

The Finnish occupational health service (OHS) system

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OHS system and its performance

In Finland, OHS are not only seen as part of the primary health care system, but also as part of the workplace health and safety system. Occupational health is an integral part of the government policy to develop work life, promote health, and secure adequate, effective social and health services for everyone. The Ministry of Social Affairs and Health formulates the strategy and runs the occupational health 2015 action programme (1). It also supervises the occupational health service and safety systems (2). All important issues concerning legislation and the development of OHS are discussed in the tripartite Advisory Board on OHS at the Ministry, which comprises social partners, the government, the providers of OHS and the Finnish Institute of Occupational Health (FIOH). (3)

The Occupational Health Care Act (1383/2001) obligates employers to organize and pay for preventive services for all workers regardless of the size, industrial sector or form of the enterprise or organization (2). It covers both private and public sectors. Organization of curative services is voluntary, but 93% of workers eligible for curative services have access to them. OHS is voluntary for self-employed persons and entrepreneurs, such as farmers.

The employer can acquire OHS from municipal health centres or private medical centres, the services may be integrated into the enterprise, or enterprises can jointly organize their OHS. In 2007, one third of OHS units were municipal, one third in-plant or joint clinics of the employers, and 40% were private OHS units. Private OHS increased its share by 11% in a relatively short time – between 2004 and 2007. Approximately half of Finland's employees receive OH services from private clinics, one third from municipal health centres and the rest from employers' self-organized services. Sixty per cent of the enterprises, mostly smaller ones, are served by municipal health centres, 36% by private OHS centres, and the remaining 4% organize services themselves. (4)

The number of OHS units has been gradually decreasing over the past ten years, and totalled 663 at the end of 2007. These units serve 1.87 million workers. The coverage of OHS was highest among salaried employees (87%). Sixty-three per cent of entrepreneurs in agriculture, and 37% of other self-employed persons and entrepreneurs organized OHS them-

selves. The coverage was lowest, at 55%, in micro-companies employing fewer than 10 persons. (4)

Several reasons for decreasing the number of OHS units exist, such as the ongoing mergers of small municipalities, and the restructuring of health and social services. The services in the private sector are also going through changes: private OHS centres organized in the form of a chain are operating nationwide, and getting bigger. From the beginning of 2005 to the end of 2007 they gained some 200,000 employees from municipal and employer-organized OHS. Today, it is also possible for municipalities to organize OHS in the form of a public-service company. These totalled 16 in 2007. Municipal public-service companies are already serving one of four employees in municipal OHS. (4)

The employer is entitled to reimbursement from the Social Security Institution (SSI). This covers 60% of necessary reasonable expenses of preventive services, and 50% of curative services. In 2006, the reimbursement sealing value for preventive costs was 145 euros, and for curative services 218 euros/

employee/year. The financing for reimbursements is collected mainly from employers, as a deduction from the payroll for the Sickness Insurance Fund. In the same year, the total costs of occupational health services were 459 million euros, and reimbursement costs were 218 million euros; the average yearly costs per employee was 257 euros, and reimbursement costs 122 euros. (5)

The Occupational Health Care Act (1383/2001) aims at promoting co-operation between the employer, the employees and the occupational health service provider in order to: 1) prevent work-related illnesses and accidents; 2) raise the level of health and safety of work and the work environment; 3) maintain and improve the health, work ability and functional capacity of employees at different stages of their work careers; and 4) promote the functioning of the work community.

OHS is working closely with workplaces to identify hazards and strains at work, assess health risks associated with these, and to prioritize actions together with employers and employees in order to minimize their adverse effects. The focus is on the planning, implementation and follow-up of actions to improve work, the work environment, and work communities in organizations. At the individual level, the focus is on maintaining employees' health and work ability by considering both work-related and public health concerns in health check-ups, and when administering medical care. OHS provides rehabilitation counselling, refers employees for further treatment or rehabilitation as needed, and helps them to return back to work. All actions in OHS should be based on conclusive scientific and/or practical evidence. These principles are expressed in the law, applied in the Good Occupational Health Practice guide (3), and implemented in OHS processes. Continuous quality improvement is required, and OHS should assess and regularly monitor the quality of its performance, and the impact of its actions. According to the latest SSI statistics from 2006, some 5 million medical visits were made to OHS and one million visits for medical check-ups. OHS teams used 285,000 hours for risk assessments, and 260,000 hours for counselling and advisory services.

The core team in Finnish OHS consists of an occupational health physician and an occupational health nurse. In many units, a physiotherapist and a psychologist also belong to this team. Other

experts, who complement the team when needed, are ergonomists, occupational hygienists, construction engineers, agricultural advisors, opticians, dieticians, speech therapists and physical fitness trainers. In 2006, the total number of posts in OHS was 7,300: 2,369 physicians, 2,355 public health nurses, 751 physiotherapists, 316 psychologists, and 799 auxiliary staff. Half of the units had a certified occupational physician. Ninety per cent of the core team members had completed the 11 study point post graduate training, which is required when working regularly in OHS. (4)

Discussion

Higher employment rates in all population groups are needed for maintaining and developing social welfare and economic growth in Finland. Both younger and older workers are needed in work life. Despite the economic recession, the focus of the Finnish government policy remains the same: to extend the working career of the working population, maintain the good health and work ability of the population, and to offer adequate social and health services. OHS plays an important role in the implementation of this policy. (2)

There is a consensus among stakeholders to keep OHS viable. This is reflected in legislation and regulations, strong institutional support, and in the work of employers, employees and OHS professionals. As OHS in Finland provides comprehensive prevention, promotion, and curative services, it is in an excellent position to encourage the employer and employees to discuss safety and health issues, and to define corrective actions. This is particularly important in small and medium-sized companies which have less resources and are seldom visited by safety inspectors. Workplaces can benefit from OHS' multidisciplinary expertise. Moreover, OHS allows control of the work environment, work community and personal factors in maintaining and improving health, well-being and the work ability of workers. It also follows the public health approach, which is becoming as important as the control of hazards at work.

The strengths of OHS in Finland are health promotion at both the individual and workplace level, the recognition of lowered work capacity, rapid diagnosis, treatment, and rehabilitation. Rapid, easy access to service improves the quality of life and maintains the earning po-

tential of a worker. It saves the costs of companies and society at large. Special emphasis has therefore been placed on improving the early detection of lowered work ability. From the health system's point of view, building seamless service chains between primary health care, specialist health services, and rehabilitation is important – this is the focus of the present health and social services reform. A centralized national electronic system of keeping health records and following the patients' contacts in health services is under construction in the SSI and will be available in 2015.

The coverage of OHS is high among salaried employees. Self-employed entrepreneurs have had access to comprehensive OHS, including both preventive and curative services, from the beginning of 2006. Since then, many have joined OHS, but the coverage is still low among micro companies and self-employed entrepreneurs. The goal should be full coverage of all working people (actively employed and unemployed) in Finland. Special research and development projects for small and medium-sized enterprises are in progress at FIOH.

New ways to organize OHS have been initiated in order to improve services particularly in small municipalities and areas in which it is difficult to attract qualified OHS professionals. A regional OHS model, a public enterprise model, and a joint venture model of public and private OHS are some of the recent developments. It is still too early to draw conclusions on their effectiveness, but studies are underway. However, it already seems that a bigger unit size would be more feasible. For example, multidisciplinary is now being realized in OHS units serving more than 4,000 people. Adjustments have been made to make the compensation system meet the demands of new OHS organization models.

Competent OHS personnel is necessary in order to provide quality services, and the current situation is satisfactory. However, the number of specialized occupational health physicians is still insufficient, and core competences and minimum training requirements have now been set for all OHS professionals. Postgraduate training in OHS has been going on for many years at FIOH, universities and polytechnics for public health nurses, physiotherapists, psychologists, and other OHS specialists. Four-year specialization studies are required to become an occupational health physician, and increased number of specialisation

posts and educators in the universities and FIOH have led to the number of graduates doubling. Multidisciplinarity has been strengthened already by offering joint courses for occupational health physicians, nurses, physiotherapists and psychologists for several years. A virtual university for occupational health has also been running since 2005.

The content and practices of OHS need to be researched and developed continuously. The second edition of the Good Occupational Health Practice guide was published at the beginning of 2006. Evidence-based OHS practice guides are available on several topics, such as work-related upper extremity disorders, occupational asthma, and depression. FIOH will continue to co-ordinate the Cochrane Occupational Health Field, and produce systematic reviews (6). At the OHS unit level, FIOH has developed a self-assessment tool called the 'Quality Key', which is currently in use in many OHS units.

Regular surveys of OHS activities, working conditions and activities related to the maintenance of work ability, combined with the OHS statistics collected by SSI will form a sound basis for the formulation of health policies and strategies in the future. In addition, FIOH and other national research institutes complement statistics and survey data with the results of targeted research and action-oriented development projects. A firm legal base, long traditions in negotiating occupational health and safety matters between social partners, together with the existing reimbursement system have enabled systematic continuing development of OHS in Finland.

Conclusions

- Occupational health enjoys strong societal support, has a firm legal basis, and is supported by specialist organizations
- The coverage remains high among salaried employees, but is still low among the self-employed and private entrepreneurs for whom OHS is voluntary
- The services have shifted to private OHS clinics, and the number of public-service companies is increasing
- The size of OHS units is still small in terms of the number of clients, although the proportion of bigger units is increasing
- The number of qualified personnel is developing favourably, especially in private OHS clinics and public-

service companies, although physicians are still in demand, in municipal health centres in particular

- The level of OHS preventive activities has not increased as well as expected, as focus is still placed on primary care, particularly in physicians' work
- OHS processes and collaboration with workplaces should be further developed based on the results of health service research and evidence of the effectiveness of interventions; e.g. early detection and support models for workers suffering from stress and depression and other conditions which lower work ability.

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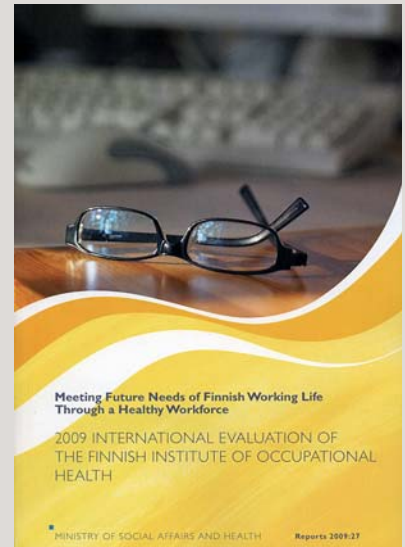
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International evaluation of FIOH

The Finnish Institute of Occupational Health (FIOH) was evaluated by an independent international evaluation group of experts appointed by the Ministry of Social Affairs and Health. The evaluation covered FIOH's activities in 2006–2008: policy relevance and results, and operational efficiency in innovations and quality. The evaluation report is available at www.ttl.fi/evaluation2009.

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