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# OCCUPATIONAL HEALTH CARE: ADMINISTRATION, STRUCTURE, CONTENT

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**ABSTRACT**

Occupational health care may be considered as part of three different, more comprehensive systems, namely, labor protection, public health, and personnel management. These systems set goals to occupational health care; these goals are partly parallel and partly conflicting. To what extent these goals will be realized in occupational health care depends largely on the way in which occupational health care is organized.

Private occupational health care lays emphasis on the personnel management aspects. The goals of labor protection can be achieved more or less satisfactorily – depending on the respective working conditions – while the public health aspects usually remain on a low level.

Communal occupational health care in Finland involves mostly small enterprises. It forms part of the public health responsibilities of communal health centers and thus is, subject to communal democratic control. At the same time communal occupational health care has strong connections with both public health and labor protection authorities.

In private occupational health care, a third party enters the physician-patient relationship, namely, the employer who has directional authority over his industrial physician. This has led to situations where the medical professional ethics and the concern for the patient's health come into conflict with the administrative orders of the enterprise management. Even if this kind of open conflict does not arise, the fact remains that private occupational health care always carries with itself a structural conflict against traditional ethical principles of medical practice and international (e.g. WHO, WMA and IMS) recommendations on the professional ethics of the medical occupation.

The development of health care in Finland since the end of the Second World War has been directed primarily towards maternity, infant, and child care raising these sectors of outpatient care to a very high level. At the same time, however, the health care of the working-age population and the old has seriously suffered from lack of a comprehensive developmental policy. As examples of the gloomy indicators of the working-age population's health may be cited certain mental health statistics according to which in 1975 over one-third of the disability compensations were due to mental health disturbances[1]. The number of disabled workers in 1976 exceeded 250 000, whereas in the preceding years it was half this number[10].

Although morbidity and mortality statistics in different occupational branches are poorly developed in Finland, even the scanty statistics available

reveal the fact that morbidity increases with increasing strain of the occupation. This tendency has been observed in studies carried out at the National Institute of Social Security[6,8] in the METELI[7] study (a project on the working conditions and health of workers in the heavy metal industry), and in a study on the health of Finnish lumberjacks[5].

In addition to the alarming morbidity and disability rates, the mortality rate of Finnish workers is very high. In certain occupations workers do not live up to the retirement age, or are seriously disabled long before the retirement age. This applies especially to the mining, glass and building industries. Thirty-six per cent of the Finnish male population die before retirement[9]. Finland has one of Europe's highest adult male mortality rate[10]. Work and working conditions have a crucial influence on health, on off-work living conditions, indeed, on the whole social status and way of living. The Public Health Act which came into force in April 1972 did not lay down the obligation for communes to organize occupational health care. The reason for this was the fact that a year earlier, in connection with the collective labor market agreement on salaries, the central labor market organizations, namely, the Finnish Employers' Federation and the Confederation of the Finnish Labor Unions, signed a top-level agreement on health care in enterprises which removed occupational health care from its legislative base into the domain of labor market agreements. Occupational health care is not to become regulated by law before the beginning of 1979. The law will not essentially alter the content and administration of occupational health care; instead, it will authorize the practice that was started on the basis of agreements.

The employers understand occupational health care as a part of personnel management, i.e. part of the policy of controlling the workers[11]. This is why the employers insisted and still insist on having occupational health care strictly under their own control as private business.

The situation in Finland provides a good, concrete basis for considering the administration, structure and content of occupational health care and the social issues involved, since the Finnish occupational health care system offers different ways for the realization of occupational health care. Occupational health care system has been a much discussed topic during the last ten years among different fractions up to the President of the Republic. The business features of private occupational health care, with the employer as the third party in the patient-physician relationship, have been viewed as particularly problematic, at least by workers and health care personnel[4]. The following is to show the different goals in the functioning of occupational health care and how they affect the whole system.

Considering the situation in the light of 1976 statistics, the consequences of the agreement can clearly be seen: private occupational health care – either occupational health centers of single enterprises or plants, or health centers of several enterprises on a cooperative or company basis – covers more than 90 per cent of organized occupational health care[3], while communal health centers, account for less than ten per cent of occupational health care, and cover, only about 160 000 workers and employees. During the same year the number of

persons belonging to organized occupational health care increased to over a million; the private sector thus covers about 900 000 workers and employees.

As stated before, employers regard occupational health care as a sector of personnel management. According to the Finnish Employers' Federation, personnel management means those actions which co-ordinate the objectives of the enterprise and the personnel; "it is understood to cover all those actions with which the resources of the enterprise are formed, maintained, and directed so that the goals of the enterprise are achieved as fully as possible"[11]. Occupational health care has an important function in the domain of personnel management both in the collection of information and in the indoctrination of the workers. The role of occupational health care is significant in that it is practiced by health care workers who have the obligation to keep the patients' information confidential. In private occupational health care, employers are often able to obtain information that otherwise would not be available to them. The violation of the confidentiality duty stems not necessarily from the willingness of this or that health care employee to deliver information to the employer, but rather from the fact that in private occupational health care the highest authority is the employer ("the employer hires and fires, and distributes the work"). Since the personnel in private occupational health care is subordinated to the very employer whose workers he or she takes care of, a three-party relationship develops in which one party, the employer, exercises authority over the others, i.e., the workers and the health care personnel.

"Most conflicts have been due to problems of principle and ethics which arose when a third party, the employer, entered the patient-physician relationship". This quotation is from the editorial of Suomen Lääkärilehti (Finnish Medical Journal) of July 7, 1978, which then stated as follows: "In this kind of triangle setting, it simply is not possible always to take action to the satisfaction of all the parties involved. This can be seen most clearly in the issue of sick leaves."

When the occupational health personnel takes the side of the patient, i.e. the worker, either for reasons of professional ethics or for simple practical reasons, it is threatened by the same authority which is directed towards the workers. There are enough examples of this in Finland. In most cases, however, when complaints against the physician have been impartially investigated, the physician has been judged to have acted correctly[13].

The ethical problems arising from the existence of a third party in private occupational health care are problems of principle, since the traditional principles of the medical practice require that in health and sick care the physician must always stand on the side of the patient[4]. In addition to registering information, occupational health care has manipulative function. The physician-patient relationship makes it always possible to influence the patient. Since the organizers of private health care underline that "personal education has proved to be effective in producing positive attitudes and behavioral patterns", and, since the concept of personnel management implies that the goals of the enterprise and the workers should be integrated, it is clear that "education" becomes an essential part of occupational health care[4]. The recommendations on

occupational health care also state that "occupational health care personnel provide health education according to their judgement". Since most industrial physicians in Finland identify themselves with the employers and since, especially in big industrial plants, the selection of the health care personnel is controlled by the Finnish Employers' Federation the education provided by the workers or their organizations remains outside this "health education".

Private occupational health care, organized by the employers, plays an important role in increasing profits. According to the Commission of Commercial and Industrial Life (Elinkeinoelämän Valtuuskunta), occupational health care is an important sector in the development of what is called calculation of personnel resources[2]. The latter "has as its aim to pursue the evaluation of the personnel of the enterprise (human capital) with similar computational methods as are those used in the evaluation of other resources of the enterprise. One specific goal is the presentation of personnel in the annual balance of accounts of the enterprise in the assets of the balance sheet as a factor increasing the resources".

As private occupational health care has been able to expand on the basis of this ideology, we are today in a situation where the human capital is indeed treated according to these computational principles. For example, in the ASKO and UPO concerns the employers have taken up mass vaccinations in order to decrease absenteeism during flu epidemics and thus increase profits[12]. For the vaccinations, a random vaccine antigen combination was used against which Finnish workers usually have good immunity without in any way controlling what diseases were later contracted by the vaccinated. These vaccinations which involved about 2 000 workers were nothing but experimentations with the workers. "The uninterrupted continuation of production is often hard to be measured in marks", writes the spokesman of the economic and commercial circles, the newspaper Kauppalehti (17.3.1977), in its article entitled "Notable savings with workplace vaccinations". According to this paper, the respective companies saved in these experiments 30 000 – 40 000 FMK (US $ 7500 – 10 000) in five months. In this connection it should be mentioned that the State Medical Board's directives specify that vaccinations against flu should be given only to risk groups, i.e., to persons who are seriously ill or weak, or to those who must necessarily maintain their working capacity during epidemics, i.e., health service personnel and the like. The healthy do not meet these criteria, – especially in the case of a disease which is usually cured with three to five days with medication.

It is characteristic that occupational health care legislation (1978) separates sick care from occupational health care[3]. The employers are able to accomplish their aims of personnel management with "preventive" activities which, in the narrow meaning of prevention, are reduced to health checkups "where health education always must be added". Talking about prevention, however, appears rather superfluous when, for example, industrial physician paid on the average only five visits to working sites in 1974[4]. Removal of sick care from occupational health care clearly means loss of an achieved advantage. On the other hand, prevention is an entity including diagnostics therapy and rehabilitation. It cannot be accomplished if its central component, sick care, is removed from it.

The Social Security Institute compensates employers for 25 to 60 per cent of the costs of occupational health care. The average compensation percentage is over 50%, meaning that, with a few exceptions, private occupational health care – which accounts for over 90% of all organized occupational health care – receives the highest compensations (60% of the expenses). Occupational health care provided by communal health centers is usually compensated by only 25%. As the costs of occupational health care in 1975 were approximately 140 million FMK (about 35 million US $), and as the compensations are taken from the sickness insurance funds – half of which are financed from workers' salaries – the workers have to participate on a large scale in financing the costs of the employers' personnel management[4]. This is not in accordance with the ILO recommendation (ratified also by the Republic of Finland) which says that occupational health care should be free for workers.

The fees of private occupational health care often exceed five times the compensation rates of the sickness insurance on which the State Medical Board has based the fees of communal occupational health care. The Institute of Social Security does not regulate the fees; instead, it compensates according to whatever the employers charge. During strikes, the employers have very often forbidden the workers to use occupational health stations. The justification of this action is indeed doubtful, especially when considering it in the light of the expenses for the maintenance of these stations that are covered by the workers.

Considering that the Institute of Social Security employs only three inspectors for occupational health care, and that the annual number of applications for compensation is 3 000, it becomes obvious that the control of the Institute is not sufficient[4]. In addition, the State Medical Board does not exercise control over private occupational health centers, nor do the workers have any right of control. It follows that the monetary compensation is based solely on the needs of the employers and private physicians. Private occupational health care has become an important sector of health care. As early as in 1974, visits of physicians in occupational health care amounted to over one third of the visits in all private health care. This trend has since intensified: it is estimated that visits to physicians in occupational health care already make half of the physician visits in all private outpatient care.

Simultaneously with the realization of "saving policy" in the public health system, and reductions in social expenses, the agreement-based private occupational health care has been given good possibilities to expand, even with the support of the Institute of Social Security.

The unbalanced situation in Finnish occupational health care is seen clearest when analyzed according to the size and nature of the enterprises covered by private or public occupational health care. Big and middle-sized enterprises utilize services of private occupational health care, whereas communal health care organizes these services mainly for small enterprises with fewer than 100 workers. Communal health care, however, is being extended so that workers and employees employed by the respective commune have priority in urgency. It may therefore be concluded that even the existing scanty communal occupational health care does not keep to a priority order based on actual risks.

Despite the ethical principles of the medical profession, the situation in the Finnish occupational health care is in conflict, with the resolutions and recommendations of the UN organizations WHO and ILO.

In its recommendations WHO warns against considering the health of workers from one viewpoint only, leaving the other health-related actions to other systems. The separation of occupational health care from the rest of health care means, according to WHO, a waste of resources and a decrease of the efficiency of health care actions, particularly when the cooperation between occupational health care and other health care services is not very good. WHO also recommends integration of occupational health care with the public health system, and directs attention to the development of occupational health care in agriculture, small enterprises, the building industry, mining, and high-risk groups.

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