into account the relational character of the work, and did not consider organizational and cultural factors. Locally, the larger institutions established training programmes for the personnel in lifting techniques in order to prevent low-back pain and injuries. Experiences however showed that this kind of training was far from effective.

A new concept – the transfer instructor system

In the following decade different solutions to this problem are developed. In Scandinavia the dominant concept for prevention is to educate local transfer instructors, who are trained in broader ergonomic approach to the problem and are seen as change agents in the organization. In 2004 80% of all Danish municipalities were covered by a transfer instructor system (SWEC 2004).

This concept is based on two pillars:

- Caregiving is the crux of the matter in the carer's professional identity. So, if caregiving and taking measures to protect the carer against strain are conceived as opposites, caregiving wins the game. The new concept looks upon transfer and lift of clients as an active process that involves *both* carer and client, focussing at the relation between the two parties. The

philosophy is that when the client is involved in transfer she is empowered physically and mentally. Techniques and technical aids are developed that support this conception.

- The problem is socio-technical, and consequently solutions cannot be confined to the job-situation. In order to deal with complexity, training of local ‘transfer instructors’ to change agents is needed. The transfer instructors must facilitate change at different levels: organization, culture and job routines.

This concept is developed by a network of public, quasi public and private institutions. Authorities – i.e. the labour inspectorate - are only weakly included in the network.

Building network and agenda

The strategic part of the network

The sector working environment council (SWEC) is one of the central institutions in the network.¹ SWEC is an advisory board, whose activities are based on the cooperation between the labour market parties in the sector. SWEC discusses the problems in the care sector as a case where disagreement between the labour parties at central level paralyzes action. The solution therefore to demonstrate agreement and joint political vigour, to create political focus, and to give prevention of low-back pain priority at the work places (Social Analyse 2000).

Consequently, in 1995 the parties establish the Action Plan on Manual Handling of Persons. The explicit aim is to reduce the number of injuries to the half in 5 years. The trade unions are particularly active in establishing the plan, while the employers’ organizations are more reluctant (Social Analyse 2000).

Some of the means employed are resembles the ones used in traditional campaigns: seminars, pamphlets, theatres, videos etc. But, an important innovation in the work of the board is seen. Realising that SWEC itself cannot solve this big societal problem, it must ‘push the snowball’, trying to involve and engage other actors. SWEC sees itself as network builder (Korreman 1999).

Cooperation with the newly established Occupational Health and Safety Services (OHSS) for health and social sector is strait forward. But SWEC also tries to involve institutions at other levels as the Ministry of Health and the Ministry of Labour. One of SWECs agendas is that a major research programme must be created, as research in this area is scarce and acutely needed. And actually SWEC is successful in establishing public funding of theoretical and praxis-related research regarding manual handling of persons. (Korreman 1999, Social analyse 2000). The resulting research projects constitute opportunity and means for building the network: The projects involve many actors: research institutions, OHSS’s, the relevant insurance company (Pen-Sam), technology firms etc. And many of the praxis related projects test solutions models involving the use of transfer instructors (Eskelinen & Boll 2004).

¹ SWEC is established as part of the working environment act, with the aim of assisting individual enterprises within the sector to solve working environment issues. Their activities consist in preparing information and sector guidelines, to identify the special working environment problems in the sector and contribute to the preparation of documentation, and to develop and implement training activities.

SWEC sees itself as a nexus for these activities. Results from the pilot-projects are resumed, compared and communicated to the care sector. And in year 2000 a network for the local transfer instructors is established, and annual seminars with around 300 participants has been carried out since then.

The professional part of network

The concept of transfer instructors is mainly developed in the OHSS. It represents a fusion of two lines of thought: one (prominent among working environment professionals) on how working environment should be improved, and the other (prominent among health care professionals) who focus on the care of the client.

In the 90ies the Danish OHSS are concerned with how to enable and empower the safety organization to handle of the working environment, and how to create consciousness and learning in the organization in relation to working environment problems. Thus, OHSS professionals see themselves as process consultants promoting organizational learning and change (Limborg 1999) Involvement of actors at shop floor level is a necessary part of such a strategy.

From 1994 the municipalities, and with them a great part of the public care sector, is covered by OHSS. Consequently OHSS expands. Considering the great ergonomic problems in the sector, mostly physio- and ergo therapists is employed. Many of these come from an employment in the health care sector. They are inspired by different 'schools' or paradigms on how to transfer persons. The dominant ones (e.g. Per Halvor Lunde 2006) maintain that you should stop thinking of the job as passive lifting or transfer, but focus on the relation, using the resources of the client.

Most therapists in the larger OHSS combine these two types of insight. They develop training courses for instructors as their main activity. The emphasis of these courses is not only on transfer techniques, although this is an important part of it. The concept that is taught is kind of a new philosophy, which is supported by different techniques, so focus is also on changing organizational and professional culture.

Research institutions

Two types of research institutions are brought into the field. First, the regional clinics of Occupational Medicine, who receive injured carers as patients, second, the National Institute of Occupational Health. The research is mainly medical or physiological in its approach. Up to the mid 90ies muscular-skeletal diseases are a low-prestige research area and very little research is actually done. The great attention on the problems and the possibilities for research funding however promote new interest.

In the view of these institutions the ergonomic problems constitutes a knowledge problem: Why does work in the public care sector produce that many injuries, when the workload – compared to industrial work - is rather low? (Donbæk et al 1998). But, this rather narrow approach is soon left for a broader focus on possibilities for change. One string research tries to demonstrate qua biomechanical experiments that the new techniques that rely on client-carer cooperation actually lead to reduction of strain. Another string of research takes departure in the currently used concept for prevention, namely training programmes for instructors, and try to document an effect of the effort in terms of reduced incidents of low-back pain.

So, the research play an important role in consolidating the concept, and the researchers are widely used as experts in professional media, and cooperates with OHSS and SWEC in numerous projects.

The private institutions of the network

Private institutions are also included in the network. The pension assurance company Pen-Sam, is involved already in the early 90ies. For Pen-Sam injuries and early retirement constitutes an acute economic problem, which strongly motivates it to act. First, Pen-Sam funds broader initiatives such as research. They do for example fund a cost benefit analysis that point out to politicians how much these injuries cost society. Second they carry through different campaigns in order to impact their clients to behave safely. But also, they have a general policy of knowledge sharing, implying that they participate in most activities (meetings, seminars, background groups) in the field.

Technology firms also play a role in the network. The Danish industry of technology for disabled is one of Europe's biggest and most innovative². Focus for development of technology in this industrial sector has been the clients, their features and needs and their physical surroundings. In the 90ies however, attention is taken to the carers and their use of technology in order to reduce strain and prevent injuries. Consequently technology for disabled is (also) seen as technology for improvement of working environment. Moreover technology, which is based on the principles of transfer as a process of cooperation between client and carer is developed. Bigger technology firms are involved in working environment research projects, they are involved in planning of campaigns, and they contribute to the network seminars of the transfer instructors.

Summary

This network is developed around a common agenda, the transfer instructor system, based on a specific understanding of the character of the ergonomic problems and how they should be solved. This concept represents one solution to the dilemma between taking care of the client and reducing physical strain. Moreover it attends to the socio-technical aspects of the problem, by perceiving it as a question of organizational change, and by introducing a new actor group – the transfer instructors - as change agents. In that way the network has indeed contributed to renewal of governance.

The network includes very different institutions: research institutions, consultants, labour market parties and private firms. Some of those belong to the OHS policy field, others (Pen-Sam and the technology firms) to the social policy field. And the therapists as professional group bring in a client-centered view of work, and play an important role in different institutions in the network. The heterogeneity of the network is clearly an important source of innovative capacity and contributes to consolidating the concept.

The network is grown from below, implying that the members must create the arenas and resources necessary for its development and maintenance. Projects play an important role as an arena for interaction, and as means of resources in terms of time and economy. However, also other arenas are developed. The annual seminar for transfer instructors is one of those. But, regular meetings among the institutions are established too. In this way the political capacity among the actors is developed. They actually see themselves as actors who play a significant role in governing this specific field, and develop experiences with different forms of political action.

² The Danish social act states – in broad terms - that disabled persons has a right to technical assistance so that she/he can maintain same living conditions as other citizens. This is one of the factors that have created an advantageous environment for this industrial sector in Denmark.

The establishment of public funding is crucial as a condition for developing and maintaining the network. But this is of course also a source of instability as funding is precarious. The network is therefore in itself a kind of project, who must constantly be renewed.

Case 2. Workplace Health Promotion³

Introduction

In a Danish context Workplace Health Promotion is considered a new approach to improving the occupational health and safety, or as it is phrased in Danish, the working environment. Or even a complementary approach as indicated in this quote from the Governments Health Programme *Healthy Lifelong* (2002): "Working Environment. The scope of health depreciating working environment strains must be reduced significantly. It must happen through goal oriented prevention activities in the working environment field and integration with goal oriented health promotion activities". A more representative formulation is this: "Health promotion is both about the improvement of the working environment and about creating conditions that make it easier to make healthy choices inside and outside work." (*Healthy offices*, Labour inspection). The distinction is between the health effects of work and work as an arena for health promotion, for making the individuals live more healthy lives.

Challenges for traditional regulation

It is an establish truth that the costs related to bad working environment is huge. Nevertheless, the health benefits from improving the working conditions seem much more elusive and hard to get than if people, employees that is, could be made to smoke less, to drink less, to excise more and to eat healthier. In Denmark, generally speaking, the working environment regulation through actors like the labour inspection, occupational health services, and the SWECs, has been less oriented towards sickness and health of individuals and more oriented towards technical and organisational prevention, compared to other similar countries. The heading is working environment rather than occupational health and safety, and for years the slogan went: "It is the work place that is the patient, not the worker". Because of this non-health bias in the Danish regulation the shift that work place health promotion constitutes, may seem more challenging in Denmark than elsewhere.

Seen from the health sector perspective it is important to 'mainstream' health concerns into other sectors such as the labour market. The concept of work as an arena or even a sluice for health promotion indicates how the health sector wants to move from cure to prevention, and how the participation of people in this requires other arenas than the health sector itself. Work as such an arena is even more attractive to the health actors due to the fact that health promotion generally suffers from a strong social bias: The middle class groups in society are fairly amenable to health promotion initiatives, whereas the lower status groups are less likely to be influenced by them. At the work place the social stratification is relatively clear-cut, and that makes an even more interesting arena for influencing people health behaviour.

From within the working environment sector the health promotion agenda fits with a self proclaimed holism: Working environment is both about the whole human being, as well as it is central to any economic concern of modern enterprises that acknowledge that 'people are our most

³ This case-description is only preliminary. It based on a subset of interviews to be made. So far four informants, all championing work health promotion, has been interviewed. Also document analysis contributes to this case-description, but the document analysis is not completed yet.

important asset'. Why shouldn't health promotion fit in there? A particular interest in health promotion is stemming from the health professions in the working environment sector. The medical doctors and nurses have been few, and have felt marginalized in the sector. And they have felt that many of the well-known (mono causal) health risks have lost their significance in the general health pattern. The physical therapists have been well represented in the OH Services, but with health promotion they have gain access to a way of working that is more in line with their professional self-image.

Society at large (represented by the Ministry of Labour – now Ministry of Employment) sees absenteeism as major point of interest in a situation where there is long-term (and now even a short term) risk of work force deficits. As a large part of absenteeism is health related, but not necessarily *occupational* health related, health promotion seems a strategy to pursue.

A new concept

There is a general framing of workplace health promotion that makes it include:

- initiatives against smoking
- initiatives against alcohol
- initiatives promoting exercise
- initiatives promoting healthy food

and then there is the fifth leg that can be either:

- initiatives promoting well being, or
- initiatives reducing stress, or
- initiatives to reduce muscular-skeletal problems.

How working environment and health initiatives really integrate is not that clear-cut neither at a conceptual nor at a practical level. As one informant formulated it: [after claiming practical success in relation to the first four dots] "... but it [the link to working environment] is difficult to work with, and it is difficult to find out how to deal with it"; a few sentences later he claims that it only in relation to muscular-skeletal problems he can see a clear link.

One formulation of the concept at a more general level is the triangle with life style in one corner, working environment in another corner, and the social responsibility of the enterprises in the last corner. But the relation to that corner seems even less clear, although some informants saw the common denominator as being health related absenteeism.

But rather than to look at abstract formulations of what workplace health promotion is, it might be worthwhile looking at a more practical level: What are the tools developed and used.

What can be considered a tool is many different thing: Various forms of intervention: A course for people who want to quit smoking, courses for people disseminating workplace health promotion policies, questionnaires to be used at workplaces, etc. Here our focus is on to 'tools' that plays a pivotal role in shaping what is done in the enterprises. And to a certain extend they compete against each other.

First there is the health check. The employees are offered a thorough health check, as the basis for both an individual effort and for company. One of the new services provided by some occupational health services, as the way to do workplace health promotion. Then there is *personal health profiles* that is a questionnaire that each individual fill out through a dialog with a trained health consultant

– the course to become a health consultant is an integrated part of the tool. The personal health profile is a Danish version of ‘health risk appraisals’, and in the Danish version the individual sign an informal contract based on the results, and the enterprise get a report that summarizes what needs to be done at the workplace. A substantial part of the various projects implementing workplace health promotion has used this tool.

Now, those promoting workplace health promotion see both of these tools as tools, not as compulsory activities that are by themselves workplace health promotion. Nevertheless, do they constitute a practical, as well as a conceptual framing and a organisational underpinning of the activities.

The network’s agents

Healthy City

In the 90ies prophylaxis and health promotion became major issues, inspired by the WHO *health for all* strategy. In Denmark one of the outcomes of this interest was the *healthy city* initiative. From early on this initiative tried to incorporate working environment matters, at least in Copenhagen Municipality that fostered its own *healthy city* organisation and did relate to its internal occupational health service. *Healthy city* – itself a networked way stimulating a new health agenda – should become the cradle of the National Centre for Workplace Health Promotion.

The labour inspection

Around year 2000 the Labour inspection developed their own thinking in relation to workplace health promotion. By year 2001 the then Socialdemocratic dominated government came with a health programme that aimed at raising the Danish average lifetime (since Denmark had a slower rate of improving than most of other comparable countries), and the programme did point at the workplace as relevant arena for health promotion; and particularly it did commit the Labour inspection to taking initiatives. The recent more neo-liberal government has put forward the *Healthy Lifelong* programme that puts even more focus on the workplace, but at the same doesn’t commit the Labour Inspection to the agenda. Nowadays the labour inspection is assigned to inspect all workplaces (rather than doing randomised checks) within a limited timeframe, and consequently doesn’t use resources for more ‘peripheral’ activities such as workplace health promotion. But in the mean time workplace health promotion was incorporated in two major Labour inspection campaigns in the administrative sector and in the industrial sector. The labour inspectors were trained to incorporate an encouragement of the companies to do something in that respect, as they were doing the campaign inspections. Another place where workplace health promotion has been promoted is in the voluntary working environment certifications that the companies by the latest reform in our legislation have been encouraged to get. To achieve a certificate the companies have to have decided how it will deal with health promotion. Health promotion is in relation to the certificates, as well as in the agenda of the Labour inspection, seen as something beyond the legal requirements of the Working Environment Act, something extra.

The National Centre for Workplace Health Promotion

The National Centre; as mentioned born out of the Healthy City initiative; was in 2001 set up and funded by the Ministry of Health. The centre was prolonged in 2004, and terminated in 2006. The centre was to collect, develop and disseminate knowledge, experience and methods; organize, and create and maintain a professional network in the field. The centre has been quite active: involved in education of various groups of people – particularly the health consultants that perform the

personal health profiles – and creating networks for them; involved in many of the major research and intervention projects in the area; and involved in unfolding the initiatives of the Labour inspection – primarily the administrative work campaign. There is a general tension in the area between campaigning and evidence based interventions, fuelled by the medical disciplines growing emphasis on evidence. Some consider the national centre for being biased towards the campaigning end of the scale.

The National Institute for Occupational Health

Two institutions have been especially involved in contributing with statistical data to underpin the suggestion that public health is strongly socially stratified: the National Institute for Public Health and the National Institute for Occupational Health. The latter have used data from the national working environment cohort and have produced a report *Lifestyle – working environment in Denmark 2000* (in Danish, Andersen & Burr 2001). But the major research effort related to health promotion is the *Healthy Bus* project; the project did “... launch almost 200 interventions among 3500 municipal bus drivers in Copenhagen. Using a participative action research design ...” (Poulsen 2004, 205) and summarizing the findings: “... further work is needed to empower the stakeholders ...”(ibid., p. 205). The project was ambitious and widespread with a lot of organizing and politicking involved, and as such never fitted the normal evidence based research paradigm of the National Institute. After that project that ended in 2004, the activities of the institute have fairly limited; and some of the actors feel concerned that no solid evidence – at least from a Danish context – of whether workplace health promotion improve the health of people affected, have been produced.

Occupational Health Services and others selling

All of the actors described until consider themselves strategic actors; they initialise an agenda through their initiatives, but it is what comes after that really matters. When occupational health services and a whole range of other consultants intervene – and that is primarily a question of selling various ‘products’, and when workplaces buy these products and – or initialised from within – start workplace health promotion activities, then workplace health promotion is a reality. Almost the whole occupational health service system does indeed have it as a product on the shelves, and parts of the system also sell health checks, and some use personal health profiles; both tools are here usually seen as a minor part of a broader intervention, e.g. with the aim to make the workplace introduce a health policy. Also other types of bigger consultancy companies are active in the market. But underneath there seem to be growing another kind of suppliers: small 1-2 person companies selling more restricted products as stop-smoking courses, setting-up and maintaining a small work out studio in remote room of the buying company, etc. The occupational health service companies and the strategic actors feel concerned about the narrowness of this approach, and have started to discuss the need for a professional ethics in the field.

The Trade Unions and the employers

By the pro-‘workplace health promotion’ actors the unions are quite uniformly seen as a major obstacle to the strategy. And the employers’ organisations are in that respect just hiding behind the unions. But despite the widespread ‘the unions are a major obstacle’-perception, all informants tell particular stories of union- and employer organisation representatives, who have been facilitative in terms of advancing workplace health promotion; there has even been a ‘well functioning’ ad hoc committee under the National Working Environment Council. The unions are an obstacle, but they don’t hold a well-defined position in the discussion. The problem that make the unions undeceive are often formulate as an ethical question: Do the company (, the union, the consultant, the

colleagues, etc.) not transgress a barrier of privacy when trying to ‘improve’ personal behaviour? And for the unions in particular this represents a problem, since the ‘identity’ of unions is to provide *collective* answers to problems at work. The pro-‘workplace health promotion’ informants all tell, that in ‘reality’ – in the workplaces – neither the employees nor the employers felt that a concern for peoples health is a transgression, they see it and welcome it as an emphatic concern. And besides the unions represent those who have most to gain from health promotion.

International links

Various international documents, arenas, and actors are traceable in the Danish development; e.g. the *Luxembourg Declaration*, the *European Network for Workplace Health Promotion*, and WHO. And what is happening in Denmark doesn’t seem to differ markedly from the rest of the European scene. Nevertheless the informants are agreeing, that the international inspiration – not to say influence – has had little impact.

Some reflections

Working environment and health promotion, or working environment or health promotion?

To conceptually and tool-wise bridge the gap between health promotion and working environment improvements, is not only a matter of conceptual interest. If the bridging is successful (as perceived by the actors) then the ‘ethical problem’ is fading away, whereas as long as working environment and health promotion is distinct in terms of concepts and activities, the problem is likely to persist. All informants so far – all belonging to the pro-‘workplace health promotion’ scene – have considered the effort successful in overcoming the old ingrained ‘this is two different issues’-understanding. But looking at the concepts and tools, we allow us the privilege to say, that jury is still out on that question.

The rise and fall?

The strategic actors in the Danish scene seem to be loosing their position: The National Centre is dismantled, and whatever activities still going on are back in the local Healthy City organisations from which it came; The Labour inspection are busy doing other things, at moment the National Institute of Occupational Health gives workplace health promotion little research focus; and even the ad hoc committee under the National Working Environment Council has been ‘restructured’ out of existence. But at the same time the consultants – broadly speaking – have a lot products on the shelves and the customer’s demands doesn’t seem to be fading. But we would suggest that may the products haven’t reached a maturity level that will ensure customer satisfaction, or a least not provide them with what they should really want; improved health.

A figure common in some of the literature (e.g. Dean 1999) that inspires us, is that governance is ‘the conduct of conduct’, and a general trend in our societies is a shift towards making individuals more free to do what they ought to be doing. Society doesn’t coerce or discipline people to do what they should be doing, no, society sets people free to do what they should be doing. But the individuals are encouraged to do the right thing through a multitude of mechanisms. And workplace health promotion is a nice example of such a mechanism: Society would like you (please note the singular you) to stay healthy, do what ever you like, but your surroundings will encourage you to stop smoking, etc. Maybe the set back of workplace health promotion can be considered a counter example of the general trend; not all campaigns have to be won to the win the war.

And it maybe so, that workplace health promotion neither has found the final concepts and tools that really bridges the gap between working environment and health promotion nor have

institutionalised a network that can continue to promote the agenda; but it doesn't mean that workplace health promotion has no future; on the contrary.

Summary

The challenge that workplace health promotion meets is one bringing back in the health dimension to the way that working environment is handled in Denmark. That is so both at sector level where the health sector and the working environment sector have been almost separated for many years. And that is for those professional groups within the working environment sector that have a health related education and background.

Workplace health promotion is at general level not created in the process, but comes from the health sector, and can there be seen as being one of the ways to do something about prophylaxis and implementing the WHO strategy *Health for All*. The concept of workplace health promotion was fairly empty as first, though; it had to be filled with content. If it is only smoking, drinking, eating and exercising it is health promotion. It is when combined with well-being, stress, or work postures it becomes meaningful. It is when it provides tools to be used in the process it becomes workable. It is when it produces professional identities – through educating labour inspectors or health consultants – it gets the necessary manpower. And it is through research and other forms of knowledge product it gets the necessary legitimacy. It seems that the actual conceptualisation of workplace health promotion has moved it into market arena, in which workplace health promotion needs to take the shape of a commodity. Whether this transformation is improving health at the workplace, it is too early to say.

The network of *Health town* and its offspring the National Centre for Workplace Health Promotion, the Labour inspection, the research around *Healthy Bus*, and with lower intensity, at lot of other actors has changed the situation, so that especially those working environment professionals with a health background feel that the situation has changed positively in their favour. Health is back as a working environment concern.

The network is heterogeneous in terms of bringing together actors from both the health and the working environment sector. And the workplace are opening up to the network, and the good examples, at the moment part of the Danish Railways, are powerful arguments in favour of workplace health promotion.

Conclusion and perspectives

Bridging different fields

These two cases illustrate how network governance works as a mechanism for bridging fields, differing in their views on problems and solutions. In the first case we see how regulation of care work is caught in an industrial conception of work and working environment, implying that work is perceived of as strenuous. Bringing in client-centered professionals and institutions rooted in the field of social policy creates a bridging of two worlds and lead to an emphasis on the relational aspects of work and thereby also a conception of work as a meaningful activity. The second case pertains to a larger agenda. It deals with the renewal of OHS regulation in a context where problems seem still more complex and where individualization colours both conception of problems and solutions. Bridging OHS with Health Promotion in concept of Work Place Health Promotion could at first glance seem too difficult; an attempt to cover too wide a gap. And the case shows that it is indeed a difficult task. But the field is still young, and the arena is set for another round.

It means trying to keep focus at the collective (the organizational and technological) causes on the one hand and on the other hand include individual preconditions and problems concerning health and social life.

The state as meta-governor

In both cases the state has provided the network of strategic actors with both legitimacy and economic resources. In the first case authorities are only weakly included in the network. However their role as a kind of meta-governor should not be underestimated. The establishment of public funding is crucial as a condition for developing and maintaining the network. And later in development process the authorities also include transfer instruction system in their guidelines.

In the second case both of the two consecutive governments' programmes of public health have given attention the workplace as a health arena. That was the basis on which it was possible for the Ministry of Health to fund the National Centre. And that was the basis on which the Labour inspection involved itself in the matter, and overcame some of the resistance from the labour market parties. The Labour inspection was put in charge of some money to fund some projects (in 2001). Also the National Institute of Occupational Health were given money to do research in the field. The state not only played a role, it functioned as producer of the play. The state did not set up a coherent well-organized strategy, but nevertheless managed to support a network that would otherwise never have come into existence.

Networks, soft regulation – or simply deregulation?

The outcome of this case of network governance is a kind of 'soft regulation'. And these cases illustrate some of the positive qualities of that kind of regulation such as its flexibility and ability to deal with complex problems. The concept of transfer instructors that is developed is remarkable because it creates new actors in the field of working environment, the transfer instructors, and tries to enable and empower them to act as change agents. Transfer instructors could be safety representatives, and in some cases they indeed are. But in many cases the transfer instructors are conceived of as 'extra resources', and a person outside the safety organization is elected.

The negative aspects of soft regulation – deregulation - however also apply to these cases. The question is how the transfer instructors, supported by the consultants from OHSS and the networks of SWEC, are actually able to handle to complex problems they are intended to? Is this instructor system an excuse for not intervening in the sector and thus not solving the severe health problems of care work? Evaluation studies of transfer instruction systems are actually equivocal, when it comes to proving the results of the effort. And the health problems are not solved, though low back pain and injuries have not been increasing in recent years.

And regarding work place health promotion the actual integration of working environment and health concern, that we claim still need further development in terms of concepts, tools and examples to be truly successful, can, if not successful, be perceived as deregulation itself. The focus is moved from the health factors of work to the individual areas of responsibility; and the workplace efforts just support such a shift. Health is 'produced' both at work and through the way people 'eat and drink'; the one doesn't exclude the other. Workplace health promotion is still in risk of doing that.

This underlines in our view the necessity of interplay between traditional governance and network governance. The innovative capacity of network governance is obvious, but if authorities are not an active part of the network, results may be insufficient.

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