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The status of occupational health services in Finland and the role of the Finnish Institute of Occupational Health in the development of occupational health services

Report for the international evaluation of
the Finnish Institute of Occupational Health (FIOH)

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1. Occupational health services in Finland

The occupational health services (OHS) system is preventive health care that the employer has a duty to arrange by law.

The foundation for OHS in Finland is the Occupational Health Care Act of 1978 (reformed in 2001) and the Government Decrees issued on the basis of this Act. One of the Decrees defines the principles of Good Occupational Health Practice (GOHP), the content of OHS and the education and training of professionals and experts, and the other defines medical examinations in tasks with a special risk of illness.

In co-operation with the employer and employees, OHS aim to prevent problems resulting from work on one hand, and to promote employees' health and work ability on the other. According to GOHP, OHS is a continuous process that includes workplace needs assessment, operational planning, actual operations, monitoring and assessment as well as continuous quality improvement. It also includes good professional practice, multidisciplinary and multiprofessional operating procedure, necessary information about workplace conditions and co-operation as defined in the Occupational Health Care Act.

The statutory tasks of OHS include

- assessment of the health and safety aspects of the work
- assessment and monitoring of employees' health and work ability
- making initiatives for improvement and monitoring their implementation
- advice and guidance
- monitoring employees with disabilities and referring them to rehabilitation
- co-operation with representatives of other health care services and social insurance
- participation in organizing first aid at the workplace
- participation in activities that maintain work ability
- monitoring the quality and impact of occupational health care activities.

In practice, OHS carry out these tasks by conducting workplace assessments, medical check-ups, providing individual and group advice and guidance, as well as occupational health negotiations.

The Occupational Health Care Act applies to all employers who have at least one salaried employee in the company. For entrepreneurs and the self-employed, the arrangement of OHS is voluntary. OHS shall be implemented as required by the work, working arrangements, personnel and workplace conditions, and any changes in these. Employers can also voluntarily arrange GP level medical care and specialist consultation for their employees, in which case the responsibility for care remains with the OH physician.

The occupational safety and health authority monitors whether or not the employer has arranged OHS. An employer or his representative who deliberately or through carelessness neglects to arrange OHS may be fined. Medical supervision of OHS is the responsibility of the Ministry of Social Affairs and Health as well as the Regional State Administrative Agencies.

Municipal health centres are obliged to provide OHS for companies and entrepreneurs located in the municipality. In addition, the employer may independently arrange their own OHS ("integrated OHS") or do so together with other employers (usually in the form of an

association) or by acquiring the services from another unit entitled to provide OHS (usually a private clinic). During the past few years, the share of integrated OH units among the service providers has decreased and that of private clinics has increased. OHS provided at public health centres is increasingly arranged as municipal public utilities and limited companies.

OH professionals are persons who are qualified as a licensed physician or a public health nurse and have the necessary training to perform OHS. In the case of a licensed physician working full-time in OHS, this means specialisation in OHS. A public health nurse as well as a part-time physician must acquire OHS training of a minimum of seven credit units within two years of working in OHS.

OHS experts, on the other hand, are persons who are qualified as a physiotherapist or a psychologist or who have education or training in occupational hygiene, ergonomics, technical or other similar fields (such as agriculture, optometry, nutrition or physical exercise). In addition, they must possess sufficient knowledge of OHS. Specialist physicians in an area other than OHS are also considered experts. This mainly refers to consulting specialist physicians of different fields.

The employer is entitled to receive compensation for necessary and reasonable costs incurred by OHS. The Social Insurance Institution (SII) pays this compensation out of earned income insurance for which contributions are collected from employers (73%) and employees (27%). The maximum amounts of acceptable costs have been defined separately for statutory tasks (EUR 160 per employee in 2012), with a 60% compensation, and for medical and other health care (a maximum of EUR 240 per employee), with a 50% compensation.

On the basis of compensation applications submitted to the SII, 86% of wage earners were covered by OHS in 2010 (Figure 1). Of these, nearly 90% had access also to medical care. In the same year, the accepted OHS costs were EUR 626 million (Figure 2), of which 38% were incurred by preventive services and 62% by medical services. OHS (including student health care) costs constituted 4.2% of the total costs of the Finnish health care. Compensation paid to employers by SII with regard to OHS amounted to EUR 285 million, of which preventive services were 44% and medical care 56%.

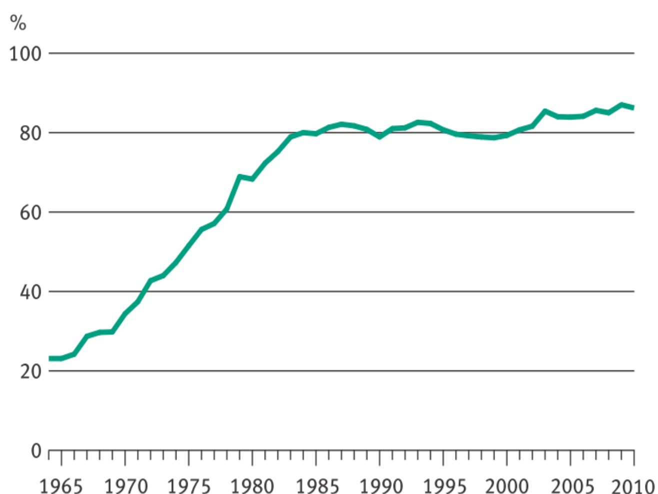

Figure 1. *Share of employees included in occupational health care (of the total workforce working as wage earners)*
(Source: Kansaneläkelaitos (2012) Kelan työterveyshuoltotilasto 2010)

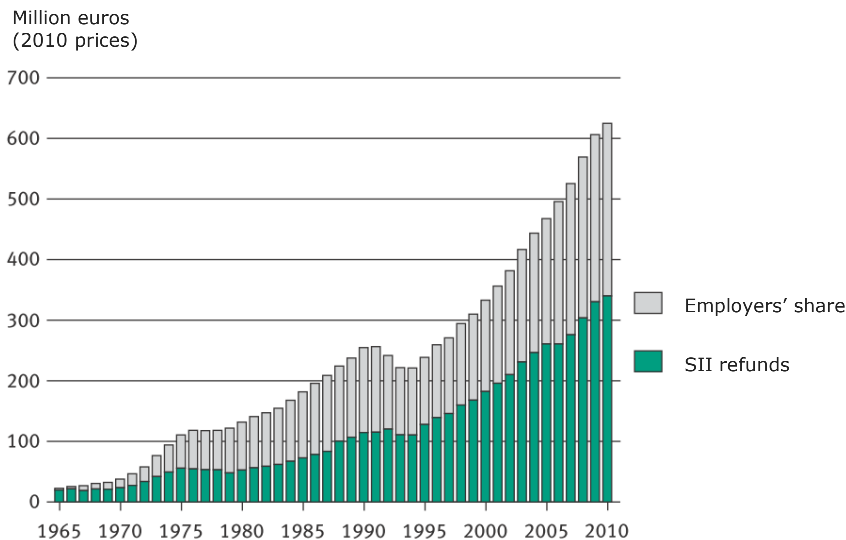

Figure 2. *Occupational health care costs and refunds*
(Source: Kansaneläkelaitos (2012) Kelan työterveyshuoltotilasto 2010)

2. Development of occupational health services in Finland

Throughout its history, the Finnish OHS system has tried to find the optimal balance between medical care and preventive services. The justification for and developments in OHS have highlighted preventive services, but in practice, medical care has increased and gained more emphasis.

2.1 "The early days: workplace health care"

The development of OHS in Finland can be divided into five phases. The first phase, workplace health care, arose in large workplaces from the employers' needs and from the lack of primary public health care towards the end of the 19th century and expanded strongly in the 1960s. In 1964 OHS already covered a quarter of wage earners and this share continued to increase until the enactment of the Occupational Health Care Act. Workplace health care kept its role as the provider of primary health care for the employed especially in Southern Finland and in large population centres despite the strengthening of public health care after the Primary Health Care Act of 1972 entered into force.

2.2 "Statutory preventive OHS"

The second phase, preventive risk and work environment oriented OHS, arose from the need to prevent health hazards caused by industrialisation. The enactment of the Occupational Health Care Act in 1978 aimed especially to increase preventive measures focusing on work and working conditions and improving the coverage of OHS. The Act dictated that the arrangement of preventive OHS was obligatory for employers. The key OHS processes, such as workplace assessment, action plans and medical check-ups, were formed at this time and are still part of the core of OHS.

The possibility to continue arranging medical care in connection with OHS and to receive compensation for this was recorded in the Occupational Health Care Act. This solution sought to secure the continuity and compensability of workplace health care arranged by large workplaces for a long time. Medical care was also included in OHS because, in the 1970s, the funding and development of the public health centre system concentrated heavily on Eastern and Northern Finland and the availability of basic health care in Southern Finland and large population centres was still poor (Lehto 2013). The idea was that medical care in OHS would

only complement the responsibility of public primary health care and that this would help in detecting work-related problems in time.

An extensive study on the achievement of the objectives of the Occupational Health Care Act, conducted in 1985, indicated that the coverage of OHS had improved. However, the Act's objective of increasing preventive services was achieved only in part. As a whole, activities centred on medical care and medical examinations although workplace-level preventive measures had increased (Kalimo ym. 1989, Sosiaali- ja terveysministeriö 1989). In order to develop OHS, the Advisory Board on OHS of the Ministry of Social Affairs and Health prepared a national development strategy (Sosiaali- ja terveysministeriö 1989), containing 18 development items, which aimed to extend the coverage and content of OHS. For instance, the compensation system was to be developed to provide better support for preventive measures.

2.3 "Expansion attempt to assume the role as a resource for workplace development"

The third phase in the development of OHS, the expansion attempt to assume the role of a resource for workplace development, was formed as a response to several elements in the 1990s. In order to be able to influence the new working conditions and work ability of the working population, OHS endeavoured to expand its competence, operating procedures and role to become resource for workplace development.

Nevertheless, despite a great deal of enthusiasm, the expansion attempt remained half-finished for several reasons. In the early 1990s, the start was complicated by the great economic recession. Conflicts related to the expansion also later appeared. Particularly with regard to the compensation of costs of OHS activities focusing on work and workplace, clearer boundaries were defined between which activities should be financed and organized by the workplace itself and which activities belonged to compensable OHS. The definition of these boundaries returned OHS back to their narrower, risk and work environment orientated role. Participation in workplace development was no longer considered a task of OHS.

2.4 "New compensation system and Good Occupational Health Practice"

The OHS compensation system was reformed in 1995 with the aim of increasing preventive services arising from the needs at the workplace. According to a study on the change in the compensation system, in 1994–2000, medical appointments increased with all service providers, the amount of workplace assessments mainly decreased and the amount of medical examinations, advice and guidance grew slightly (Pitkämäki 2006).

After the expansion attempt in the late 1990s and early 2000s, the aim was to develop OHS by describing the key processes and recording them in the Good Occupational Health Practice (GOHP) (Manninen ym. 1997). The previous exposure and work environment orientated OHS model, mostly established in the 1980s, became the starting point for the process descriptions, complemented by information provision and advisory activities, among other measures. In addition, the Occupational Health Care Act was reformed in the early 2000s, with the aim of strengthening the role of OHS and its contribution to preventive services both in the development of working conditions and in the promotion of employees' work ability. The Act also regulated the activities of occupational physiotherapists and occupational psychologists so that their activities must always be based on a needs assessment made by an OH physician or an OH nurse.

2.5 "Medical care orientation intensifies"

The medical care orientated OHS of the 2000's arose from both the crisis in public health care and the restricted opportunities for a more extensive workplace co-operation as described above. The economic recession of the early 1990s, the crisis in public finances and the resulting poor availability of physician services particularly in primary health care opened new opportunities for utilising the possibility to provide medical services included in the Occupational Health Care Act. On the one hand, public primary health care, struggling with resource difficulties, started to systematically direct citizens to OHS for treatment if these services were available. On the other hand, chains of private clinics expanded medical services related to OHS in order to fulfil customer demand while at the same time increasing their revenue.

As a result, during the 2000s private clinics increased their number of customers from 550,000 to 950,000, which is approximately half of employed workforce (Figure 3). The volume of physician workforce in OHS increased, too. Companies were outsourcing their integrated OHS and organizing competitive bidding for new service providers essentially using criteria related to medical care. OHS units that had conducted preventive measures well were even outsourced on the grounds that the employer and the employees did not consider the flexibility of medical care sufficient. In 2013, 75% of physicians working in OHS are operating in the private sector. As a whole, in the 2000s, the physician workforce increased more in OHS than in other health care sectors (primary and specialist health care. Towards the end of the 2000s, this started to stir criticism among other parts of the health care system with regard to the unequal distribution of health services among the population and the allocation of physician resources.

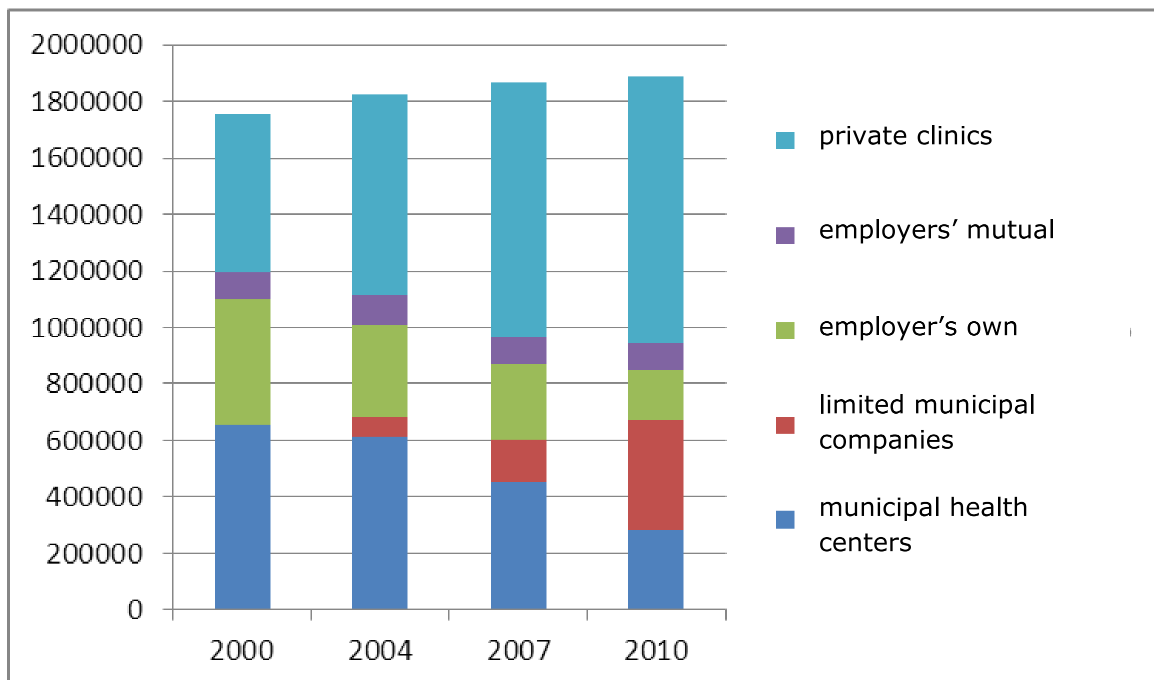

Figure 3. *Number of individual clients in different occupational health service units (Sauni ym. 2012)*

During the 2000s, the number of occupational physiotherapists and occupational psychologists did not increase significantly despite the great occurrence of work disability related to mental and musculoskeletal disorders. (Sauni et al. 2012).

The compensation system set no other barriers or restrictions to the expansion of medical care other than the maximum compensation amount. In the revision of the compensation system in 1995, the maximum amount had been set at approximately one third higher than the corresponding maximum compensation amount for preventive activities, in line with the extent of these activities at that time. Primary health care that was guaranteed and more readily available through OHS than for the rest of the population became a sought-after benefit for employees and a recruitment asset for companies when competing for talented personnel. Consequently, medical care was in practice gradually turning into the key content and the core of OHS (see Seuri ja Räsänen 2006). Medical care started to dominate especially occupational physicians' activity (Figure 4).

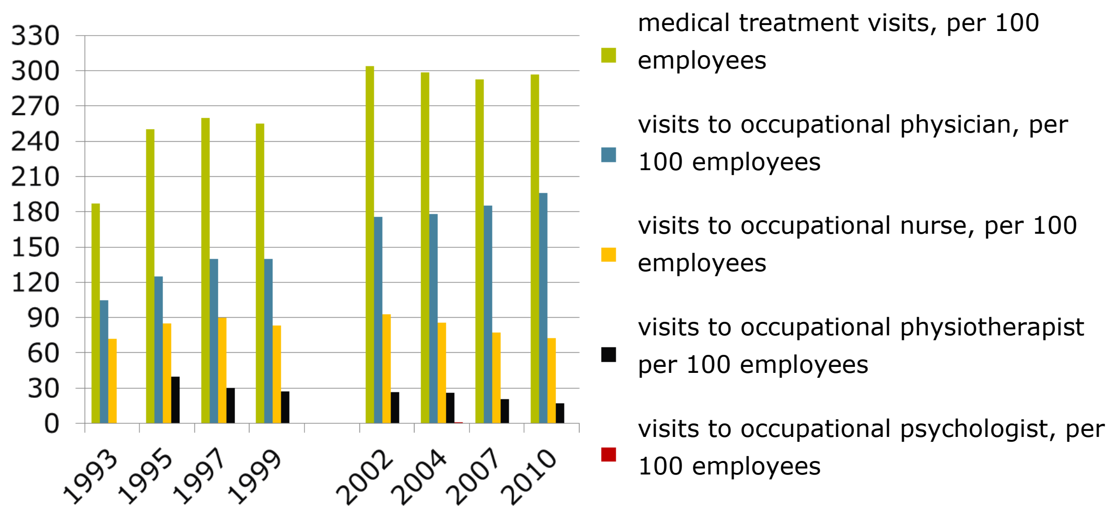

Figure 4. *Number of medical consultations of occupational health professionals*

In 2010, practice guidelines for medical care in OHS were published, emphasising the benefit of medical care for preventive activities and work ability (Työterveyslaitos 2010). For long this has been considered a particular strength of Finnish OHS. Nevertheless, existing statistics and research do not support the hypothesis that information on working conditions that is obtained in connection with medical care leads to preventive measures and early support for work ability (Figure 5) (Kansaneläkelaitos 1996, 2002, 2005, 2007, 2009, 2009, Ikonen 2012, Soini and Suuronen 2011).

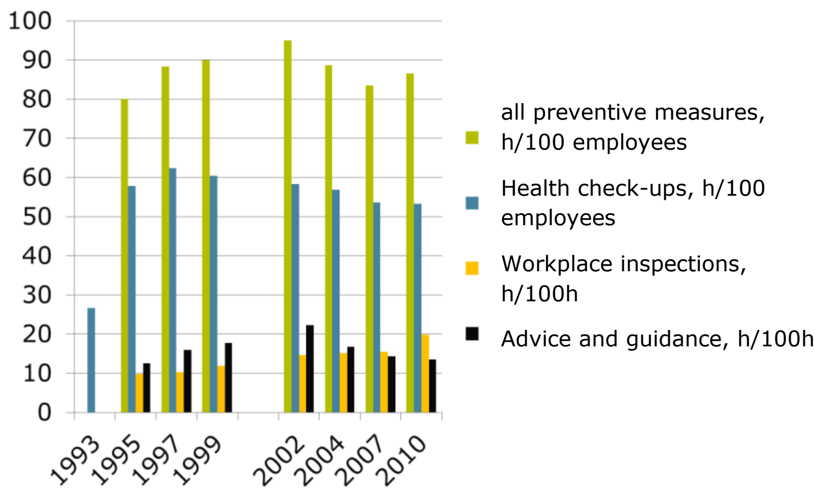

Figure 5. *Amount of preventive measures in occupational health services*

2.6 Economic crisis draws attention to the prevention of work disability

A clear turn in directing OHS towards the prevention of work disability took place in the late 2000's. However, already in the mid-2000's, sickness absence management and early support models for workplaces had started to appear on the OHS and workplace agenda (STM 2007, Antti-Poika 2006). This was in part an international trend (sickness absence management in the Netherlands, for instance) and in part a reaction to the Finnish sickness absence and disability pension costs that had remained at a high level.

Towards the end of the 2000's, new OHS development proposals were processed in several working groups. A key stimulus for these proposals was the fact that the economic growth that had continued throughout the 2000's came to an end due to the financial crisis of 2008 and resulted in economic recession and uncertainty. The sustainability gap in public finances and the alarming population dependency ratio as well as the question of raising the retirement age became the core issues in social dialogue. Consequently, raising the retirement age and extending working careers started to become the key objectives of the social security reform and also of OHS.

The SATA Committee, tasked with the preparation of the social security reform, proposed that the OHS compensation system be changed so that activities that promote work ability and prevent work disability would become more effective. In practice, this pursued a more wide-ranging implementation of sickness absence monitoring conducted in co-operation with workplaces (Sosiaali- ja terveysministeriö 2009). This would be encouraged by applying a compensation percentage of 60% (instead of 50%) to preventive activities in OHS. The related change to the Health Insurance Act was implemented at the beginning of 2011.

Other working groups (Ahtela 2010, Sosiaali- ja terveysministeriö 2011a, Sosiaali- ja terveysministeriö 2011b) proposed that OHS be redirected so that, in order to reduce the number of new disability pensions, the promotion of work ability and support for continuing at work were introduced as new focal points alongside the prevention of work-related health hazards. Closer co-operation between the employer, OHS and the employee, for which a new term "occupational health co-operation" was coined, is regarded as a key prerequisite for this.

On the basis of these proposals, several projects have been launched in 2013: reforming the Government Decree on the Good Occupational Health Practice, updating the related guide and building an OHS quality system. To develop the assessment process for work disability, the

working group proposed that a special OHS statement be required in cases in which work disability continues for a period longer than 90 sickness allowance days. The related amendments to the Health Insurance Act and the Occupational Health Care Act entered into force on 1 June 2012. It is still too early to assess the diffusion or impact of these changes.

The official control of OHS is conducted through legislation, funding criteria, training and education, as well as research and development. Since the 1990s, the aim has been to strengthen control by publishing a good practice guide on the key OHS processes (Manninen ym. 2007), compliance with which has been supported through legislation and partly also through funding criteria.

3. Control of occupational health services and mechanisms that have influenced development

3.1 Tripartite co-operation

Particularly characteristic of the official control is close tripartite (government authorities, employer and employee representatives) co-operation, in which the Social Insurance Institution of Finland (SII), the FIOH and organizations representing OH professionals also participate. Nevertheless, this co-operative body does not outline criteria of funding and refunds; for this purpose, the SII has its own advisory board on OHS. In practice, strategies concerning compensability are discussed and prepared in the Work Section of this advisory board that consists only of the representatives of the three largest employers' and employees' organizations and the Ministry of Social Affairs and Health. The FIOH has not been admitted to membership of the Work Section. The role of universities in the tripartite co-operation has remained smaller, and service providers have no direct representation in it. This tri- or multipartite control is intensely consensus-seeking and applies a top-down approach.

3.2 Legislative efforts

Control of OHS through legislation (laws and decrees) has been rather active. The Occupational Health Care Act of 1978 has been reformed (e.g. in 1991, 2001, 2012) as has the health insurance legislation of 1964, essential for the funding of OHS (e.g. in 1969, 1978, 1995, 2011, 2012). After the enactment of the Occupational Health Care Act 1978, the legislative amendments have not been substantial. Decade after decade, proposed amendments to law repeat the aim of increasing preventive activities focusing on working conditions and employees' health while also preserving medical care in OHS. Legislative amendments concerning funding, that is: the compensability of OHS, have also included minor incentives encouraging preventive activities without changing compensation for medical care. Several studies on the diffusion of GOHP indicated that in OHS units included in the study, the good practices described in the Decree and the guide are used only to a small extent (Palmgren ym 2008, Laine ym. 2009, Savinainen ym. 2010). Consequently, the impact of legislative amendments on practical activities after the enactment of the Occupational Health Care Act have been minor. The impact of the latest legislative amendments that aim at making periods of work disability shorter cannot yet be assessed.

3.3 National development strategies

In addition, medium-term development strategies have been prepared in tripartite co-operation in 1989 (Sosiaali- ja terveysministeriö 1989) and in 2004 as a Government Resolution called 'Occupational Health 2015' (Sosiaali- ja terveysministeriö 2004). Assessment of 'Occupational Health 2015' shows that in 2004–2012, the development strategy objectives were achieved only in part. The main shortcomings were discovered in

increasing the OHS activities focusing on the workplace and in developing human resources, information systems and ethics in OHS. Coverage, especially with regard to small workplaces, has hardly improved either. (Husman 2012)

3.4 Role and functions of FIOH

The FIOH is the most significant body that provides OHS professionals and experts with training leading to a qualification. In addition, universities of applied sciences offer training leading to a qualification for OH nurses and occupational physiotherapists. At universities, professors of OHS are responsible for the content of degree programmes for specialist physicians in OHS. On the basis of regular evaluation of qualification training provided by FIOH as well as the feedback received, the quality of training is good. However, development needs have been discovered in the content of the training and pedagogic solutions. With the support of the Ministry of Social Affairs and Health, an extensive training development project was launched in FIOH and in the universities of applied sciences in 2013.

In addition, FIOH has developed operating models, new practices and electronic tools to be used in OHS units. On a smaller scale, there have also been regional and nationwide development activities in co-operation with OHS units. The impact of new methods and operating procedures on the changing of OHS practices has not been very significant. Joint development in co-operation with service providers has proved more fruitful, but coverage is substantially more modest and development has not reached all service provider groups as hoped. To some extent, the weak impact of information-based control has resulted from the manner in which OHS is arranged and from changes that have taken place in services. In part, the diffusion of new methods and operating procedures has been slowed down or impeded by the principles adopted in the compensation practice of the SII with regard to the definition of boundaries between OHS and activities for which the workplace is held responsible.

The significance of the official information-based control (legislation, good practices, new information, new methods) for the development of the content and practices of OHS has proved rather modestly although communications from the FIOH have been active.

3.5 Funding criteria by the SII

The funding criteria by the SII are considered the most effective of the means of official control. As the compensation level is as high as 50–60% of OHS costs, it significantly guides their activities and utilisation. The SII has bound its compensation practices to the Occupational Health Care Act and the principles of GOHP. However, the SII must interpret these extensively in order to solve practical compensation issues.

The publicly expressed aim of the compensation system is to support preventive OHS. However, in practice GP level medical treatment in OHS is compensated up to the maximum amounts without questioning. However, the planning, content and methods of preventive activities are inspected carefully before making compensation decisions. This procedure is applied especially if the costs of preventive activities have increased significantly in the previous year. In the event that the content of preventive activities does not correspond with the SII's interpretation of OHS compliant with law and good practice, the compensation will be refused in this respect and the costs of the activities will be payable by the employer in their entirety. In practice, this has led to a situation in which the expansion and development of preventive activities have been partly transferred away from OHS and placed under well-being at work activities.

Activities that OHS carries out in co-operation with the workplace – and which many legislative amendments and development strategies have aimed to increase – have proved especially difficult in terms of compensation. At the core of the problem is the question of which part of the development of working conditions belongs to the normal activities of a workplace and in which development activities OHS should participate. On the one hand, the idea is to prevent the utilisation of SII compensation to fund activities that are the responsibility of workplaces; on the other hand, OHS should participate in developing everyday operating procedures and working conditions in a healthier and safer direction at workplaces. The spirit of the Occupational Health Care Act is that the objectives of the Act are promoted through co-operation among the employer, employees and occupational health care.

3.6 Development of the health care system as a whole

The slowly aggravating crisis in Finnish primary health care influenced the development of OHS in the 1990's and 2000's more than any of the forms of official control. It has significantly increased the need for medical care in OHS. Legislative amendments supporting preventive activities or other information-based control have not been able to resist this force.

4. Future drivers and scenarios of change

In this section, we will take a closer look into the drivers of change that will impact OHS in the future and scenarios that can be derived from these drivers. In addition, we will present suggested actions to be executed by FIOH under different scenarios.

4.1 SCENARIO A: An extensive reform in primary health care

The crisis in primary health care described above is culminating in Finland. In October 2013, the National Institute for Health and Welfare published an initiative to strengthen Finnish primary health care (Erhola ym. 2013). The initiative proposes that the availability of outpatient physician services be improved by expanding the possibility of providing them to the private sector and the third-sector service providers, by reforming the funding of services so that money follows the patient and by increasing the customers' opportunities to choose their physician. The initiative also suggests that OHS focus on its basic task by increasing the maximum compensation amount and the compensation percentage of preventive activities. FIOH has participated in the preparation of the initiative and supported it with a public statement.

OHS providers, both public and private, would probably join the new arrangement as service providers and employees/citizens could, if they wished to do so, choose them as their care service providers. It would also be likely that OHS units could continue to provide medical care, but the content and scope of the services would be agreed with a strong health care organizer and within the framework of capitation-based funding. Part of the personnel currently working in medical care in OHS would become operators in primary health care organized within the framework of the new agreement – even employed by the same private clinic, for instance.

Preventive OHS would still be arranged with employer-specific agreements based on the needs of the workplace. In co-operation with the workplace, OHS would concentrate on improving work and working conditions and preventing incapacity for work. Employers could still sponsor curative services exceeding the basic level for their employees through private insurance or sickness funds, if they wished to do. Nevertheless, these could be influenced by what happens to SII's compensation for the costs of private medical care in the future.

4.2 Developmental actions of OHS in scenario A

The reform described above contains both threats and opportunities. When the reform gradually starts, the following two aspects should already be developed in order to prevent the threats from being realised. Firstly, the participation of OHS in the preventive and corrective measures at the workplace should be intensified. The maximum amount of the compensation category for preventive activities should be increased considerably from the current level, and the possibility of increasing the compensation percentage should be reviewed, taking especially small workplaces and self-employed persons into account. All current obstacles and restrictions related to legislation and the compensation criteria should be removed from obstructing workplace co-operation while keeping in mind the definition of boundaries with regard to other services that develop work life. The opportunities of occupational physiotherapists, occupational psychologists and other experts as defined in the Decree to operate in workplace co-operation should be improved.

The increasing role of OHS in workplace co-operation requires that the roles and co-operation of all of the current workplace-level operators be reviewed. In the current system, at least three separate parties in addition to OHS analyse the healthiness of working conditions in the workplace and employees’ well-being, each from its own point of view and within the framework of the legislation applicable to it. First, workplaces have a statutory occupational safety and health organization that participates in risk assessments for which the employer is responsible and in the preparation of the OHS action plan for the workplace. Second, in larger companies HR administration prepares its own plans for the development of the personnel’s well-being and competence each year. Third, recent development has led toward a situation in which immediate supervisors have responsibilities in the areas of safety, well-being at work, early support and competence development. In addition, external experts are also hired by the employer operating in the workplace, at least some of whose assignments are related to the same themes.

Each of these four parties (functions) have traditional responsibilities that are currently changing and expanding as the issues to be managed and problems to be solved have changed. The concept of the management of work ability and well-being at work aims to take a holistic approach and highlights the considerable opportunities for saving resources, improving the impact of different parties and supporting immediate supervisors in workplace development. First and foremost, this type of more comprehensive view of workplace development parties might provide a better understanding of the role and opportunities of OHS rather than viewing the situation solely from the point of view of the OHS function. This would require the development of both legislation and the common tools and processes of the parties.

The second aspect that should be strengthened in connection with the reform is the division of labour and the flow of information, particularly with regard to sickness absences, both between OHS and other health care sectors and between workplaces and OHS. For the speciality of OHS, this would mean a new type of orientation: moving away from general practice of working-aged people with certain work-related emphasis areas and becoming a speciality of treatment and prevention of work-related diseases consulted by other health care sectors.

The extensive health care reform could also offer a chance to review the possibilities of OHS to also adopt the responsibility for services supporting work ability of unemployed persons. OHS has the best competence for this in the entire health care system. In this case, the entire workforce would be included within the scope of OHS expertise.

4.3 SCENARIO B: Deepening crisis in public finances

The second future driver of change influencing OHS is the deepening crisis in public finances. The Finnish economy is afflicted by both the structural problem related to economic growth and the sustainability issue in public finances.

It is possible that in such a grave economic situation, the government would not initiate the overall health care reform described above but on the contrary try to preserve the multi-channel funding solutions that have already been created in the different health care sectors and that lighten the burden on public finances.

In the current situation, employers voluntarily finance the medical care of their employees by approximately EUR 400 million per year, of which the earned income insurance compensates approximately 160 million (Kansaneläkelaitos 2010). It is possible that the government cannot afford not to use this private share of funding and the earned income insurance system that lightens the burden on public services and funding. In addition, the diminishing public health care would encourage citizens to complement their health care with different private individual- and group-based insurance policies. Finland would begin to gradually move from tax-based health care funding towards an insurance-based health care funding model, despite the increase in differences in health that this may cause. In this case, the earned income insurance would function as the health care insurance for the employed, possibly complemented with employer-specific medical expenses insurance or a sickness fund system.

This could lead to a situation in which the primary health care of the employed would be more clearly and comprehensively transferred among the tasks of OHS funded by employers and the earned income insurance. This would probably require that medical care is no longer voluntary in OHS and its arrangement to a sufficient extent would be made obligatory and statutory for all employers. In order to even out the funding shares of employers, employees and the state, the current earned income insurance accrual contributions would probably need to be reviewed. The earned income insurance could more clearly be directed for use as health care insurance for the employed. Due to legislation and international commitments, preventive tasks could not be discontinued, but in practice the change might lead to their significant reduction in order to ensure sufficient resources for medical care and to provide funding for expanding medical care. Instead, the important task of OHS with regard to putting an end to prolonged work disability or fighting the threat of prolonged work disability could be preserved. However, the increasing pressure on medical care would probably complicate the execution of this task.

In the event that OHS would become more clearly the primary health care of the employed, there are three aspects that should be strengthened. Firstly, in case of work-related diseases, the obligation to inform the persons responsible for preventive activities in the workplace should be improved. Secondly, the flow of information and co-operation models with other health care sectors should be improved both to develop the smooth flow of care and to prevent incapacity for work. Thirdly, co-operation with regard to rehabilitation should be developed.

4.4 The impact of changes in work life

For OHS, the transformation of work life means both increased emphasis on the significance of psychosocial working conditions and the emergence of new physical, chemical and biological risks. Amidst constant changes and in network-like organizations, the risks of mental strain are significant. Mobile work is becoming more common and working conditions are becoming more complicated and multifaceted. The effects of increasing information

technology and influencing through information technology play a central role. (Alasoini ym. 2013)

Improving working conditions requires closer co-operation and joint development with persons operating at the workplace. Work becomes increasingly fragmented into activities of networks formed by several parties, and as a result, the traditional approach of influencing one workplace at a time becomes increasingly challenging. Alongside full-time employment permanently bound to a single workplace, multiple employment relationships and part-time employment relationships are becoming more common, which poses new challenges to the availability of people and the definition of employer and OHS responsibilities.

As workplace contact and knowledge have been challenges for a long time and as the models for determining risks related to industrial work are still at the core of OHS, it can be noted that the ability of OHS to influence the development of work in the future from the perspectives of health, work ability and well-being at work does not seem particularly good. The significance of work and working conditions for health and work ability is increasingly difficult to predict, and pre-defined recommendations for corrective measures do not help employees amidst changes.

The transformation of work life fits both the scenarios described above. In Scenario B, OHS moves legitimately away from workplace development and focuses on the primary health care of the employed and supporting their work ability with recommendations that have the individual's needs as the starting point. Another development possibility is related to the development of new co-operation among different operators in the workplace, outlined in connection with Scenario A; in this case, the task of knowing the workplace and influencing work would not fall only within the scope of OHS competence and activities.

4.5 Impact of the ageing working population

The aging of the working population results in an increase in challenges related to partial work ability and the adaptation of work. OHS has been prepared for this through the recent legislative amendments and various new operating models related to work ability guidance and support for work ability have been developed. Nevertheless, the impact of these measures may be questionable without better knowledge of work and workplaces and the possibility to adapt work and workplaces so that they are better suited to the remaining work ability. The multiculturalism of the workforce poses a competence and tailoring challenge for OHS. The conceptions of health, sickness and working stemming from different cultures have an impact on the content of the service provided to the representatives of these cultures in various ways.

4.6 Impact of the new quality system on OHS

By 2016, each occupational health care unit must have a documented quality system compliant with the GOHP. The quality system seeks to be a solution to the situation described above in which, despite legislation and funding control, OHS units do not extensively and fully comply with the published principles of the GOHP. Particular concerns have been the planning of activities on the basis of the needs of the client workplace, content of preventive activities, underdevelopment of the multiprofessional operating procedure and scarce impact assessment with regard to activities.

FIOH is responsible for the establishment of the quality system and for the provision of related training. In addition, FIOH has made plans for organizing training for the quality personnel of the service providers in order to support the implementation of the quality system. Plans for the creation of a special national quality portal are also being drafted. The

model for the portal is the practice used in Great Britain. The SII is planning to link OHS compensations with the existence of a quality system.

The impact of an obligatory quality system depends on its content, implementation and impact on the practices of OHS units. There is a risk that the quality system becomes only a folder on a shelf, its impact on the execution of the services remaining small. Proper impact would require either wide-ranging external auditing or a quality portal that would lead to mutual benchmarking among the units and which would also be open to customers. If it is practically impossible to implement the GOHP, as OHS units have stated in their criticism, the implementation of the quality system should be monitored through studies and thus discover those issues that prevent compliance with good practice.

5. Conclusions with regard to the operations of the FIOH

FIOH has opportunities to influence how OHS evolve and are developed. As a research and expert institute, a key task of FIOH is to produce information for different parties in work life to support decision-making and to serve as a foundation for new solutions. In addition, FIOH plays an important role in education and training with regard to OHS. Nevertheless, the most crucial solutions in the control of OHS are achieved through co-operation among government authorities, labour market organizations and the SII; in this, a research and expert institute has only the role of an advisor.

The extension of working careers and the development of the quality of work life are important social objectives, to the promotion of which both government authorities and labour market organizations have committed. In public dialogue, OHS has been regarded as a key operator in the achievement of these objectives. Although employers have increasingly invested in OHS year after year, so far the current activities have not succeeded in significantly preventing the development trend related to work disability or in solving the well-being at work challenges related to the transformation of work life. For this reason, there have been legislative changes (early support models, "the 30-60-90-day rule", the part-time sick leave allowance and the decree on the GOHP, for instance) that aim to develop OHS activities by using new emphasis areas and improving the likelihood of achieving the objectives.

A factor that is crucially linked with new emphasis areas is the resolution of questions related to the content of OHS. These include the position of medical care and workplace co-operation practices. As the question of medical care is related to the crisis of outpatient medical treatment in primary health care, it cannot be solved without more extensive reform in primary health care. Employees and employers will not abandon the well-functioning medical care offered by OHS before there is another, equally flexible alternative available. For this reason, FIOH participated in the preparation of the initiative by the National Institute for Health and Welfare and supported it publicly.

As the current workplace co-operation practices in OHS, which are based on recommendations from experts (suggestions for actions), have not been sufficient, the requirement of closer co-operation between workplaces and OHS has been added to the GOHP in the new decree that comes into force in 2014. This requires both parties to investigate the state of the personnel (the principle of awareness), plan necessary support measures in co-operation (the principle of preparation) and to be active (the principle of participation). In transforming work life, standard solutions are rarely functional and as a consequence, this co-operation with the aim of effective activities requires that the workplace and OHS develop solutions jointly.

This creates a problem for workplace co-operation from the point of view of SII's compensation criteria in which it has been considered important to clearly separate the tasks of the workplace (especially HR administration) on the one hand and the tasks of OHS on the other, as well as the costs related to these tasks. In co-operation that generates new ideas, a rigid division of labour restricts the creation of innovative solutions, be it the promotion of occupational health, occupational safety or work ability. In the resolution of related conflicts, FIOH can adopt an active role. It could initiate a participatory process involving all parties in which the opportunities and obstacles related to the development of preventive activities would be reviewed broadly. This review process should also include the workplace's occupational safety and health, line management and personnel development (HR) functions. The best domestic practices and examples from abroad (at least from Sweden, Norway, the Netherlands and Great Britain) should be scrutinised analytically.

Research themes important for the development of OHS have been described above. These include an impact study on the prevention of work disability, the extension of working careers and the development of the quality of work life which takes the opportunities for OHS into account. In addition, other important research themes are a study on the opportunities and obstacles related to co-operation between OHS and workplaces, a study on the role and tasks of OHS in the totality of health care and a study on the execution of OHS in small workplaces.

Of the means of exerting influence, information-based control has clearly proved to be a limited approach. FIOH has devoted a great deal of resources to participation in legislative work, he preparation of different development strategies, individual research and development projects, and to writing different guides and guidelines in co-operation with the Ministry of Social Affairs and Health and the representatives of employers' and employees' organizations. There has been extensive active work. However, it is evident that the impact of these measures on the activities of service providers and workplaces has been insufficient. There is a great deal of variation in the quality of operations of OHS units, and current development activities have not succeeded in reducing this variation. The situation could be described as a pyramid illusion or a pyramid scheme. At the top level, among a few operators, there is a lot of activity but at the lower level, among the actual operators, not many signs of the top-level activity can be seen. Development is seemingly active but hardly anything changes.

A great untapped opportunity to influence the evolution of OHS lies in increasing co-operation with service providers. From the concept's point of view, development could be based more on the utilisation and joint development of service provider innovations than on top-down information-based control. The change that has taken place in the service system as well as increasing unit size, centralisation and chain formation among service providers offer better opportunities for co-operation. The vision could be a development network of OHS units; some promising examples of this have already been witnessed in the SEITTI projects. In this model, good practices are based more on the results of pilot projects and the development of a practice created with service providers than on models that have been written in consensus "at the apex of the pyramid". Development co-operation would also offer good research topics for intervention and impact studies.

In the end, there naturally remains the challenge of combining the bottom-up and top-down perspectives. If legislation, guidelines and funding control do not support new practices created in the development network, they will not become established in practice. For this reason, it should be possible to link financial support from SII to development projects by reserving a certain part of earned income insurance for OHS pilot projects.

6. References

Ahtela J (2010) Ehdotuksia työurien pidentämiseksi. Työelämäryhmän loppuraportti 1.2.2010.

Alasoini T, Järvensivu A ja Mäkitalo J (2012) Suomen työelämä vuonna 2030. Miten ja miksi se on toisenäköinen kuin tällä hetkellä. TEM –raportteja 14/2012. Työllisyys- ja yrittäjäosasto. Työ- ja elinkeinoministeriö. Helsinki.

Antti-Poika M (2006) Sairauspoissaolojen hallinta yrityksen ja työterveyshuollon yhteistyönä. Työterveyslääkäri 2006; (1): 12-15.

Erhola M, Jonsson P M, Pekurinen M ja Teperi J (2013) Jonottamatta hoitoon. THL:n aloite perusterveydenhuollon vahvistamiseksi. Terveyden ja hyvinvoinnin laitos. Tammerprint Oy. Tampere.

Husman K (2012) Valtioneuvoston periaatepäätös: Työterveys 2015 väliarviointia. Työterveys 2015 –kutsuseminaari 31.10.2012, Säätytalo, Helsinki. Julkaisematon käsikirjoitus.

Husman K. Suomalaisen työterveyshuollon kehitys. Kirjassa: Martimo KP, Antti-Poika M, Uitti J (toim.) Työtä terveyttä. Kustannus Oy Duodecim, 2010.

Ikonen A (2012) Primary care visits in the Finnish occupational health care services and their connection to prevention and work-related factors. Studies in social security and health 120. Kela, research department. Juvenes print – Tampere university print. Tampere.

Kalimo E, Karisto A, Klaukkala T, Lehtonen R, Nyman K ja Raitasalo R (1989) Suomalainen työterveyshuolto 1980 –luvun puolivälissä. Työterveyshuollon valtakunnallinen arviointitutkimus. Kansaneläkelaitoksen julkaisuja A:24. Karisto Oy:n kirjapaino. Helsinki.

Kansaneläkelaitos (1996) Työterveyshuoltotilasto 1993. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Kansaneläkelaitos (2002) Työterveyshuoltotilasto 1999. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Kansaneläkelaitos (2005) Työterveyshuoltotilasto 2002. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Kansaneläkelaitos (2007) Työterveyshuoltotilasto 2004. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Kansaneläkelaitos (2009) Työterveyshuoltotilasto 2007. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Kansaneläkelaitos (2012) Työterveyshuoltotilasto 2010. Kansaneläkelaitos, Tilastoryhmä. Helsinki .

Laine T, Peurala M, Rautio M, Manninen P: Asiakasorganisaatioiden työterveyshuollon toimintasuunnitelmien arviointi ja kehittäminen. Työympäristötutkimuksen raporttisarja 42. Vammalan kirjapaino 2009. Vammala.

Lehto J (2013) Terveydenhuoltopolitiikka. Kirjassa: Sihto, Palosuo, Topo, Vuorenkoski ja Leppo (toim.) Terveyspolitiikan perusta ja käytännöt. Terveyden ja hyvinvoinnin laitos. Juvenes Print – Suomen yliopistopaino Oy. Tampere.

Manninen P, Laine V, Leino T, Mukala K, Husman K (toim); Hyvä työterveyshuoltokäytäntö. Sosiaali- ja terveysministeriö, Työterveyslaitos. Vammalan Kirjapaino Oy 2007. Vammala.

Nevala N, Kalliomäki-Levanto T, Jääskeläinen K, Hirvonen M, Pekkarinen A ja Elo J (2011) Työn sisältö ja työolosuhteiden mukauttaminen avoimilla työmarkkinoilla toimivilla vammaisilla ja pitkäaikaissairailla. Loppuraportti. Työterveyslaitos. (http://www.ttl.fi/fi/ergonomia/esteeton_tyoelama/Documents/TOS%20LoppuraporttiIsbn.pdf)

Palmgren H, Jalonen P, Jurvansuu H, Kaleva S, Tuomi K: Tietojen antaminen, neuvonta ja ohjaus (TANO) työterveyshuolloissa. Työ ja ihminen. Tutkimusraportti 35. Työterveyslaitos. Tampereen yliopistopaino Oy - Juvenes Print 2008. Tampere.

Pitkämäki S (2006) Työterveyshuollon korvausjärjestelmä työterveyshuollon kannustimena. Pro gradu –tutkielma. Yhteiskuntatieteellinen tiedekunta. Terveyshallinnon ja –talouden laitos. Kuopion yliopisto.

Sauni R, Niiranen K, Hirvonen L, Hirvonen M, Loikkanen P, Manninen P, Pulkkinen-Närhi P, Räsänen K ja Viluksela M (2012) Työterveyshuolto Suomessa 2010. Työterveylaitos ja Sosiaali- ja terveysministeriö. Helsinki.

Savinainen M, Peurala M, Hakkola M, Hietamäki P, Lappalainen J, Liuhamo M, Manninen P, Pääkkönen R, Rantanen S, Rautio M, Sillanpää J, Oksa P: Työterveyshuollon työpaikkaselvitys osana yritysten hyvinvointi- ja turvallisuustoimintaa. Työympäristötutkimuksen raporttisarja 55. Vammalan Kirjapaino Sastamala 2010.

Seuri M ja Räsänen K (2006) Työpaikkasairaanhoito – työterveyshuollon kova ydin? Työterveyslääkäri 2006; 24(4): 126-129.

Soini S ja Suuronen K (2011) Työperäisten sairauksien preventio työpaikoilla selvitys. Loppuraportti Sosiaali- ja terveysministeriölle 22.6.2011. Työterveyslaitos.

Sosiaali- ja terveysministeriö (1989) Työterveyshuollon valtakunnalliset kehittämislinjaukset.

Sosiaali- ja terveysministeriö (2004) Valtioneuvoston periaatepäätös Työterveys 2015. Työterveyshuollon kehittämislinjat. Sosiaali- ja terveysministeriön julkaisuja 2004: 3. Helsinki.

Sosiaali- ja terveysministeriö (2007) Sairauspoissaolokäytäntö työpaikan ja työterveyshuollon yhteistyönä. Sosiaali- ja terveysministeriön julkaisuja 2007:7. Helsinki.

Sosiaali- ja terveysministeriö (2009) Sosiaaliturvan uudistamiskomitean (SATA) ehdotukset sosiaaliturvan uudistamiseksi. Sosiaali- ja terveysministeriön selvityksiä 2009:62. Helsinki.

Sosiaali- ja terveysministeriö (2011a) Työhyvinvointiryhmän raportti. Sosiaali- ja terveysministeriön selvityksiä 2011:4. Helsinki

Sosiaali- ja terveysministeriö (2011b) Työterveyshuolto ja työkyvyn tukeminen työterveysyhteistyönä. Työryhmän loppuraportti. Sosiaali- ja terveysministeriön selvityksiä 2011:6. Helsinki

Työterveyslaitos (2010) Työterveyshuollon hyvä sairaanhoitokäytäntö 1.4.2010.

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