TRENDS AND DEVELOPMENT OF OCCUPATIONAL HEALTH SERVICES IN NORWAY

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Abstract. Occupational Health Services (OHS) in Norway cover approximately 1.2 million employees, equivalent to 60% of the total workforce. They employ nurses (800), physicians (500), physiotherapists (360), safety engineers (400), psychologists (30) and others (400), a total of 2500 full time employeys. The average cost of the OHS amounts to 150 euros per employee, a total cost of 180 million euros per year.

In 1998, the OHS in Norway were evaluated. The evaluation, initiated by the Ministry, revealed that although 80% of the enterprises are fairly satisfied with their OHS, there is still much to be improved, in particular quality development and customer focus.

By 2000 the National Practice Guidelines (“Good OHS”) were developed as a joint effort of the professional OHS associations, representatives from the social partners and the NIOH. These guidelines have been evaluated and well accepted by the OHS.

Last year the Ministry of Labour appointed an advisory group of experts on OHS. The group was asked to examine: the “branch provision” on obligatory OHS and the availability of health resources; the legislation on OHS tasks; the quality improvement of OHS; and the OHS in small enterprises.

The report was ready in May 2001 stating that the OHS may be a useful contributor to the improvement of the health, environment and safety in enterprises and included the following recommendations: to establish the OHS for all within 10 years and to ratify relevant ILO convention; to develop a certification system for the OHS; to ensure financial public support of the OHS for the small enterprises; and to expand the OH hospital departments as important supportive agents for the OHS.

The report will be a background document for the revision process of the Work Environment Act to be soon put into force.

Key words: Occupational health services (OHS), Quality, Objectives, Strategies

INTRODUCTION

The occupational health services (OHS) in Norway cover approximately 1.2 million employees, equivalent to 60% of the total workforce. It has been an everlasting discussion whose origin dates from the 1970s. Ten years ago, a new legislation stating what types of services the employer should ask for from the OHS was adopted. This may be somewhat different form other national legislations on the OHS, but the idea is that since the employer is responsible for the work environment and thereby the negative side effects, legislation should be addressed to the employer, not to the OHS. Still, this is not fully understood neither by employers nor by the OHS and employees.

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Basically the idea about what the OHS should do is quite similar within the European countries. The 1989 European Framework Directive [1] indicates the direction. Still, 13 years after the Directive was imposed, the OHS practise varies considerably between the countries and even within them [2].

EVALUATION OF THE OCCUPATIONAL HEALTH SERVICES

In 1998, the Ministry of Local Government and Regional Development took the initiative to evaluate the OHS. The findings have evoked positive and constructive discussion on the OHS and quality development. Some major findings are as follows [3]:

- The OHS have a good impact on the health, environment and safety (HES) in enterprises. Still there is much to be improved.
- In all, 80% of the customers are generally satisfied.
- The OHS should be more focused on quality issues.
- The OHS should be more adjusted to and focused on the customers' needs.

A recent Danish OHS-evaluation study also revealed that 80% of enterprises are satisfied with their OHS. The Danish OHS-model is quite different from the OHS model of most other European countries. The OHS in Denmark is characterised by very few doctors and nurses. Instead they use other categories of personnel like architects, engineers, ergonomists and psychologists. And they have been quite successful. They also have been able to arouse a lot of public and political interest, leading to a decision on the OHS for all Danish employees by 2005, and an easy to perform certification system for the OHS. They provide occupational health services with fewer resources than most other European countries.

In Finland an evaluation of its OHS showed that “only” 70% of enterprises are satisfied. This, of course, should not be misinterpreted that Finnish OHS are inferior to Danish or Norwegian. It simply states that the customers are slightly more satisfied in Norway and Denmark. The standard used for the evaluation is basically born in the customer’s mind. It may be influenced, to some extent, by the national legislation, but probably more by a traditional customer perception on what OHS should deal with.

In Norway customers are still asking for yearly general health examinations and curative services, in spite of national legislation and professional bodies stating that this is not the way to do it.

QUALITY IN THE OCCUPATIONAL HEALTH SERVICES

Based on the findings of the Norwegian evaluation study of 1998, a process called “Good OHS in Norway” [4] was started and involved all the professional OHS bodies, authorities, social partners, the National Institute of Occupational Health and the Section of Occupational Medicine in Bergen. Inspired by a similar Finnish process [5,6] we were able to reach a consensus on the 15 important quality criteria in an audit matrix. This has been tested on many OHS units and has been well accepted as a useful tool for self-evaluation.

WHO and ICOH have recently started a joint effort to make practice guidelines for good OHS in Europe involving the authors from many European countries. Hopefully this may contribute to a necessary convergence of the OHS in Europe towards working in a more similar way.

All quality management people state that things being done in many different ways may be an indicator of poor quality [7]. Although “there are many ways to skin a cat”, one way may be more successful that the others.

OBJECTIVES AND STRATEGIES FOR THE NORWEGIAN OCCUPATIONAL HEALTH SERVICES IN THE FUTURE

A task group of experts initiated by the government made a report [8] on this issue last year. The group was asked to advice on the following:

- The “branch provision” on the obligatory OHS and the availability of health resources. Which occupational branches are in the greatest need of OHS, and is an expansion of the branch provision possible with the available resources, in particular health professionals.
Is the present legislation on the OHS tasks sufficient?
How to accomplish quality improvement in the OHS?
How to improve the OHS in small and medium-sized enterprises (SME)?
The group started by asking some basic questions:
Does the OHS system work?
What are the “outcomes” of the OHS?
We know that the OHS involve a lot of activities focused on risk evaluation and assessment, health surveillance, prevention of accidents and occupational diseases, prevention of sick leave, improvement of work ability, etc. – but – does it really work? Is it beneficial to enterprises and society? There is surprisingly little “hard” scientific evidence to answer these questions. This, of course, should be improved in the future. Nevertheless, there are many indicators of the OHS being beneficial to the enterprises and society. The already mentioned national evaluation study proved their value. A large European study [2] came to the same conclusion. There are also several examples of the OHS being successful in working with chemical exposures, noise, rehabilitation issues, ergonomic factors, safety issues etc. and thereby preventing occupational accidents and disorders and promoting good health.

Who should have the OHS?
Based on the above and the fact that many traditional HES problems, like chemical and physical exposures are being well taken care of whereas the psychosocial work environment, work force ageing, rehabilitation and work ability issues tend to become more and more important, it is difficult to link the need for OHS to certain specific occupational branches. The group of experts therefore stated that the OHS should be expanded to cover all employees and that the expansion from a 60% coverage of today to a 100% coverage should be done within a timeframe of 10 years.

Do we need a certification system for the OHS?
Today we have a free market for OHS. Anyone can call himself the OHS. Our experience is that enterprises in Norway today are, unfortunately, not able to distinguish between the good ones and the “charlatans”. The situation in Norway therefore makes it necessary to have an obligatory certification system. The Danish certification system, which is inexpensive and easy to perform, may be a good model. The European Union of Medical Specialists (UEMS) has recently started a process on the certification of the OHS.

What about the OHS for small and medium-sized enterprises?
The problem with the OHS and the SME seems to be a common European problem. It will be an increasing challenge since more and more employees will be working in SME in the future. A Nordic research indicates that having an OHS contact person for the SME with general OHS competence and the troubleshooter ability may be one way to facilitate the co-operation between the SME and the OHS. Economic support to the SME for having the OHS like in Austria or Germany may be beneficial.

What should be the future tasks of the OHS in Norway?
Risk evaluation and risk assessment are core elements of the tasks for the OHS and so is surveillance of the work environment and the health of workers. Rehabilitation and work ability issues will be of growing importance with the ageing work force in the years to come. Education and training of the employers and employees in HES are also areas to which the OHS personnel should contribute and so is workplace health promotion. The focus on the external environment and the impact of the enterprise is a new arena for the OHS, which needs to be further developed. Some OHS units have the knowledge and skills to contribute, whereas others do not. These are all elements of the HES management.
The management has the responsibility, the employees should be involved and the OHS shall contribute as a professional body. For the OHS it is important to accomplish their various roles as a professional contributor. The contribution should be based on the customers’ needs. The customer orientation does not however mean that the customer is always right, but is entitled to have the best possible solution from the OHS. This means that every cus-
customer should have a “tailor-made” solution with the costs of the services correspondingly differentiated.

What about curative services?
Should the OHS be engaged in primary health care? In Finland OHS are defined to be a part of the primary health care (PHC) system and the National Insurance is reimbursing the costs for the curative services provided. Their experience is that curative care facilitates the rehabilitation work and even the general preventive work. In Denmark and Norway curative health care should be taken care of by the public PHC system based on every citizen having his/her own personal PHC physician. The challenge by this system is to create a best possible collaboration between the PHC and the OHS.

Who should work in the OHS?
In Denmark, the OHS are doing their job virtually without nurses and doctors, while in most of the other European countries, they are, to a large extent, based on these professions [2]. This may look like a paradox. It really reflects a long OHS tradition. The OHS are a multidisciplinary arena. One should ask the question which are our tasks and obligations and which profession is best fit to contribute to such a process? From my point of view, in future the Norwegian OHS should probably have a lower fraction of nurses and physicians than today, and more engineers, psychologists, social scientists, pedagogues etc. The requirement common for all the professions is the need to possess specific training for the work in OHS.

CONCLUSION
There are fairly good indicators that the OHS are an important contributor to the good HES work in enterprises and a prerequisite for the good rehabilitation work which will be increasingly important with the European ageing work force. There is, however, a need for more “hard” evidence of the OHS “outcome” – a challenge for the OHS scientific milieus like ICOH. A “Cochrane Collaboration” for the OHS would be nice to have. My view is that the OHS in Norway should be expanded to cover all employees. In order to attain such an objective it must be obligatory. To ensure the quality of the OHS, a certification system is needed. Market mechanisms simply do not seem to work when it comes to OHS. The certification system should be easy to perform and at a low cost, creating as little bureaucracy as possible. The Danish certification model may be a good example.

Certification takes only a small part of quality issues. National guidelines seem to be beneficial. Hopefully the coming WHO/ICOH quality book on the OHS may become an inspiration to anybody in this sense.

Last, but not least, the customer orientation in the OHS is important. Discuss with your customer. Decide what to focus on during the next time period. Avoid doing things that you cannot stand for from a professional point of view and evaluate what you are doing. The good OHS must have high ethical standards. Integrity and evaluation of the services is an integral part of good ethics. Realize that HES claim the joint efforts made by employers, employees and highly professional and multidisciplinary OHS. In consequence, you may get a more skilled and satisfied customer – asking for the right types of services.

REFERENCES


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