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Welfare-State Expansion and Conflicts in the Nordic Countries: The Case of Occupational Health Care

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Introduction

The protection of the health of employees has been on the political agenda for at least a century in the Nordic countries. State intervention was hesitant and relatively inactive until the 1970s, by which time the rather passive and curative way of dealing with occupational health problems became contested by a more active and preventive approach. This was prompted by the growing concern for dangerous environmental working hazards and research documentation about health risks.

Even though these countries introduced policies to expand occupational health services (OHS) at approximately the same time, under comparable political and economic conditions, the results seen in terms of conflicts turned out to be surprisingly varied. The purpose of this article is to show how and why state involvement in OHS resulted in such different patterns of conflict in the Nordic countries. In Norway the *level of conflict* between employers, employees and the state became very high during this period, but remained virtually absent in the other countries. The main proposition of this study is that the level of conflict in OHS may be associated with the degree of state interventionism related to the content and coverage of OHS.

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State involvement may conflict with the vested interests of both *employers* and *trade unions*, as well as the *general health service*. When private employers' interests do not coincide with those of the state, there are two possibilities. The state may cooperate and compromise with the employers; or exercise control, opening for confrontational processes. While Kuhnle (1983) and Seip (1984) suggest that the Norwegian welfare state basically was founded as a result of consensual processes and compromises on elite-level, Esping-Andersen (1985) sees the Scandinavian welfare states as being a result of conflictual processes between social classes.

Our purpose is to examine why conflicts occurred in Norway, while compromises were established in the other Nordic countries in the case of occupational health services. The following propositions will be considered.

- *Policy objective:* the more ambitious the policy objectives, the greater the potential for adversary reactions from groups affected.
- *Way of regulation:* the more direct regulation, the higher the propensity for conflicts.
- *State administrative structure:* the more sectorized the structure, the higher potential for interdepartmental conflicts.
- *Corporate structure:* the more closed the access for participation, the higher the possibility for confrontation with interests left outside the process.
- *Political culture:* when employers have a liberal ideology, the conflict potential will be higher than where the political culture determines a more ready acceptance by the employers of state intervention.
- *Socio-economic conditions:* an industrial structure with small and scattered enterprises will result in more resistance from employers than under conditions of larger enterprises.

The propositions can be grouped into three main categories of theories in political science. *Policy theory* maintaining that intentions and means (here policy objectives and way of regulation) determine how political actors behave. *Institutional theory* states that organizational structures and procedures (here administrative and corporate structures) are the determinants of political behaviour. *Rational choice theory* presupposes that individual strategies of maximizing economic advantages (here the economic interests of the employers) are the main explanation of political behaviour.

When the authorities make employers responsible for establishing OHS in private enterprises, the main problem is how to introduce this policy without provoking resistance and conflicts. The term *conflict management* is a useful concept which underlines the importance of how interests are affected by policy objectives and how the involved parties will influence the outcome of the process. Schattschneider (1975) proposes the principle that the scope of a conflict determines its outcome. Conflicts are not

only concerned with certain policy issues, but also the procedures for participation of interest groups. One of Schattschneider's propositions is that the outcome of a conflict is determined by who is allowed to be participants in the process. Another of his propositions, derived from the first one, is that political strategy will be mainly concerned with determining the participation procedures.

The problem of how to socialize the conflict not only raises the question of which interests shall be permitted to participate in the decision-making process, but also how ambitious the policy goals are. In two studies, Lowi (1964, 1972) argued that the *content* of policy and the specific issues at stake will not only determine the level of conflict, but also which political arena and political interests will be activated.

The Janus Face of OHS Policies

Occupational health services may be concerned with traditional *curative* health care – reacting to health injuries – or with *preventive* measures – acting towards anticipation of health hazards in the workplace by rearranging the working environment. Both types of OHS are associated with vested interests. Curative OHS often was attractive to employers, employees and doctors because of short-term individual health benefits. Preventive measures have more long-term, diffuse effects, are resource-demanding and presuppose some kind of state intervention. The perception of the problem and proposals for solutions came to be heavily influenced by this inherent tension of OHS. This "Janus character" of OHS was aptly captured by a Swedish scholar who argued that the problem is that "unless OHS can be made to carry out its tasks as an integral part of the company, it only too easily becomes a provider of free-of-charge medical services to employees" (Westerholm undated, 9). At an early stage, this was seen to have negative consequences for the recruitment to OHS positions, leaving out experts on preventive health care. Often only medical personnel were hired "because the curative part so to say was easier to sell" (Lindskog 1976, 310).

The trend toward curative OHS under the forces of sectorial interests wanting short-term benefits has parallels in other state activities. Richardson (1982) asks why "reactive policies" seeking consensual solutions are so prevalent in many countries. "Anticipatory policies" employing imposition are, according to him, encountered increasingly seldom. Ahonen (1986) suggests that structural aspects of the policy issue itself may explain why there are so few examples of comprehensive anticipatory policies in occupational safety and health services. He leans towards Lowi's proposition that policy-type determines the policy arena and which conflicts will

evolve. Ahonen maintains that because of certain "structural mechanisms" related to interests in this policy sector, policies necessarily tend to be reactive rather than being anticipatorily active. In addition to the question of content, OHS raises the classical welfare problem of who shall be covered. Regarding coverage, ambitions may be high, aiming at universal *coverage* of all employees, or a more *selective* type covering only those employees in the most exposed industries. OHS in the most polluted and health-hazardous industries is not controversial. The difficult question has been to expand OHS to include all kinds of enterprises, when the need for preventive measures is not self-evident.

Historical Background

State inspection of working conditions in the Nordic countries became regulated by law before the turn of the century[1] due to the dangerous nature of many workplaces and high accident rates (Bull 1953). Some enterprises, mainly the largest, employed a company doctor to carry out medical examinations and some basic treatment. The state lacked personnel for effective inspections. Improvement was largely dependent on the goodwill of the employers. This situation persisted until after World War II.

After the war health conditions for all employees were of increasing concern among the trade unions. Local agreements between employers and employees evolved, resulting in a variety of health-care systems that differed considerably in quality. State involvement gave priority to inspection of the largest and most hazardous workplaces. Occupational health care was mainly defined as a part of the production process and therefore the responsibility of the employer.

By the end of the 1970s similar ambitions to make occupational health services available to all employees had been arrived at in the Nordic countries. The aims became incorporated in the various Working Environment Acts, something that has been considered as the last building-block in the development of the Nordic welfare states.[2] OHS came to be one of the core areas of the welfare state, that of health care (Bostedt 1991).

Moreover, the expansion of the OHS area took place at a rather late stage in the development of the modern welfare state, and coincided with the welfare state "crisis" of the 1970s and 1980s. While lack of active support for the welfare state eroded its political basis, and therefore incentives for new reforms in this period (Heclo 1981), the new optimism of OHS expansion was based on other premises. The implementation and the brunt of the costs were to be borne by the employers.

Occupational safety reforms were founded on an ideology of political

mobilization among employees. Workplace democracy became a policy task for the authorities from the mid-1970s and was regarded as being particularly important in reducing workplace-related health risks. Workplace democracy influencing local working conditions was regarded as an important supplement to the established political institutions (Kalleberg 1984).

The expansion in the 1970s ran parallel to the environmental movement and concern about environmental hazards outside the factory gate from pollution and exploitation of natural resources. Growing public concern over hazards to human health was a reaction to the side-effects of unlimited economic growth. Damage to nature often resulted in aesthetical, visual and long-term indirect effects on human welfare. New medical advances demonstrated a direct link between polluted work environments and health injuries (Eckersley 1992). In this perspective, the focus on OHS can be seen as part of a broader "green" development. But in contrast to pollution of nature, dangerous internal working environments often had direct and dramatic influence on human health.[3]

Patterns of Conflict

Conflicts of interest can be negotiated, value-conflicts cannot (Aubert 1963). Because interests can be compromised, consensual solutions are possible. Since values are often not negotiable, confrontation will take place and both parties hope to be the winner. Pure preventive goals in OHS are much more value-laden than the more flexible and "compromisable" goal of curative measures. When the preventive goal is connected to universal coverage we will expect confrontation. Because the very explicit universal value-laden preventive goal in Norway had to be interventionist in its implementation, we would here expect the most non-compromising process with a high conflict level.

Finland: Conflicts Before the Rules, Consensus About Implementation

Finland is the only Nordic country with a special law on occupational health care, implemented in 1979. A more general law on occupational safety from 1958 stressed the employer's general responsibility for health in the workplace and regulating local cooperation.[4] In 1973 a new law regulating local cooperation and inspecting bodies was enacted.[5] Finland passed more general occupational safety acts at an early stage compared to the other Nordic countries.

Before the specific occupational safety act was passed in 1978 the rate of expansion of occupational health care was rather slow, and covered about

40 percent of all employees. On the other hand, the percentage was considerably higher than that in the other Nordic countries at this time. Until then OHS was regulated by agreements between the partners in the labour-market.[6] The problem was that the spread did not fulfil expectations of the employees' organizations. Voluntary agreements seemed to slow down the process. The law instrument therefore became an attractive possibility.

The question of workplace related health care and full coverage was conflictual during the 1960s and 1970s. The controversy followed the main party lines of the socialist and bourgeois parties (Koskiaho 1987). The Social Democratic party programme openly confronted the employers. On the initiative of the Trade Union Federation (LO) they proposed a new law, making OHS *obligatory* for all employees. The employers were to be responsible for establishing the OHS, covering all costs. The employers' organization, most of the doctors and the bourgeois parties feared a law-enforced obligatory full coverage policy. This would result in socializing the private doctors and conferring considerable economic costs onto the employers.

A "deadlock" situation continued until the autumn of 1977. Then the question was taken out of party politics. The Employers' Federation (AFC), the Trade Union Federation (LO) and the Ministry of Health negotiated and came to an agreement concerning the new law on occupational health care.

One reason for the involvement of the authorities in the drafting of the law was that the general health condition of people of working age was "unsatisfactory". Another was the lack of OHS in the smaller industries. In the government proposal the situation of construction workers, who were particularly exposed to work-related health injuries, was specifically discussed.[7]

A broad compromise was adopted. The law was to be obligatory for all employers irrespective of size or kind of industry, or location. For farmers and self-employed persons OHS was voluntary. But the Social Democrats had to make considerable concessions. The employers would receive 60 percent reimbursement from the state health security budget for their expenses associated with establishing and running OHS. Furthermore, the employers were free to buy OHS-services from private doctors or private health centres.[8] On the other hand, the employees became more influential in how the local OHS should be run. The provisions of the Act from the Ministry of Health stated that by 1983 all employees were to be covered.[9] By the end of 1984 the coverage was about 80 percent. A considerable acceleration of the process had taken place, doubling the coverage within five years.

Why this success? *First*, conflicts were taken out of party politics and

negotiated in the corporative arena with the interest organizations. *Secondly*, the corporate compromise made considerable concessions to the employers' fears that all economic costs would be borne by them. *Thirdly*, the market of private doctors was preserved, increasing the choice of the employer, and securing this income source of doctors. *Fourthly*, by transferring many of the costs to the social security budget of the state and therefore to the tax-payer, the OHS became partly a state responsibility. When the state became involved in financing, OHS became a part of an overall welfare state responsibility with a high degree of legitimacy.

The ambitious Finnish policy of obligatory law-enforced OHS seems to have as one of its most important preconditions an integrated corporate process giving concessions to the employers and doctors. When, at the same time, a considerable proportion of the costs was socialized, this paved the way for a highly consensual process.

Sweden: Agreement About Continuous Negotiations

The policy in Sweden has been that OHS ought to be a right for all employees[10] and some flexibility in the local adaption of OHS. The instrument has been voluntary establishment based upon agreements between the organizations in the labour-market.

The main agreement between the Employers' Federation and the Trade Union Movement (LO) came in 1976 and included more than 1.3 million employees. Later supplementary agreements were made covering new groups of employees.

The question of more direct law-enforced OHS was discussed during the 1970s. The LO and the left wing of the Social Democratic Party were sympathetic to the idea. In 1976 an expert commission was established to review the question. However, it was voted down by the majority in the commission who rejected "enforcement by law".[11]

The position of the social democratic government was clear. Referring to the responsibility of the partners in the labour-market, the government was convinced that a further expansion of OHS could be best achieved through other procedures than law-enforcement.[12] The government explicitly stated that "its intention was not to contribute to more centralized government or to specify the content of occupational health care" (Prop. 1984/85:89, 19). State influence should be restricted to what "indirectly was a consequence of the new system of reimbursement" (ibid). Additionally, OHS became associated with the question of how workers could influence their own working conditions. The role of the employees and the local trade unions was emphasized. The Working Environment Act is especially concerned with aspects of workplace democracy, regulating the appointment of "protection officers" and "protection committees".

The reluctance towards compulsory OHS is also found in the corporate sector. The agreements gave rather general guidelines to the "protection committees". The employers' and employees' organizations agreed that the conditions of the different industries varied widely as regards needs, organization and traditions. Therefore as concerns occupational health care "to the employers' organization (SAF), to the trade union movement (LO) and to the cartel of privately employed white-collars (PTK) it is obvious that general rules cannot be made for the activities of the protection committees of the single enterprise".[13] First of all, the Swedish position was a flexible approach to variations in needs, or as one commentator on Swedish OHS put it, "basically OHS is a pragmatic compromise between different demands".[14]

The role of the state became indirect. Leaving the specification of rules to the organizations, the state came to rely on the effect of financial reimbursement of employers' expenses to OHS. The local state labour inspectors were given a more active role from 1986 and onwards. At that time, it was up to the local state labour inspectors to control whether conditions for reimbursements had been fulfilled. But state control never interfered directly with the organization of the local OHS.

The central corporate agreements became obligatory for the employers. The agreement turned out to be a problem and more binding for the employers than they would have preferred. The tension between standardization and flexibility in the agreement broke out into an open conflict in 1991. The Employers' Federation (SAF) terminated the agreement. The reason was that owners of smaller enterprises felt that the agreement imposed too specific demands on OHS requirements, resulting in high costs and low flexibility. In a period of economic recession the costs and effectiveness of OHS were questioned. SAF did not want to continue the central corporate regulation of OHS. The argument of SAF was that the employer had the responsibility for the working conditions of the employees, but how the problem was solved was up to the single employer, i.e. to purchase OHS in the market if that was the best solution. SAF's opinion was that OHS issues should be decided locally between employers and employees in the single enterprise "not by directives from the authorities or the central partners in the labour-market" (SAF 1991). The employers should have more influence on OHS affiliation, therefore as a SAF official formulated it: "The enterprises must not be forced to use some service they don't need".

The Swedish Trade Unions' position was that "it is impossible to regulate in detail the quality of OHS".[15] On the other hand, the LO had a clear position against "market OHS". The dilemma of the LO was that the local federations with members in small enterprises, such as in commerce and service, wanted law regulations, otherwise it would be impossible to provide OHS.

This section of the LO was on the same footing as the left wing of the Social Democratic Party which prevailed in the *Riksdag* where they promoted compulsory OHS legislation.[16] As the LO considered the situation in the autumn of 1992, one possibility was to decentralize the negotiation of agreements to the local federations. If this was not possible, the option of law regulation remained (LO 1992:12). But the LO was hesitant because law regulation would mean a new confrontation with the employers. Neither was the bourgeois government in power the best ally on this issue. On the other hand, as was stated in an LO document, "If agreements are not possible, then of course law regulation is the only option".[17]

Denmark: Consensus about Selective Rules

In Denmark the Working Environment Act was adopted by the *Folketing* in 1975, and came into effect as from 1977. As a part of the general law there are specific regulations for occupational health series. Such integration of general and specific regulations in the same law is not found in the other Nordic countries.

The Ministry of Labour is formally responsible for determining which industries shall establish OHS. Before the decisions are taken, the corporate body the "Council of Labour Protection" (*Arbejdsmiljørådet*) is consulted. The interest organizations first agree which new industrial branch shall have obligatory OHS. The Directorate of Labour Inspection then prepares detailed regulations for the inclusion of the new branch.[18] The procedure of establishing early agreement among the organizations has something in common with the Swedish method. In contrast to Sweden, the legal basis is not a formal agreement among the organizations, but state regulations.

OHS was made obligatory for 25 industries with special health problems. On the other hand, by the end of the 1980s not more than 23 percent of the employees were covered. Even if establishment of OHS was obligatory for some industries and regulations existed concerning the local organization of OHS, tasks, local cooperation, staff and financing, it was also stressed that the local OHS itself had to establish how the objective of preventive health care was to be realized. The adaption of OHS to local circumstances was emphasized.[19]

The Danish approach calls particular attention to the *preventive* aspect of OHS.[20] The selective and also rule-oriented approach has, also a liberal component. In reality the extent to which an enterprise will take part in an OHS-service to which it is formally attached, is voluntary.[21] It is also voluntary whether enterprises other than those included by the central regulations shall establish or be a member of an OHS-service.

This restricted approach is probably the main explanation why the expansion of OHS has been so slow in Denmark, as is also suggested in one Nordic report (Rossi 1990, 81). The regulations were specified to cover the most hazardous industries. Within this closed area the aims were specific and the plans implemented by an effective bureaucracy. The steps taken to impose OHS were first negotiated in the corporate body, creating the necessary conditions of consensus between employers and employees, before the specific rules were imposed.

Norway: Conflicts Over Implementation of Rules

The period from World War II up until today can be divided into two phases. Up to the introduction of the Working Environment Act, public involvement in OHS was very modest. OHS was established and run in the post-war period according to an agreement between the employers, employees and medical organizations, with no participation from public authorities (Steen 1991).

The agreement opened for substantial influence by the employers at the local level on extent and content of OHS. Occupational health doctors or "factory doctors" until then appeared to be more interested in curative than preventive health care. Controlling health was the main activity (Natvig 1974). The LO was rather dissatisfied with the slow expansion of OHS and the lack of a preventive profile. The corporate arrangement became contested in the beginning of the 1970s by the LO which meant OHS should be a public responsibility, integrated in the general public health care outside the hospitals. In 1973 the LO raised these issues in a letter to the Standing Committee of Social Affairs of the *Storting*. A public commission was appointed proposing a law on occupational health services, but preserving the system of agreements between the interest organizations (NOU 1976:48, 50).

Simultaneously, the LO and the Labour Party drafted a joint programme for a general work environment reform before the parliamentary elections in 1973 (LO-DNA 1973). There was no broad criticism of the reform as such from the employers. The socialist majority was safe and the law was passed unanimously by the Parliament. Gustavsen & Hunnius (1981) explain the lack of conflict by the long period of cooperation between the employees' and employers' organizations.

Following the introduction of the Working Environment Act, considerable *disagreement* arose among the old corporate partners concerning the interpretation of the law and its implementation in the field of OHS. On the basis of the newly proposed law, the Directorate of Labour Inspection was recommended to take a more active role. Article no. 30, which

laid down the responsibility of employers regarding the establishment OHS, became a particular focal issue of the opposing viewpoints.

The article states: "When it is necessary to carry out a special surveillance of the work environment or of the health of the employees, health care personnel shall be recruited, such as a company medical officer (doctor), company nurse, safety manager, etc.". According to the authorities and the employers' and employees' organizations, the individual employers were responsible for establishing OHS when necessary. But how do we define "necessary"? This led to a decade-long conflict on how the law should be interpreted and the legitimacy of intervention of the Directorate of Labour Inspection into the area of the local employer.[22]

The problem was that the local employer frequently had a different conception of the needs of the OHS from that of the authorities and the Trade Union Federation. The employers argued that the employers' responsibility applied only under certain conditions where the employees were exposed to clear health hazards. The LO and the state authorities had a much broader interpretation, asserting that not only open risks, but also indirect, long-term risks should be prevented by establishing OHS. The consequence of this uncertain and conflictual situation was that the expansion of OHS almost came to a halt. The Directorate of Labour Inspection wrote: "Uncertainty has resulted in employers not having established OHS on their own initiative, even if such responsibility is clear according to the law".[23]

To solve the problem of uncertainty, two options were at hand: negotiation of a new agreement between the organizations, or specifying the rules. The interventionist solution was chosen and regulations specifying which industries should establish OHS were passed and came into effect from 1990.

The abolishment of the former tripartite negotiating structure had two important consequences: First of all there no longer existed a consensus-making body between the employers and employees. The LO took a very active position in influencing the policies of the Directorate. Close links between the LO and the Directorate evolved from the beginning of the 1980s (Steen 1992). On the other hand, the employers' organization was opposed to this alliance between the authorities and the LO, which reduced the possibility of its influencing the decision-making process. Secondly, the medical association found an ally in the Directorate of Health, which also opposed the interventionist policies advocated by the Directorate of Labour Inspection and the LO.

The lack of an open corporate structure resulted in selective alliances, splitting the administration and the organizations into two opposing segments. When little consideration had to be taken to employers' interests, it was possible for the Trade Union Federation and the Directorate of

Labour Inspection to pursue ambitious goals concerning content and coverage of OHS, which in turn provoked other interests.

Perceptions of Conflict: A Local Perspective

Because of the open conflicts at the central level in Finland and Norway, these countries were chosen for a closer study of how the conflicts were reflected at the local level as perceived by the local inspectors. In all the Nordic countries there are local state labour safety inspectors. From a modest beginning at the end of the last century with only some very few, Norway had about 140 inspectors in 1992 and Finland some 330. In order to find differences in attitudes to conflicts a questionnaire was used.[24] The response rate was 96 percent from the Norwegian inspectors and 71 percent from the Finnish. For a more detailed description of methods and data, see Steen (1994).

The more modest preventive OHS ambitions, "softer" regulation, and compromises combined with flexible local provision of OHS found in Finland, are expected to result in more consensual attitudes among the inspectors than those found in Norway.

The inspectors were asked to assess the level of turmoil in connection with establishing OHS. The general question is supposed to capture attitudes to turmoil related to employers' and professional interests, as well as state regulation problems.

Table 1. Perception of Turmoil About OHS Establishment (in Percent).[1]

	Great turmoil 1	2	3	4	Little turmoil 5	
Finland	6	16	29	41	8	(100%) = 233
Norway	25	38	19	16	2	(100%) = 138

[1]Question: "Considering the establishment of OHS in your district during the period you have been in the present position, how would you characterize the process?"
The process has been characterized by:
Great turmoil 1 2 3 4 5 Little turmoil.

Sixty-three percent of the Norwegian inspectors are placed on 1 and 2 on the turbulence scale, but only 22 percent in Finland. The table indicates very different "climates" in the process of OHS expansion. The interventionist model with specific instructions about solutions fuels much more conflict than the model based on flexible options for the employers. One interpretation is that conflicts of interest in Finland are easier to accommodate than conflicts of values such as in the Norwegian case. Ideal

standards and little room for flexibility in the implementation process seem to be provocative to the participants involved.

Arenas of Conflict

The involvement of the medical sector and the internal struggle between the Directorate of Health and the Directorate of Labour Inspection were important in the Norwegian case. How much of the conflict in Table 1 is accounted for by the employers compared to other actors is difficult to say. One indication of the relative importance of different conflicts is to ask the inspectors to evaluate whether different participants have had a negative or positive influence on the development of OHS. The inspectors were asked to assess the influence of participants on the development of OHS on a scale from 1 (positive) to 5 (negative) 1. In the table values 4 and 5 on the scale are put together as "negative".

Table 2. Percentage of Labour Inspectors Evaluating Participants' Influence as Negative.[2]

	Norway	Finland
District Office of Labour Inspection	7	3
Trade Union	16	11
Dir. of Labour Inspection	27	5
Employers' Federation	43	30
Doctors	60	16
Employers	64	47
Dir. of Health	65	8
The Medical Association	68	19
Average	44	17

[2]Question: "What influence have, in your understanding, the following instances/groupings had on the development of the OHS during the period you have been connected with the OHS?"
Positive influence – 1 2 3 4 5 – Negative influence.

For Norway, the participants are ranked from top to bottom according to negative influence. The average proportion of negative values is considerably higher in Norway (44 percent) compared to only 17 percent in Finland. The ranking order is also different. In Norway the medical sector is regarded as the most negative, while in Finland the employers have the most negative position.

For every participant the "negative" percentage is higher in Norway, and is considerably higher for some participants, especially the medical sector.

The Employers' Federation and individual employers are regarded as substantially more negative in Norway, but a considerable proportion of the Finns are also critical of the employers.

The table clearly shows the special pattern of conflicts between governmental agencies. First of all the labour inspectors in Norway are very negative towards the Directorate of Health, 65 percent compared with only 8 percent in Finland. This reflects the deep cleavage of conflict between the Directorate of Health and the Directorate of Labour Inspection in Norway.

Within the sector of labour protection tensions have also been much higher in Norway. As many as 27 percent of the inspectors perceive the role of the Directorate of Labour Protection as negative, as against 5 percent in Finland.[25] This is rather surprising at first sight, but fits very well into the picture of vertical administrative conflicts within the labour inspection sector, described in Steen (1992). Lack of sufficient resources for regulation in terms of personnel among the state inspectors seems to have turned into criticism against the top of the inspectors' own Directorate. Another explanation may be that a most of the local inspectors have listened more to the problems of the local employers than to the leaders of the Directorate.

The wider range of contesting participants in Norway is explained by more ambitious policies and interventionist strategies. In addition to the distrust between labour authorities and employers, medical interests and internal administrative antagonism were involved. The issue of distribution conflict related to medical resources came on top of the traditional conflict caused by state intervention in the market sphere of the employers. Therefore, the general level of conflict in Norway became that much higher. The hypothesis that differences in policy content and measures cause differences in levels of conflict and decision arenas gains support. Ambitious policy goals on coverage and content, combined with interventionist regulation and standardized implementation, trigger off more conflicts than more modest policy goals combined with "soft" regulation and flexible implementation.

The negative attitudes in Norway towards the interest organizations of the employers and doctors may be explained by the conflict potential of the closed corporate structure. There was no formal structure to pave the way for negotiations and compromises, which could make local implementation smoother.

In Norway OHS responsibility was split between two directorates, with quite opposite interests. The negative attitudes to the Directorate of Health fit in very well with the expectation of conflicts when the state administration is fragmented.

Resistance from the Employers

The willingness of the employers to comply with the law, regulating enter-

prise activities, is a general problem. In the liberal tradition, most prominent in the USA, it is legitimate to promote self-interests. This value is deeply rooted, especially in American business (Wildawsky 1982). The European tradition of strong state authorities has nurtured the notion of deference to the authorities. Self-assertive liberal values will create resistance to regulations. As Kelman (1981) has maintained, when it is necessary for the state to intervene under such circumstances it will be difficult to make people comply with the rules. Furthermore, the opposite will be the case when there is tradition for state regulation and rule compliance. The reaction of the employers under a liberal market tradition will be more conflictual than where regulations have been accepted as a part of the political culture.

Kelman tested this proposition of cultural differences by posing a question to the labour inspectors in the USA and Sweden about the law "abidingness" of the employers. The approach was somewhat broader than here, and included safety regulations in general. Here the focus is limited to the OHS. However, in Sweden the model of regulating work conditions by labour-market agreements is, as we have shown, also applied to OHS.

The Norwegian and Finnish state interventionist approach seems at first glance to have more in common with the American tradition of enforcement based on legal punishment than with the Swedish cooperative tradition.

The Finnish, Norwegian and American inspectors have much less confidence in law-acceptance among employers than in Sweden. The Swedish figures support the contention of a well-established, negotiating and coop-

Table 3. Perception of the Employers' Law-compliance in Finland, Norway, Sweden and the USA.[3]

		Finland (1991)	Norway (1991)	Sweden (1981)	USA (1981)
Most employers abide by the rules					
	I	1	2	18	9
	II	13	6	26	6
	III	28	23	22	8
	IV	48	47	20	21
	V	9	23	15	56
Most employers ignore the rules					
		99%	100%	100%	101%
		N = 233	N = 138	N = 74	N = 78

[3]Question: "When the work conditions make it necessary, it is according to the Working Environment Act the responsibility of the employer to establish OHS. How would you characterize the attitudes of the employers to this provision in the law?
Most employers abide by the rules 1 2 3 4 5 Most employers ignore the rules.

erating system resulting in a high degree of trust between the partners of the labour-market.[26]

There are two pressing questions: What can explain the fact that Finland and Norway are so similar to the USA? And why are the negative attitudes so high in Finland, when open conflicts have been low?

The Norwegian position is what might be expected. A confrontational political-administrative process and active employer resistance to regulations have created an atmosphere of distrust. Ignoring impositions from the local inspectors was a coordinated strategic move by the employers (Steen 1992). When almost a quarter of the Norwegian inspectors selected category 5 on the scale, it is a clear indication of very low confidence in the employers.

One surprising finding is that despite an OHS coverage of more than 90 percent and low level of conflict after the law on OHS was adopted in 1978, the Finnish inspectors report a low level of confidence in the employers. On the other hand, the success of Finnish OHS expansion has, to a large extent, been dependent on employer cooperation. This somewhat paradoxical Finnish situation needs special comment.

The ambitious objectives after 1978 were possible after compromises in government and parliament. The background was that of very conflictual processes along left–right cleavages at all levels. Former clashes in the local processes and the experiences of the inspectors from the turbulent period are perhaps reflected in attitudes of today. One part of the compromise was a system with flexible local implementation, leaving it to the employers to decide how OHS should be established. One explanation may be dissatisfaction among the inspectors with the will of the employers to establish a high quality and preventive OHS. Buying OHS in the market is flexible, gives high coverage and is cheap for the employer. This is not necessarily a good type of OHS from the perspective of the local labour inspectors.

Kelman's cultural explanation of the importance of liberalism and cooperation among employers for the understanding of conflicts gains less support from the cases of Norway and Finland. It is not reasonable to assume that the political culture in Finland and Norway has more in common with the USA than with Sweden. Our argument is that the political culture and liberalism among employers in the Nordic countries is relatively similar. The reason why Finnish and Norwegian attitudes have something in common with the US pattern must be something other than the liberalism among the respective employers.

According to Kelman, culture-based liberalism presupposes intervention, which in turn triggers off employer disloyalty. Wilson (1986) criticizes Kelman for this cultural explanatory bias. In comparing occupational health regulations in the UK and the USA, he argues that the interventionist approach taken by the regulating authorities in the USA is better explained

by the legislative mandate given to the regulating agency, than by political culture. Further, he maintains that "American culture has never seemed in the past to produce antagonism between government and industry" (1986, 298). The "hard" regulating strategy adopted in the USA was more a consequence of past regulatory failures "than a product of American culture" (ibid.).

If this observation is correct, it turns our attention to policy formulation and implementation processes as explanations of conflicts. Wilson explains the low level of conflict in the UK by the different functions of the interest group systems. Comprehensive interest groups in Britain were taking part both in formulating, legislating and implementing state provisions. Because of a more fragmented interest group system this was not possible in the USA, resulting in a direct clash between state agencies and employers.

The negative reaction of Norwegian employers is easier to understand when state intervention is used as an explanation. First, the high ambitions of the authorities to implement standardized OHS within a short time using "hard" regulation have much in common between Norway and USA. Secondly, no consensus about the responsibility of the employers existed following from different interpretations of the legal framework. Differences in interpretation of the law, raising the question of bringing cases to the court, are parallel in Norway and the USA. Thirdly, interest organizations are not integrated in the decision-making process and implementation in the two countries, whereas they are prominent in Sweden.

The resistance among employers depends on how regulation is carried out. "Soft" regulation, including interest groups in formulating and implementing state goals, will result in quite different consequences for the level of conflict from "hard" regulation where only the employers' organization is included, as in Norway, or where interest organizations are not included at all, as in the USA. The Finnish case, with a relatively high scepticism toward employers, but lower than that in Norway, can be explained by the fact that the conflictual legislative process before 1978 is still reflected among the state labour inspectors. In addition, the extremely flexible implementation process, being the core of the legislative compromise in 1978, left it largely to the discretion of the employers in deciding the content of OHS. Lack of local control over how OHS is implemented is frustrating to the state inspectors, but keeps manifest conflicts away.

Conflicts and Policy Impacts

Differences in conflicts between the countries seem to be reflected in the patterns of impact. The Danish rule, and sector orientation, with no conflicts, resulted in preventive impacts as expected, dominated by technical expertise. Here the coverage of working population in 1988 was 23 percent

(Rossi 1990). The more bargaining approach of Finland and Sweden resulted in compromises with the employers. Leeway had to be given to a considerably curative treatment within the OHS, resulting in a coverage of 93 percent in Finland and 75 percent in Sweden in 1988.

In Norway, the confrontational process has resulted in lower coverage, 39 percent in 1988, but also in a rather high component of preventive activities. Concerning the "success" of OHS in the four countries, no definite answer can be given. From one point of view, deviations from original policy objectives may be regarded as policy failure. But taking into consideration the context of implementing occupational health care in the private sector, the actual adaptation to local circumstances may be seen as the criterion of success. OHS may be better evaluated as an on-going process, rather than an end product. There is no single hallmark of successful implementation, but several, dependent on policy issue and the context. Implementation within the state sector, where control is possible, should be evaluated more by end product. Implementation of public goals in the private sector, where control is limited, should pay more attention to a continuous process adapting to aims and possibilities.

The Nordic Welfare States: Why the Difference in Conflict and Consensus?

Corporate Structures and the Role of the Trade Union

One crucial factor has been how the interest organizations have been integrated into the decision-making process. The strategy of the trade unions has been of two kinds: a non-compromising strategy as in Norway where OHS expansion became associated with the state administrative hierarchy, planning efforts and absolute standards for OHS content; and a compromising strategy where the expansion of OHS became an incremental, step-by-step, flexible and negotiated affair.

The ideal requirements for OHS of the Norwegian Trade Union Movement made it impossible to integrate the Employers' and Medical Federations. The ambition of fast OHS expansion covering all employees necessitated medical resources from the health sector and conferred open costs on the employers. This policy of redistribution confronted the interests of the health sector and the employers. The Norwegian Trade Union seems to have deliberately chosen a confrontational strategy in order to realize its ideal goals. It became impossible to compromise and organize a negotiating process with other interest groups. No corporate bodies for OHS were established in Norway, leaving issues of redistribution open to confrontation with the Employers' Federation and the medical sector.

When unionization is as low as it is in Norway, how then did the trade union become so active? One explanation is that because of the dispersed industrial structure and low unionization, the central trade union elite felt a special responsibility for realizing the egalitarian value of providing a high quality OHS irrespective of kind of industry and place of living. The egalitarian commitment of the trade union in OHS is consistent with a long Norwegian tradition of deciding upon welfare matters, not in cooperation with the employers, but with the state. In contrast to most other welfare areas, provision of OHS places special commitments on the employers. Lack of state control in the private property sphere of the employers made possible either a cooperative strategy or one which was confrontational.

The large proportion of small industries in Norway and Denmark made it difficult to motivate the employers, who often questioned the need for OHS. The low degree of unionization has contributed to inadequate local pressure. Therefore the state had to play an active role in these two countries. Involving the state in an active way meant that the policy content could be more comprehensive in terms of preventive ambitions. The higher degree of trade union membership in Finland and Sweden made it simpler to come to terms with the employers. Compromises between the employers and employees resulted in a state that played a less active role. The policy content therefore came to be more open for including curative health services.

Because of the confrontational process, the Norwegian Trade Union had to find allies. The solution became a close relation between the trade union and the Directorate of Labour Inspection. The interventionist regulative style carried out was especially provoking to other interests, and contrasted particularly with the all-encompassing negotiating Swedish style. In Finland and Denmark, the organizations also played an important role in formulating and implementing policies.

The confrontational process in Norway can only be understood when taking into consideration the lack of negotiating mechanisms with the employers that we find in all the other countries, and the special position of the Trade Union Movement. The special relation between the Trade Union Federation and the Directorate of Labour Inspection in Norway opens up possibilities for a more refined explanation than that of Wilson (1986), arguing from a dichotomy between open plural participation and a completely closed process. The Norwegian case shows that when only one single interest organization is given access to the decision-making process other patterns of cooperation, conflict and policy ambitions will emerge, than if none or several are participating.

Contrary to Beers' (1982) proposition that detailed state intervention necessitates broad participation, the case of OHS shows that *limited participation* was a precondition for carrying out detailed, standardized and

ambitious regulations. The irony is that an advanced anticipatory state policy could only be formulated by closing access to the decision-making process, as in the case of Norway. Thereby, implementation resulted in confrontation, making bad odds for realizing ideal aims.

Employer Resistance and Political Regime

The resistance of the employers to OHS and, more generally, their negative attitudes to workplace regulation have been a commonplace explanation of conflicts. Kelman's (1981) cultural theory of the high level of conflicts in workplace safety regulations in the USA as a consequence of a market-orientated political culture among the employers seems attractive at first glance. The antagonism of Norwegian employers was not because they have more in common with their American counterparts than with their Swedish colleagues. As in the USA, the Norwegian employers reacted to the direct method of state intervention, leaving out institutions of negotiation and local accommodation. Enforcement and punishment were from the employers' point of view illegitimate means of violating property rights.

The shortcomings of such a cultural explanation of conflicts in occupational safety regulations leaving out institutional contexts are underlined by Wilson (1986). He maintains that the strong legislative mandate of the state agency "explains much more simply and directly than culture the approach the agency took" (1986, 298).[27]

Rejecting the notion that differences in conflicts may be explained by employers attitudes, we will turn to the political–cultural approach from another angle, focusing on the political and organizational context of which culture is a part. Wildavsky (1982 and 1987) and Douglas & Wildavsky (1982) take such a broader more dynamic view, maintaining that political culture has to do with the social context in which the actual political processes are embedded.

In Wildavsky's study of how research concerning threats to health is used in the policy-making process in six countries, one conclusion of the two extreme countries, Sweden and the USA, is that "the Swedes act slowly in policy in order to secure consensus; once achieved, implementation of programs is virtually automatic. The Americans proceed swiftly to make policy in order to overcome opposition; but implementation proceeds slowly, facing opposition all along the way" (Douglas & Wildavsky 1982, 71). This might have been a description of differences between Sweden and Norway as well.

According to Wildavsky, it is possible to distinguish between three types of "political regimes". "Collectivism", "sectarianism" and "individualism" describe three ideal-types where "collectivism" is characterized by rule-

orientation and a holistic social approach; "individualism" is competitive and market-oriented; while "sectarianism" is egalitarian in value, and critical of market competition and the state as well. The sectarian culture is particularly preoccupied with early anticipation of dangers from technology, thus confronting the problems created by the market. Wildavsky's point is that sectarian values and market forces are confronting each other. While the conflict is softened in Sweden by collective and cooperative institutions, it is accelerated in the USA by an open and adversary policy-making process, lacking consultative institutions. One interpretation is that because the sectarian forces are stronger in Sweden than in the USA, negotiating institutions between egalitarianist and market adherents resulted in social integration and made possible the far-reaching and consensual Swedish OHS system.

The argument that strong sectarian forces led to a social democratic political regime comprising governmental and bureaucratic intermediating institutions between sectarian and market forces does not apply in Norway in the case of OHS. Even if the political regimes in the Nordic countries have much in common, the institutions in the field of OHS became very different. Here we will conclude that institutions purposely were shaped differently because of different trade union engagements. The employers' resistance in Norway was not because of a stronger liberal culture among the employers, but because they had to bear the costs of intervention more directly than in the other countries. The strong sectarian forces in the Norwegian LO purposely confronted the market interests in order to promote egalitarian values.

Administrative Structure and Conflicts

Emphasizing the coalition-building capacity of the organizations does, however, underestimate the interests of the state as such (Scockpol 1985). The elaborate version of structural effects is found in Steen (1994). As argued by Egeberg (1989), administrative structures may influence behaviour. In the case of OHS the formal division of tasks between the Ministries of Labour and Health and their corresponding directorates, and the responsibility of the Ministry of Health for the allocation of medical resources, have to a large extent influenced the level of conflict. While administrative conflicts have been almost absent in the other Nordic countries, not only horizontal conflicts, but also vertical conflicts between the central and local level of labour inspection were common in Norway.

The functional division of tasks does seem to have influenced the process. In Denmark, the Ministry of Labour has the sole responsibility for OHS. In Norway, the Ministry of Labour is formally in charge, but dependent on the interests of the Ministry of Health. In Finland, the Ministry of Health

has the main responsibility for administration, leaving the Directorate of Labour Inspection to control the workplaces. The Swedish model is the opposite: the labour inspection authorities are in charge of administrating most aspects of the OHS.

It is striking that the OHS in all the countries, with the exception of Norway, is dominated *either* by labour inspection authorities *or* by medical authorities. The more equal footing between the two ministries in Norway, and consequently the more unstructured administrative decision-making process, seems to have created a fertile ground for conflicting processes.

Socio-economic Conditions and Economic Rational Employers

The more scattered and smaller industries in Norway and Denmark created more difficult conditions for establishing OHS. It was an easier task in Finland and Sweden to expand the OHS without conflicts because of the size of their industries. In large industries many employees have similar working conditions. The OHS becomes relevant for collectives of people in the same area. It is easier to come to terms with measures involving relatively low economic costs per working unit.

In Norway, the great variation among enterprises resulted in variation in the need for occupational health services among the companies (Wannag 1989). The low level of conflict in Denmark can be explained by the explicitly low-ambition policy of not including the small industries in OHS. This incremental strategy was declared by the Minister of Labour in 1983. The explanation given was that a pause was necessary in order to evaluate effects. The decision was strongly greeted by the employers and condemned by the trade unions (Bunnage & Nørregaard 1987).

The Finnish low level of conflict can be explained by the fact that the employers were allowed to make flexible arrangements adapted to the industrial structure including use of public services, and buying OHS in the market.

There seems to be one important inherent tension between industrial structure and public intervention. Employers and employees in large industries can more easily agree on OHS without central intervention because situations and needs are similar. When there is a considerable proportion of smaller industries, the needs become more flexible and therefore more prone to demands for regulation by the trade union. In such a situation the argument of the employers has been that heterogeneity makes central regulation unsuitable.

Policy Ambitions and Conflicts

The anticipatory *and* more comprehensive Norwegian policy ambitions for

taking measures to prevent future illness for all employees are in contrast to the more reactive measures in Sweden and Finland, and the more restricted target group strategy in Denmark. How do such differences in policies relate to conflicts?

Richardson (1982) proposes the terms "anticipatory" and "reactive" policies in order to describe different policy styles in Europe. Anticipatory policies are comprehensive using imposition to attain policy objectives. Reactive policies are incremental and dependent on negotiation with the several interests involved. Because of sectorization of public policy and active interest groups, governments find it increasingly difficult to use anticipatory and comprehensive strategies of problem-solving (Richardson 1982, 197). Demands for accommodating interest groups and administrative sectors in several stages of the implementation process, establishing strong policy communities or segments, make only reactive policies possible. Anticipatory, active and comprehensive policies therefore become more rare.

Richardson does not explain why anticipatory policies are rare. Earlier we discussed how corporate and administrative coordination impinges upon policies and implementation of OHS. Here we will underline the importance of the redistribution implications of the policies. Redistribution will be especially provocative when policies are defined in term of winners and losers. It is not possible to understand the differences of OHS between the Nordic countries without taking into consideration how costs and benefits were distributed among employers. When the employers were not compensated for their costs by economic support from the state, compromises on the OHS content or by leeway in how to implement OHS, the clash became inevitable.

Ahonen (1986) asks why occupational safety and health policy in Finland tends to be reactive instead of anticipatory and active, and therefore a "failure". He asserts that the reactive policy approach is related to a prevailing "labour protection paradigm" that does not reflect the real function of labour protection, but to prevailing cognitions of people where the labour protection problem is basically defined as a medical and technological problem. According to him, a reactive and consensus-oriented policy will necessarily continue as long as the problems are defined more in terms of individual problems than in terms of the context and structure producing these problems.

Using the "paradigm approach" in the Norwegian case, the turmoil not only from the employers, but not least from the medical sector, may be seen as a reaction against efforts at redefining the existing reactive paradigm. The curative cognition of work-related health problems was deeply rooted in the interests of the employers and doctors, and was also supported by employees looking for easy access to medical treatment. In shifting to an

alternative ambitious preventive paradigm, the Trade Union Federation and the Directorate of Labour Inspection could only succeed by closing the access of participants and using imposition. This was the only way of protecting the preventive paradigm against compromises and a "watering down" of the policy content. The redistributive core of the OHS policy had to be protected.

Between the stepwise, reactive and consensual Finnish and Swedish approaches, and the Norwegian comprehensive, active and impositional method, the Danes found a third way: a pragmatic down-to-earth approach, rooted in realities of what was possible given a certain industrial structure. The lack of a legalistic approach in the field of occupational health has been criticized for not being effective. Cooperation and consultation have replaced instruction and control (Ahonen 1986). This criticism seems, however, to forget that regulation within and outside the state sector may be two very different things. The dilemma is that by intervening in the private sector, a "rule-based policy" will always be confronted with high political and administrative costs, jeopardizing the outcomes. An "adaptive-participatory policy" compromises the policy objectives at an early stage in order to settle conflicts. Here the outcomes will be safer, but become less in accordance with more ideal standards a more ambitious approach could have attained.

Concluding Remarks

Kuhnle's (1983) idea of consensual processes related to welfare expansion fits best with Finland, Denmark and Sweden; while Esping-Andersen's (1985) argument of conflicts in the labour-market as the driving-force of welfare development is more in accordance with the Norwegian experience. The conflicts in OHS are special because they occurred during the implementation process, as in Norway, and in policy formulation, as in Finland, but never at both stages in the same country.

Three theories shed light on the processes. However, the explanations are not contradictive. Rather, they illuminate different actors and aspects of the process. The *policy approach*, underlining the intentions of the state and state intervention, to a large extent explains the patterns of interaction in the four countries. Policy and its potential for redistribution between social sectors lead us to understand how political actors and interest organizations came to be mobilized along group cleavages in different ways. *The institutional approach* was most useful in explaining conflicts within the state itself, emphasizing the structure of the state apparatus as an independent variable. *Rational choice theory* gives a supplementary perspective on the reactions of the employers based on self-interest in rejecting new economic

burdens. The industrial structure in Norway, with small industries, laid the foundation for an especially turbulent employers' protest.

The idea of a common social democratic political culture in the Nordic countries may be useful in accounting for similarities in traditional welfare state activities. However, the differences between the Nordic countries in the field of occupational health services encourage us to search for variations. When welfare is implemented outside the state sector, as in the case of OHS, the potential for conflicts grows. The main reason why they became manifest in Norway, and not in the other countries, was more egalitarian goals requiring interventionist strategies which created a different arena for participation and conflict-solving. The strong coalition between the LO and the Directorate of Labour Inspection was based on egalitarian and anticipatory policies. From their perspective, confrontation was a price well worth being paid in order to avoid compromises about fundamental values related to human health.

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NOTES

1. The first factory supervision laws were enacted in Norway 1892, in Sweden 1889, in Denmark 1873 and in Finland in 1889. In Sweden and Norway (at that time forming a joint kingdom) the initiative for the Acts came unexpectedly from King Oscar II, who appointed a special commission in Sweden. He wrote to the Norwegian Prime Minister about the importance of this issue and the Prime Minister subsequently appointed a commission in Norway (Bull 1953).
2. The latter part of the 1970s, it is asserted, marked the climax of the establishment of the Nordic welfare states. The prevailing ideology in Norway maintained that it was possible to introduce ever new welfare reforms. The period 1975–81 has been described in Norway as the time of the most advanced welfare state (Lafferty 1986). In Denmark the crisis of the welfare state in the early 1970s was probably one reason for a different and less ambitious approach to occupational health care than in the other Nordic countries.
3. Research about work-related health dangers prospered during the 1970s and 1980s. In particular, reports about life-threatening cancer dramatically increased the attention of the public, trade unions and the state.
4. Lag om skydd i arbete, 1958:299.
5. Lag om tilsynen over arbetarskydd, 1973:954.
6. Avtal om skyddsarbete på arbetsplassen, 1969. Avtal om utveckling av företagshalsovård, 1971.
7. Government amendment to the Parliament about occupational health care. 1978 rd. nr. 26, p. 12.
8. This liberal way of implementing OHS was stated in the law on occupational services paragraph no.7. (Lag om företagshälsovård. 29.9.1978. Helsinki). The Finnish practice of giving the employers considerable influence on how to establish OHS will be examined in more detail later.

9. Occupational Health Care Act 743/78 and Council of State Decree 1009/1978, paragraph 113.
10. The expert commission of 1976, which presented its report in 1983, was in agreement that within 10 years OHS should cover all employees. SOU 1983:32 "Företagshälsovård for alla", Stockholm.
11. The Swedish term was "tvingande lagstiftning".
12. The Swedish text: "parternas uttalade beslutsamhet att ta sitt ansvar för utbygnaden inom respektiva avtalsområde, talar for att en fortsatt utbyggnad bör kunna ske utan generelt tvingande lagstiftning" (Prop. 1984/85:89, 19).
13. Agreement on environmental protection between the SAF, the LO, the PTK (1985, 19).
14. Westerholm in Lindskog 1988:8.
15. Interview with LO official, 2 September 1992.
16. LO, internal document, 1992.
17. Ibid.
18. In the first period (1978–81) OHS was imposed on the industries most exposed to work-related health hazards. The next period from 1988 to 1989 included industries with lower priority.
19. Cf. Nørregaard et al. 1984:18.
20. The regulations have these formulations:"The purpose of OHS is to *prevent* work-related health injury, hereby accidents, illness and wear and tear, by taking preventive measures against physical and psychological work related injuries; and to promote the physical and psychological security and health of the employees" (Ministry of Labour. White Paper no.889, 28.12.1987).
21. Nørregård et al. 1984:16.
22. The conflict became very intense, involving the employers, employees and medical organizations, and central and local public administration. This process is thoroughly described in Steen (1992). In a report from a public commission on OHS problems it was stated that "The development the first years after 1978 must be characterized as disorderly and conflictual" (NOU 1992:20, 19).
23. Quoted from Steen (1992).
24. The questionnaire together with a letter of introduction was sent to the inspectors by the Directorate of Labour Inspection in the two countries in 1992.
25. The reasons for the vertical administrative conflicts in Norway were several. One important reason was local frustration about the lack of administrative resources to carry out inspections as instructed by the central authorities. For a detailed study of these conflicts, see Steen 1992.
26. Lundberg (1982, 159), in his study of the implementation of the Swedish work environment rules, maintains that Kelman is exaggerating about the harmony between the parties of the Swedish labour market. We will assert that the breakdown of the negotiating system in the field of OHS in 1992 seems to suggest that there are long periods of extreme stability replaced by short and intensive sequences of confrontation in the the Swedish labour-market.
27. Wilson (1986, 86) even argues that "American culture has never seemed in the past to produce antagonism between government and industry".

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burdens. The industrial structure in Norway, with small industries, laid the foundation for an especially turbulent employers' protest.

The idea of a common social democratic political culture in the Nordic countries may be useful in accounting for similarities in traditional welfare state activities. However, the differences between the Nordic countries in the field of occupational health services encourage us to search for variations. When welfare is implemented outside the state sector, as in the case of OHS, the potential for conflicts grows. The main reason why they became manifest in Norway, and not in the other countries, was more egalitarian goals requiring interventionist strategies which created a different arena for participation and conflict-solving. The strong coalition between the LO and the Directorate of Labour Inspection was based on egalitarian and anticipatory policies. From their perspective, confrontation was a price well worth being paid in order to avoid compromises about fundamental values related to human health.

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NOTES

1. The first factory supervision laws were enacted in Norway 1892, in Sweden 1889, in Denmark 1873 and in Finland in 1889. In Sweden and Norway (at that time forming a joint kingdom) the initiative for the Acts came unexpectedly from King Oscar II, who appointed a special commission in Sweden. He wrote to the Norwegian Prime Minister about the importance of this issue and the Prime Minister subsequently appointed a commission in Norway (Bull 1953).
2. The latter part of the 1970s, it is asserted, marked the climax of the establishment of the Nordic welfare states. The prevailing ideology in Norway maintained that it was possible to introduce ever new welfare reforms. The period 1975–81 has been described in Norway as the time of the most advanced welfare state (Lafferty 1986). In Denmark the crisis of the welfare state in the early 1970s was probably one reason for a different and less ambitious approach to occupational health care than in the other Nordic countries.
3. Research about work-related health dangers prospered during the 1970s and 1980s. In particular, reports about life-threatening cancer dramatically increased the attention of the public, trade unions and the state.
4. Lag om skydd i arbete, 1958:299.
5. Lag om tilsynen over arbetarskydd, 1973:954.
6. Avtal om skyddsarbete på arbetsplassen, 1969. Avtal om utveckling av företagshalsovård, 1971.
7. Government amendment to the Parliament about occupational health care. 1978 rd. nr. 26, p. 12.
8. This liberal way of implementing OHS was stated in the law on occupational services paragraph no.7. (Lag om företagshälsovård. 29.9.1978. Helsinki). The Finnish practice of giving the employers considerable influence on how to establish OHS will be examined in more detail later.