The uncertain legitimacy of occupational health policies

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Abstract:
Because they deal with issues of bodily integrity and health, the policies managing occupational risks reveal the contradictions of public action in the field of occupational relationships, and the fragile compromises to which they lead. This paper sets out to question the difficulties related to the legitimisation of public policies in the field of workplace health. We analyse the reasons why these policies are difficult to legitimate and present an overview of the solutions that have been elaborated to answer this problem. The recent evolutions of public health policies, notably the arrival of new actors in traditional arenas of negotiation tend to weaken these compromises and force actors to elaborate new modes of action. These evolutions should then be analysed by taking into account other public policies, in order to determine to what extent the management of occupational risks is undergoing the same transformations or if this field remains unaffected.

Keywords: public policies, public health, workplace health, publicity, legitimacy.

Résumé :
Parce qu'elles touchent à l'intégrité corporelle et à la santé, les politiques de gestion du risque professionnel sont particulièrement révélatrices des contradictions de l'action publique dans le domaine des relations professionnelles et des compromis toujours fragiles auxquels elles aboutissent. Ce texte propose d'interroger les difficultés liées à la légitimation des politiques publiques menées dans le domaine de la santé au travail. Il analyse les raisons pour lesquelles ces politiques sont délicates à légitimer et de mettre en évidence les solutions qui ont été élaborées pour répondre à cette difficulté. Les évolutions récentes des politiques de santé publique, notamment l'arrivée de nouveaux acteurs dans les arènes traditionnelles de négociations tendent à fragiliser ces compromis et contraignent à l'élaboration de nouveaux modes d'action. Il est alors intéressant d'analyser ces évolutions en perspective avec celles touchant l'ensemble des politiques publiques pour voir dans quelle mesure la gestion des risques professionnels est soumise aux mêmes transformations ou s'il constitue un domaine à l'écart de ces évolutions.

Mots-clés : politiques publiques, santé publique, santé au travail, publicité, légitimité.

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Many recent studies in the field of political science[1] deal directly or indirectly with the issue of the legitimisation of public policies. These include texts discussing the issue of democratic deliberation[2] in complement to studies of political philosophy[3] and analyses of the innovative mechanisms of popular participation in decision-making in the framework of the so-called "technical democracy" (including Manin 1996).

The aim of this article is to move beyond these questions by confronting them to a new area of public intervention. A lot of studies on deliberation or on technical democracy have been carried out on the basis of policies in which the issue of popular participation in decision-making[4] arose or on the basis of environmental or public health issues.[5] It is therefore impossible to determine whether the mechanisms analysed depend on specific sectors of public action or if they represent a more general evolution of the latter. Applying these questions to the occupational health sector is the first step in order to start answering them, as the analysis of the sector contradicts observations according to which a generalised imperative of publicisation, discussion or deliberation of public decisions exists.[6] On the opposite, decisions or adjudications tend not to be publicised in the social space: only a few directly concerned social groups follow these issues on a regular basis.

In contrast to the prevailing analyses, the study of occupational health reveals the extent to which a society creates "shadow areas" in order to be in a position to carry on a certain number of activities. Without being deliberately supported by all the agents involved in this process, these "shadow areas" are however necessary and are thus defended against the risk of a reconsideration of the existing balances. The aim of the management of occupational hazards is to set an "acceptable" level of risk for workers, which inevitably raises the issue of the definition of an "acceptable" risk: it cannot be defined otherwise than as a socially accepted risk, i.e. justified for the actors involved in the decisional process of definition, and successfully imposed to those who are subjected to the consequences. Thus this risk is first and foremost the result of a balance of power between the actors and groups of actors who have to define, accept or be subjected to it. Public actors recognize this balance of power as "regulation". However, it is

[1] Though it deals with all legitimisation processes related to governments and politicians, the fundamental text on these issues remains Lagroye 1985: 395-467.
[2] See « Démocratie et délibération », *Politix,* vol 15, 57, 2002, and more recently Blondiaux 2008.
[3] The books which best sums up this orientation is Callon/Lascoumes/Barthe 2001.
[4] For information about transport infrastructure, see Lolive 1999 and Blatrix 2002: 79-102.
[5] See the studies about the AIDS epidemic and as a synthesis, Dodier 2003.
[6] Even though some authors underline the ambiguity of these evolutions – see Lascoumes 2001: 303-321.

problematic to announce publicly these decisions which recognise the existence of a risk for occupational populations, since it boils down to acknowledging that despite the regulations on worker protection, certain categories of the population have less rights than others in terms of health.

We posit the hypothesis that these choices can be made and legitimised precisely because their implications are repressed and shielded from the public. Indeed, they become illegitimate and unjustifiable in certain (rare) situations when occupational risks caused by toxic products such as asbestos or glycol ethers[7] (which are also toxic for the environment) become highly publicised.

Thus the frequent media coverage criticizing the acceptance of workplace risks from a social point of view shows that its legitimacy lies partly on its misrecognition. After providing an analysis of the traditional paths of legitimisation of those public policies, we will study some of the current difficulties they face, owing to the increasing media coverage of some decisions.

I - A discrete legitimisation

1 The difficulty of legitimising the differential management of population health

Though occupational health policies deal with public health issues, they have traditionally been associated to the field of industrial relations and imply modes of action that are very different from general health policies. Given the low interest of health administrations for workplace health in France and the division of competences between the Directorate General of Health and the Directorate General of Labour (the latter dealing exclusively with all occupational regulations) it is legitimate to wonder if this sector of intervention actually is part of the public health field.[8] As with all occupational issues (such as wage levels or working hours), one of the main characteristics of workplace risk management is the necessity for the different agents involved in the decision process (including trade union representatives and employers) to reach compromises. In the case of workplace health, these compromises must be reached between independent values that may have little to nothing in common such as worker health or economic viability of some industrial sectors or even job consolidation. These are therefore delicate compromises, as they pretty much depend on the hierarchisation process between those different values, which in turn depends on the agents' position, on the interests they serve and on the hierarchies in force within other sectors of public action or society in general.

The fragility of these compromises impacts the legitimisation processes of these policies. The most widely known aspect of health policies is that they aim to ensure the protection of workers, because it is the one that best meets the official imperatives of public health policies carried out in Western countries, i.e. ensuring population protection. However, compared with the other public health policies, occupational health policies can also be analysed as a part of the differential management of population health. This means that the objectives and the modalities of public action in the field of public health are not the same for everyone and differ according to the status of the individuals, to the circumstances that alter their health or according to whoever is responsible for the degradation of their health. In this respect, workplace health policies, by making workers fully aware of health risks, are discriminatory policies towards employees, who are placed in situations where their protection is lower than that of

[7] On asbestos, see Henry 2007; on glycol ethers, see Jouzel 2006.

[8] This could also be applied to road safety because the Directorate-General of Health started tackling this issue only recently, judging that it did not belong to its competence framework.

other individuals who are not concerned by these policies.
The case of asbestos regulations shows that workers are still exposed to risk situations. The first text regulating the use of this carcinogenic material sets the maximum exposure limit at 2 fibres per cubic meter (f/cm^{3}). However, this maximal exposition limit which reduces risks of asbestosis, a disease similar to silicosis, does not preclude the possibility of carcinogenic risks.[9] This limit has then been frequently lowered to reach 0,1f/cm^{3} in 1996, i.e. 20 times less than the initial threshold. However, in spite of this reduction, the maximum limit still induces theoretical risks of lung cancer caused by asbestos that are three times superior within occupational populations than among other people who have been exposed to the maximal amounts allowed in buildings during their entire life.[10] The analysis of maximum exposure limits to all occupational toxic substances leads to the same conclusions: the policies of occupational risk prevention actually aim at managing the exposure to risks that are already known. This is clearly confirmed by the ability form filled by occupational doctors at the end of the worker's preliminary health inspection: it attests that the worker "has no medical contraindication" to exposure to chemicals classified as carcinogenic, mutagenic or toxic to reproduction (CMR).[11]

Experts are very familiar with this dimension of occupational health policies, but it remains however difficult to grasp for actors who have no particular reason to be interested in these questions. Indeed, as the articles on asbestos management show, the general press never mentions this issue or only refers to it in terms of scandal or malfunction. The idea that the decisions about this material are in no way exceptional compared with other occupational health policies never emerges either.

2 Producing discretion: the creation of a non-problem

Beyond its content, the elaboration of the regulation on the occupational use of asbestos highlights the importance of the role played by employers in the adoption of this regulation. For instance, the 1977 decrees were elaborated only when industrials accepted a compromise. They understood that without the implementation of a minimal regulation, the production of asbestos itself could be threatened following strong mobilisations in the 1970s and their subsequent media coverage. The industrials decided to run negotiations on this issue within an institutional framework, thereby giving an advantage to employer representatives in the balance of power.[12] This strategy proved rather successful as between 1977 and 1996, without any action from the industrials, only two modifications were made to the 1977 decree, i.e. the adaptation of two European directives to French law. Following the point of view of Peter Bachrach and Morton S.Baratz, we may talk of "nondecision" in this field of public action. These two authors indeed suggest considering the decisions that have been made as the result of power relations, but also of the absence of decisions, nondecision:
"But power is also exercised when A devotes his energies to creating or reinforcing social or political values and institutional practices that limit the scope of the political process to public consideration of only those issues which are comparatively innocuous to A."[13]

[9] "It has been acknowledged that this limit (2 fibres per cubic meter) is applied to the fibrogenic effects of asbestos and not to its carcinogenic effects, for which there is presently no data" (ILO 1974: 10).
[10] According to the studies of Inserm experts (National Institute for Health and Medical Research): Goldberg/Hémon 1997: 233-237.
[11] See article 12 of the decree 2001-57, 1 February 2001, on CMRs.

[12] For information on the processes through which employer representatives acquire this central position, see Déplaude 2003: 707-735.
[13] See Bachrach/Baratz 1962: 947-952 (948), in which they clarify the difference between the power manifested by a decision and that which imposes a

In the case of asbestos, the work on values and modes of definition of the problem is perceptible, as the idea of "controlled use of asbestos" has been successfully imposed. This definition, which was first introduced by industrials, is now used by all the actors who have to make decisions on this issue and reveals power relations where industrials clearly have the upper hand. This situation and the policy-making processes remain hardly visible. Indeed, political and administrative arbitrations are made during technical debates within specialized para-administrative organisations such as the *Conseil supérieur de prévention des risques professionnels* (CSPRP), which gathers representatives of syndicates of employees, employers and the State. The debates are therefore limited to the circles of specialists who are directly involved in the issues. As these decisions depend on the domain of regulation and not on the domain of legislation, they have few opportunities to be widely publicised, and are therefore not discussed in arenas with bigger audiences, such as the Parliament. As a result, the actors involved in the elaboration of these norms belong to specialist circles and form a relatively limited group in which the position of employers remains very strong. Besides, the fact that the State has invested very little in the monitoring of the implementation of those regulations helps employers to keep their central role in the decisions. The number of labour inspectors (around 1400) compared with the number of workers (15 millions) or companies (1,5 millions) that they are supposed to control[14] gives a good idea of this state of affairs. In practice, employers and trade union organisations implement and control the application of the norms on occupational risks. The presence of trade unions within companies therefore plays a key role in the implementation or the non-implementation of a text.

Following Peter Bachrach and Morton S. Baratz's research about "nondecisions", occupational risks can be seen as a non-problem, i.e. a problem that many actors seek to render non-problematic. Even though numerous studies have shown that no problem is ever in itself a public or a political problem, but that it has to be constructed and carried by actors or social groups that work to constitute it as problematic, it is worth mentioning that the importance of some potentially problematic issues needs to be constantly lessened, in order to avoid too much public attention (see also Cobb/Ross 1997).

3 An invisible risk

Among the elements contributing to screen the adverse effects of workplace health policies and thus making them more acceptable, the modalities of reparation of the risks play a key role. Indeed, if the management of workplace health consists in keeping risk levels "acceptable" for workers and if an acceptable risk is defined as a risk that is effectively accepted, then it becomes necessary to consider the logic that enable a risk to be accepted by the populations who are subjected to it without raising opposition in other social spaces. The insurantialisation of occupational risks organised by the law of 9 April 1898 for occupational accidents and then extended to some occupational diseases by the law of 25 October 1919 is a factor that makes this acceptance easier (Ewald 1986). For many actors, occupational health is a risk managed by institutions whose role precisely is to indemnify a risk (especially since 1946, the ATMP – the branch of the French social security in charge of occupational accidents and diseases). The importance of occupational accidents and diseases is effectively perceived mainly through the contribution rate set every

non-decision: " In the one case, A openly participates; in the other, he participates only in the sense that he works to sustain those values and rules of procedures that help him keep certain issues out of the public domain", *ibid,* note 11.

[14] Ministry of Social Affairs, Labour and Solidarity, *L'inspection du travail en France en 2006. Rapport rédigé en application des articles 20 et 21 de la Convention 81 de l'Organisation Internationale du Travail*, Paris, Ministère du Travail, des Relations Sociales, de la Famille et de la Solidarité, 2008.

year by the Regional Sickness Insurance Funds (CRAM) for enterprises. Known and socially accepted since specific institutions are supposed to be in charge of it, work-related pain constitutes a factor among others in the organisation of production. Because of the generalization of the financial and insurantial logic, it turns out to be difficult to attribute a responsibility to one author.
By eliminating the notions of blame and responsibility from the recognition and reparation processes, the system set up is both an insurance system and an instrument aiming at normalising and imposing the ineluctable character of occupational risks. In this system, the industrials, producers of the risk, benefit from a situation of impunity. First, this situation is due to the specific rules of the code of social security, since a victim asking for reparation of their occupational disease or accident cannot obtain an additional indemnity in a civil court. It will only be the case if they manage to have the employer's inexcusable fault recognised in a court of social security affairs. Secondly, it is due to the modalities of the application of penal law in social matters and in particular to the very low penalisation of the violations of social law (work and social security law), making very difficult the recourse to law as an element of transformation of these situations of domination (see Serverin 1994: 654-662 and Henry 2003-1: 39-59). In social law, the elision of the responsibility of employers is even more problematic when it comes to occupational accidents and diseases since the bodily security of employees is involved and the violations of the law may have irreversible consequences on their health.

Moreover, most diseases are not recognized as occupational diseases even if they are the result of a professional activity.[15] Evaluating the under-recognition of occupational diseases remains complex, since the only data available are communicated by social security funds, and only take into account cases that effectively led to indemnification. For instance, until the 1990s, every year, only a hundred of occupation-related cancers - according to epidemiologists, there are at least 5000 such deaths per year (Imbernon 2002) - were recognised as occupational diseases. Following a progressive increase, in 2001, 1365 cancers were recognised, including 1149 asbestos-related ones. This only concerns cancers that are well known for their occupational origin, such as leukeamia or mesothelioma, but not systematically, and many other cancers have yet to be taken into account (see Saint-Jours 1995: 520-524 and the numbers released every year by the Ministry of Work during the CSPRP's plenary session). This lack of recognition of occupational diseases contributes to making them even less visible.

II - An increasingly precarious legitimacy

The previously analysed logics which lead to the screening of these public policies can only be fully effective if they are completed by powerful domination mechanisms which contribute to the confinement of pain to dominated social groups and to the localisation of the discourses on this pain within restricted social areas. Nevertheless, in spite of these mechanisms, several current evolutions jeopardise this situation of acceptance and lack of knowledge on the long term. This weakening is first due to the specific character of health compared with all the other dimensions of occupational life, which are the subject of negotiations in the field of professional relations. Indeed, if in lots of areas of labour regulations (such as working hours or wages), compromises reached between trade unions and employers seem, in practice, to be accepted by all the actors concerned, they appear to be much more problematic when it comes to health. Can the physical integrity of employees be an element among others when social partners

[15] Annie Thébaud-Mony's study was the first to shed light on this issue (Thébaud Mony 1991).

negotiate? Can it be merged with other questions of public health? Historically, worker health has only been progressively the object of specific public intervention. Even if the first 19th century social laws were meant to protect some categories of workers from hard working conditions, rather than ensuring good health, they aimed more at guaranteeing their survival in the context of the imposition of capitalism to the first generations of workers (Supiot 1994, Noiriel 1986). Only recently, with the rise of health-related preoccupations in the population, has worker health gotten to be increasingly difficult to negotiate in discussions between social actors and the State. The compromise reached by the 1898 law on the compensation of occupational accidents is part of 19th century social history. Nowadays, this compromise is questioned by a number of evolutions both outside and within the risk management sector. How does an old system, based on solid and deeply institutionalised compromises, react to pressures forcing it to become more similar to the other public health policies while the potential guidelines of a new organization are not yet clear?

1 The increasing publicity on worker health issues

This weakening comes first from the increasing publicity on occupational health issues. For several years now, occupational risks, which used to be dealt with in a very confidential manner, have regularly been exposed in the media. This evolution, which is similar to the evolution of other health issues, happened at a different time and with a different scope for occupational health issues.[16]
The mass media coverage of asbestos can be considered as a trigger event. Ever since, some debates on the professional use of the most well-known chemicals such as glycol ethers, aluminium and lead have regularly arisen. Some pathologies like stress, moral harassment[17] and work-related musculoskeletal disorders (MSD) increasingly appear in the media. Even if this increasing publicity is not always related to a growing interest in working conditions, it differentiates more and more distinctly from other sectors of State intervention in the public health field. As these policies lean on a high level of population protection, how is it possible to justify publicly that in the occupational field, workers are still subjected to significant risks? In the most public spaces, no one takes responsibility for these difficult decisions; on the opposite avoidance strategies prevail, which tend to consider the problem publicised as an exception, a scandal or at least a mismanaged problem on which political actors commit themselves to take the "necessary" decisions. Thus asbestos was essentially problematised in terms of "scandal", to which political actors reacted by banning the product (Henry 2003-2: 237-272, 2004: 289-314). Similarly, some glycol ethers are still used in the workplace even though they have been banned for the general population. It is hard to understand for the broader public why the law is not the same for the professional sector and the general population. These differences enable certain actors (like trade unions and consumer protection groups) to use this incomprehension as a resource in order to demand the ban from the workplace of products that have already been banned for the general population.[18] When political actors make the same demands, it shows that they are not aware of the decisions that have been taken in these areas.[19]

[16] For information about general public health issues, see Girard/Eymeri 1998.

[17] See the success of Marie-France Hirigoyen's book and the debates it sparked (Hirigoyen 1998).

[18] On the ban on glycol ethers in occupational environments, see the stances of the French Democratic Confederation of Labour (CFDT) or that of the Federal Union of Consumers *Que choisir*.

[19] For example, Odette Grzegrzulka and André Aschieri question in a parliamentary report on environmental health safety the differences of treatment between these two intervention sectors: "The case of glycol ethers illustrates the difficulties in

Because of the increasing publicity, new actors intervene in this process and bring new definitions of the problem. The most visible actors are the political actors and journalists. Since they know very little about workplace health issues, they treat them like the questions of public health that they know better. They also bring modalities of definition of problems and goals informed by public health policies for the general population, thereby invalidating a "risk management" approach, which implies a pretty clear awareness of the risks workers incur (as shown by the latest Senate report on asbestos: Dériot/Godefroy 2005). Among the other actors that appear or are reinforced by these evolutions, there are associative actors – such as the national federation of persons who suffered from an accident at work and the disabled (Fnath) or the national association for the defence of asbestos victims (Andeva) – who use the contradictions between workplace health and public health in order to further their cause. Their ability to point out the contradictions of public action, turn them into scandals and thereby force the authorities to better deal with workplace health issues results from a strategic use of these contradictions.[20] Political-administrative actors are perfectly aware of the risk that these associations spread their points of view through the media and are therefore forced to take into account their vision of these issues or even to integrate them into certain arenas of negotiation.

This growing publicity around occupational health issues is accompanied by a judiciarisation that increasingly threatens officials working within labour administrations. As the judiciarisation of public health issues increases, will the administrative leaders of the Ministry of Labour accept to mediate in compromises that maintain a level of risk for employees in spite of the recent jurisprudence of the Council of State, which seems to indicate that the State now has an obligation to achieve results (*obligation de résultat*). in the regulation of worker protection?[21] With this judiciarisation, occupational risks are now increasingly considered as a health or environmental risk among others, and no longer handled according to specific procedures, which can be seen in the rejection of the old regulation imposing to reach compromises with employers (retrospectively regarded as compromises of principle) or through the increasing valorisation of independent expertise forms such as the collective expertise of the Inserm at the expense of the expertise implemented by social partners.

2 Contradictory evolutions

The increasing publicity around occupational health issues weakens the system of actors on which those policies rely and changes the constraints that frame their capacity of action. For example, the imperative of potentially having to expose publicly the reasons for certain decisions that have been taken in the field of occupational health or that explain the outcome of certain compromises has a

constructing a homogeneous preventive policy: 4 substances from this family have been classified as "toxic to reproduction" by the European Union since 1993. This classification results from the accumulation of epidemiologic and experimental data since 1979. In France, the use of these 4 substances in domestic products was only limited by an order issued on 7 August 1997 (…). The public authorities have brought the matter to the attention of the relevant expert committees (CSHPF, CPP, CSC, CSPRP) but until now have not been able to work out a strategy for preventing risks related to glycol ethers, especially in cases of occupational exposure" (Grzegrzulka/Aschieri 1999).

[20] Denis Duclos came to a similar conclusion on this point: "on this issue (maybe more than for other more traditional objects of demand in the trade union struggles), the 'big progress' seems linked to the ability of the social movement as a whole to create 'scandal effects' involving combinations of very diverse actors" (Duclos 1984: 86).

[21] See the judgement given by the Council of State on 3 March 2004, stipulating that the State is responsible for the fact that the 1977 legislation on the occupational use of asbestos maintained a risk for workers.

considerable impact on the universe of these actors, which is normally limited to specialist circles. In contrast to the field of public health, that has increasingly become a public concern since the 1980s, the field of occupational health appears to some actors to be "lagging behind" these current transformations, so that it has been envisioned to have the procedures of intervention of the Ministry of Labour follow those used in the Ministry of Health.

The 1998 creation of the Department of Health and Labour within the French Institute for Public Health Surveillance (InVS), under the exclusive guardianship of the Ministry of Health, constitutes the first element of these transformations. Ever since, the issue of occupational risks has been handled by actors that institutionally and professionally depend on the field of public health. These actors redefine the problem based on their epidemiological competences and attempt to assess and monitor the impact of the consequences of work on health for the general population. This modality of definition of the workplace health issue constitutes a break from the traditional approach, rooted in the companies' social realities and aiming more directly at limiting occupational hazards or at implementing a preventive policy. The sudden emergence of epidemiologists and more generally that of new approaches to public health issues objectivate the effects of work on population health and makes the increasing publicity around occupational health irreversible by gradually providing more and more (solid) data to quantify this issue. The transformation of the AFFSE into AFSSET (French agency of sanitary safety of environment *and work*) can also be seen as the importation of approaches that characterised public health administrations, i.e. the will to separate knowledge and management of risks with the creation of independent expert organisations.[22] Though this creation enables the Ministry of Labour to regain control over the expertise claimed by the InVS, it also implies reconsidering the combination of scientific expertise, social negotiations and the search for an autonomisation of expertise production. In the same way, the importance of occupational issues in the National Environment and Health Action Plan implemented in 2004 (Momas/Caillard/Lesaffre 2003) shows that occupational health issues are handled within larger administrative and political spheres (including the Ministries of Health and Environment) and not only in milieus of occupational health specialists. The debates around the implementation of an integral compensation for occupational risks (which would call into question the compromise of the 1898 law that granted an automatic compensation on a standardised basis) should also be analysed from this perspective. The increasing difficulties to justify a specific compensation for occupational risks question its autonomous management and favour the importation of approaches used for other types of risks. These debates take place at a time when the system of compensation for occupational diseases, based on charts listing activities and corresponding diseases, is no longer adapted, since occupational diseases that are univocally due to certain toxic substances or to certain well known work processes have been taken into account. The evolution of the epidemiology of occupational risks shows more and more diseases which can be caused by several factors (lung cancer being the most significant example). Those diseases do not fit within this system based on the presence or the absence of causalities between a specific occupational situation and the onset of a disease and thus impose to reach new agreements which, to this date, are not quite consensual (Dorion/Lenoir 1992). This specific compensation system is also

[22] For information on the constitution of agencies within the Ministry of Health, see Benamouzig/Besançon 2005: 301-322.

being reconsidered because in many cases, it presents fewer advantages than the general health insurance system in terms of compensations or than specific systems concerning other types of accidents set up since the mid-1980s, such as road accidents (1985), terrorist acts (1986), infractions (1990), blood transfusion (1991), asbestos exposure (2001) or medical accidents (2002). The integral compensation of occupational risks therefore seems increasingly pressing (Lyon-Caen 1990: 737-739, Masse/Zeggar 2001, Yahiel 2002).

These various evolutions in the occupational health sector jeopardise the compromises on which State action is based. Therefore, new modes of public intervention are required, and finding them is hard as there is still no prevailing alternative management model that would enable a global transformation of this domain of activity. Reluctances are observed, which seek to maintain the status quo of the existing system by keeping values, actors and power relations in relatively stable positions.

First, concerning the internal rules of the French Directorate General of Labour (DGT), a charter has been adopted in order to clarify the functioning of the committees within the CSPRP, in particular by separating expertise and social negotiations, but it does not seem to have deeply transformed the power relations between different actors on all occupational risks. The existing disproportion between employers and the Ministry (and trade union organisations) in the ability to mobilise expertise remains, for instance, a structural element that prevents any durable modification in the power relations (Déplaude 2003).

Secondly, though certain logics increase the risk of publicisation of public health issues (through the emergence of associative actors or the increasing publicity around health issues provided in the media), the situation is far from having completely changed within the DGT, which proves to be very little affected by the processes of publicisation of issues (Henry 2004). The functioning of the Ministry remains based on the search for compromises between various actors taking part in the negotiations, the strong European integration of the regulation and the relative lack of interest of political actors regarding problematiques that remain confined to the administrative space.

Finally, this preservation of existing practices can also be observed on the level of the actors involved, i.e. unionists, employer organizations, civil servants working in central administrations, who, as a rule, do not seek to publicise the issues they deal with in these arenas or, due to their highly technical character, anticipate the difficulty in translating these questions into broader and more open spaces of public debates.

Conclusion

The contradictions between the increasing imperatives of transformation inherent to this intervention sector and the considerable obstacles to these evolutions seem to be the result of the modern management system of occupational risks. On the one hand, from the point of view of the general population, this sector of public action cannot completely function based on the same logics as those of the health sector for the general population – the existence of some industrial sectors requires a higher level of risk for workers. On the other hand, the preservation of existing logics apart from the parallel evolutions in sectors of public actions is not conceivable. These contradictions allow for the analysis of the introduction of new legitimisation processes of public policies, which are based on a greater transparency of decision processes, a greater publicity of the debates that lead to decisions and the association of actors concerned by the effects of a specific policy. As of now, it appears difficult to assess whether this evolution tends to spread to all State intervention sectors or if, conversely, a strong inter-sectoral differentiation will durably remain.

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