

REPORT

for the period 1 June 2010 to 31 May 2015, made by the Government of Finland, in accordance with article 22 of the Constitution of the International Labour Organisation, on the measures taken to give effect to the provisions of the

Occupational Health Services Convention, 1985, No. 161 ratification of which was registered on 27 April 1987.

Direct Request, 2010

Articles 2 and 9: National policy and multidisciplinary occupational health services

The multidisciplinary and professional competence of occupational health care have been monitored with a survey every three years. The last data is from 2010. In 2010, the occupational health care units of private medical centre chains were not able to report on the competence of the professionals, which means the data are inadequate and unfortunately not comparable with the earlier numbers. According to the survey, 93% of the occupational health care units had a qualified occupational health nurse, 52% had a qualified physician, 38% had an occupational physiotherapist and 18% had a qualified occupational health psychologist.

From the point of view of a private customer, multidisciplinary was implemented slightly better: 96% of the customers received service from a unit with a qualified nurse, 50% from a unit with a qualified physician, 45% from a unit with an occupational physiotherapist and 37% from a unit with a qualified psychotherapist.

The Occupational Health Care Act (2001) requires teams comprising a qualified physician, nurse and physiotherapist or psychologist, as required by the work place analysis and risk assessment. According to the latest data available (2010), 94% of care giving organisations have a specialist nurse, 63% a specialist physician, 82% a physiotherapist and 67% a psychologist. However, the numbers do not include the biggest private occupational health service providers. The qualification has increased between 2008-2010 in every profession, most with physiotherapists and psychologists.

In 2010 of all clients, 73% obtained services from an occupational health care service provider with a team comprising a nurse and doctor qualified in occupational health care. In addition, 65% of clients obtained the services of a qualified physiotherapist and almost 45% those of a qualified psychologist. The qualification and multidisciplinary depends on the size of the occupational health care provider. The providers with over 10 000 clients had a team comparing a nurse, doctor and physiotherapist in 96% and also with psychologist in 86%. Multidisciplinary materialized in municipal public utilities in 97%.

Article 3. Occupational health services for all sectors.

The duty to arrange occupational health care applies to all employers in all sectors. According to the occupational health care in Finland 2010 report, the occupational health care coverage for wage earners was 91% . Small enterprises have the lowest coverage of occupational health care. During the last decade, there have been several projects aiming to increase the arrangement of occupational health care for small enterprises and entrepreneurs. An occupational health care service model for

small enterprises has been developed and approved. In 2015, measures that aim to improve the occupational health care coverage of small workplaces in the future have been prepared on a tripartite basis.

The supervision of occupational health care arrangements has become more effective. The focus of occupational safety and health enforcement during the four year period of 2011-2015 has been the arrangement of occupational health care. In 2013, instructions for supervisors on monitoring the arrangement of occupational health care were published (Instructions for Occupational Safety and Health Enforcement 1/2013). According to these instructions, inspection visits are used to ensure that the employer has made an agreement on organising occupational health care. Preventive action promoting health and working capacity should be highlighted in the agreement on organizing occupational health care. In order to verify this, the agreement on organising occupational health care, workplace investigation and occupational health care action plan are examined. The inspector also ensures that the agreement on occupational health care is up-to-date and on display for all the workers. The inspector monitors that the medical examinations in work that presents a special risk of illness have been made according to the Occupational Health Care Act. In addition, the inspections are used to ensure that the employer has done all the legally determined notifications about absences to occupational health care, and to review the manner how the employer has organised monitoring for sick leave.

3. Article 3. Occupational health-care card and construction workers

The occupational health-care card became obligatory for hired private sector construction workers in 2007. However, entrepreneurs, public sector workers and white collar workers in construction industry are not covered by the card. In total, the card is obligatory for only half of those working in construction. According to our latest survey, Work and Health in Finland in 2012, three out of four of those who were supposed to have the card had it. The implementation of the occupational health-care card has not lead to increased number of occupational health care contracts or increased amount of health check-ups. In total, however, the number of check-ups is higher in construction than other branches of industry.

Occupational health care for SME's

An approach was developed at the Finnish Institute of Occupational Health as a practical tool for occupational health co-operation, which allows small workplaces and the occupational health services to jointly and simultaneously carry out the risk assessment required in the Finnish Occupational Health and Safety Act and the workplace investigation required in the Occupational Health Care Act. The guide concerning this approach and the "Management of occupational safety and health risks in small enterprises" folder or PIRA (Finnish Institute of Occupational Health, 2011) have been well received. In an evaluation project risk assessment specialists of the Finnish Institute of Occupational Health evaluated the reliability of the approach in the detection of risks. The approach proved to be effective (Savinainen et al 2014). As a product it is spreading well at the moment.

In addition, new measures aiming towards increasing the coverage of occupational health care services in SME's are under consideration in 2015.

Occupational health services for workers in atypical employment

Employers are primarily responsible for arranging occupational health care services with regard to employment contracts and civil service relationships in the public and private sector, regardless of whether they are valid indefinitely, or fixed-term or part-time contracts and positions. Employers

must also arrange occupational health care services for hired workers. Unfortunately, at the present we have no statistics or data on how well this works for workers in atypical employment. Anecdotal evidence points out that perhaps not all workers in atypical employment receive the occupational health services they are obliged to.

Coverage and contents of occupational health services

A majority, over 80% of employees, are covered by occupational health care in Finland. The coverage is poorest, around 60% of all workplaces, in workplaces with less than 10 employees. This has not improved between 2009–2012. However, FIOH has executed in 2013-2014 a nationwide education and co-operation project to promote occupational health care in SME's and to promote a more agile way of organizing these services. In addition, separate continuing efforts to promote the arranging of occupational health care are being carried out in farms.

According to Work and Health in Finland -surveys the proportion of employees who report that occupational health services have visited the workplace diminished from 53% in 2009 to 50% in 2012. However, the statistics of Social security institute (in Finnish Kela) show that the amount of time spent in workplace surveys in occupational health services has risen from 15,5 hours per 100 employees in 2007 to 26,3 hours per 100 employees in 2012. In total the execution of preventive services (eg. workplace surveys, health check-ups and guidance) forms little more than one third of occupational health service activities in Finland. The most frequent and the most valued activity in occupational health services is medical care, which is a voluntary part of occupational health services for employers. This is mainly due to the crisis of primary care in Finland. In this situation occupational health services have served as a substitute for public primary care for those employees whose employer is willing to pay for medical care as part of occupational health services. This development has both pros and cons from the perspective of occupational health goals. According to the Work and Health in Finland –surveys customer satisfaction to occupational health services is high and rising. The Finnish Institute of Occupational Health has declared its concern for the proportion and role of the preventive occupational health services in the middle of this development. A major reform in health care in Finland is one of the primary goals of the new government starting in 2015 in Finland.

Part VI

Vera information system has been gradually implemented in occupational safety and health enforcement since the year 2011. According to its data, there have been 26 275 inspections on the arrangements of occupational health care, where 1637 pieces of written advice and 2780 improvement notices have been given, 50 cases have been directly submitted to occupational safety and health authorities (2006/44 Act on Occupational Safety and Health Enforcement and Cooperation on Occupational Safety and Health at Workplaces. Section 14, Subsection 2). 229 cases have proceeded to the authorities' decision preparation.

In the previous report, for the period 1 June 2005 to 31 May 2010, the Government of Finland reported, referring to part III in the report form (Supervision), the number and the distribution by industry of workplace inspections in 2009. The number of inspections given, 19 916, refers to the number of workplace inspections performed by the labour authority. The FIOH has no access to data sources concerning the number or outcomes of workplace inspections by the labour authority.

I Legislation and regulations

Amendments (1056/2010) to the health insurance act, chapter 13, section 5 (1224/2004), entry into force 01.01.2011

Amendments (20/2012) to the occupational health care act, a new chapter 10a and a new subchapter to chapter 12 (1383/2001), entry into force 01.06.2012

Amendments (19/2012) to the health insurance act, chapter 8, section 8, subchapter 3 and chapter 15, sections 4 and 17 (1224/2004), entry into force 01.06.2012

The occupational health care compensation practices have been amended to promote occupational health cooperation and support of work ability. An amendment to the Health Insurance Act (Chapter 13, Section 5) entered into force from the beginning of 2011. It encourages workplaces to draft a model for monitoring the working ability, which is a prerequisite for Kela's reimbursement of 60% for the preventive occupational healthcare. Otherwise the reimbursement percentage is 50.

An increased level of imbursements, from 50% to 60%, of the costs of preventive occupational health care services is granted for the employer on the condition, that a written mutual code of practice concerning the support and management of work ability is developed between the employer and the occupational health care service provider.

The amendments to Health Insurance Act and Occupational Health Care Act that entered into force on 1 June 2012 (1224/2004, Chapter 8, Section 5a; 1383/2001, Section 12, Subsection 1, Paragraph 5) aim to improve the possibility to detect prolonged inability to work early enough, and to facilitate the recovery and return to work. This is also known as 30/60/90 days rule.

The employer must inform the occupational health service provider of each employee who reaches 30 days of sick leave in order to evaluate the need for supportive actions. The occupational health care service providers are obliged to write a statement of work ability in cases when 90 days of sick leave have been realized. A statement from the occupational health physician, based on negotiations with the employer and the employee is required at the latest after 90 days of sick leave. The employer must claim for the sick leave benefits earlier, during a two months period when compared to the earlier four month period.

The labour market organisations' working group considering working life (2010) made proposals that outlined occupational health care and emphasised its role in supporting work ability and preventing work incapacity. The occupational health care services must take the responsibility of providing support for an individual worker's work ability - independent of where the care and rehabilitation are implemented. The proposals emphasised evaluation of the effectiveness of occupational health care and development of regional coverage and quality especially on small workplaces.

The working group's proposals were discussed in three other continuation working groups, and some of them are mentioned on the Government Programme level. The Government Decree on the Principles of good occupational health practices was amended following the spirit of the working group's proposals. Council of state decree on Principles of good occupational health practice, contents of occupational health care and the education of occupational health professionals and experts (708/2013), entry into force 01.01.2014

Link to the decree (in English): <http://www.finlex.fi/en/laki/kaannokset/2013/20130708>

The degree includes

- obligation for occupational health co-operation between the employer, employees and the occupational health service provider
- obligation for co-operation between occupational health care services and other sectors of health care and rehabilitation
- new issues taken into account in realization of occupational health services
- social work load, work-related diseases in addition to occupational diseases, changes in personnel, state of personnel, possibilities of the workplace to accommodate work due to changes in employees' work ability, systems to manage work ability at the workplace, including RTW practices
- obligatory quality system for all OHS units, coming into force from the beginning of 2016
- making use of workplace risk assessments in workplace surveys executed by the occupational health care services, workplace surveys in workplaces with several employees
- in addition to the significance of work factors to health also their significance to work ability should be taken into account
- co-ordination of care and rehabilitation in occupational health care
- revised chapter of guidance and counselling
- educational demands for occupational health care professionals (doctors and nurses) were elevated to 15 ECTS points
- new occupational health care expert: social services professional

Revised version of Good Occupational Health Practice Guide (Finnish Institute of Occupational Health 2014)

- explains in detail the changes enforced to occupational health care services by the Council of state decree on Principles of good occupational health practice, contents of occupational health care and the education of occupational health professionals and experts (708/2013),

II.

Article 2.

The Government resolution Occupational Health 2015 – Development strategy for occupational health care, prepared in 2004, outlines national measures and responsibilities of various actors in maintaining the health and working capacity of employees for the purpose of improving the quality of working life. A new resolution extending until 2025 is under preparation.

Article 3.

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Article 4.

Nothing new to report

Article 5.

The Government Decree on the principles of good occupational health practices, the content of occupational health care and the qualifications of professionals and experts, based on the Occupational Health Care Act (1383/2001), has been updated and entered into force in the beginning of the year 2014 (708/2013). Link to the decree in Section I.

Article 6.

See Article 5.

Articles 7-8

Nothing new to report

Articles 9-10

See Article 5.

Article 11.

The qualifications of occupational health care professionals and experts have been defined in the Occupational Health Care Act and in the Government Decree based on this Act (708/2013, Sections 12, 13 and 14).

Section 12 Physicians working in occupational health care

Only occupational health care specialists may work as full-time licensed physicians in occupational health care. A person who works in occupational health care for an average of 20 or more hours per week is considered to be working full-time.

A licensed physician working part-time in occupational health care shall have taken a minimum of fifteen credits in occupational health care studies within two years of transferring to occupational health care.

What is provided in Subsections 1 and 2 above shall not apply to a specializing physician, who is instead covered by the separate provisions in the Decree on the qualifications of specialist physicians and dental specialists (420/2012).

Section 13 Public health nurses working in occupational health care

A licensed public health nurse working full-time in occupational health care shall be a qualified public health nurse and shall have taken a minimum of fifteen credits in occupational health care studies within two years of transferring to occupational health care.

Section 14 Occupational health care experts

An occupational health care expert means a person who:

- 1) is qualified as a licensed physiotherapist and has taken a minimum of fifteen credits in occupational health care studies within two years of starting the expert activities;
- 2) is qualified as a licensed physiotherapist and has taken a minimum of fifteen credits in occupational health care studies within two years of starting the expert activities; or
- 3) has an applicable university degree in occupational hygiene, ergonomics, a technical subject, agriculture, occupational vision, nutrition, speech therapy or physical education, or other equivalent earlier vocational qualification in the field, and has taken a minimum of two credits in occupational health care studies.

Articles 12-15

See article 5.

Article 16

Nothing new to report

III-V

Nothing new to report

VI

A copy of this report has been sent to the following labour market organisations:

The Confederation of Finnish Industries (EK)

The Central Organization of Finnish Trade Unions (SAK)

The Finnish Confederation of Professionals (STTK)

The Confederation of Unions for Professional and Managerial Staff in Finland (AKAVA)

The Commission for Local Authority Employers (KT)

The State Employer's Office (VTML)

The Federation of Finnish enterprises

VII Statements of the labour market organisations:

Central Organisation of Finnish Trade Unions (SAK)

Based on the Occupational Health Care Act, the Government issued a decree on the principles of good occupational health practices, the content of occupational health care and the qualifications of professionals and experts. The promotion of working capacity in different stages of the career was a clear priority for the occupational health care services. Labour market organisations are committed to this, too.

To ensure success in this priority goal, the fundamentals of occupational health care services have to be in order. The employer has to organise occupational health care services, the occupational health care services have to be familiar with the conditions of the workplace, the occupational health care services have to be planned and in work that presents a special risk of illness, medical examinations have to be arranged for the workers. The occupational safety and health authority monitors the implementation of these statutory obligations. However, the occupational safety and health authority does not monitor the actual contents of the occupational health care services.

As to the implementation of statutory obligations, during its inspections the occupational safety and health authority has found that the medical examinations in work that presents a special risk of illness have been made appropriately in 86% of the inspected workplaces, and that the workplace analysis is in order in 71% of the inspected workplaces. If these statutory obligations are not performed, it is questionable whether the support for work capacity is implemented at these workplaces, either. Especially small workplaces have coverage deficit in organising occupational health care services.

In addition to absolute coverage deficit, there is relative coverage deficit in organising occupational health care services, which means that the workplace has an agreement on occupational health care

services, but in practice, the workplace does not receive the services or the services do not comply with the best practices.

According to a report done in Oulu, an occupational disease discovered at a workplace does not lead to any measures at the workplace. SAK believes that both occupational health care services and occupational safety and health authority should react when it is possible, taking the nature of the occupational disease into account. Occupational safety and health authority has instructions related to discovered occupational illnesses, but SAK finds that monitoring data is needed on its effectiveness and applications.

Akava

Under article 3 of the Convention, each member state agrees to gradually organise occupational health care services to all the workers.

Based on the Occupational Health Care Act, the Government has issued a decree on the principles of good occupational health practices, the content of occupational health care and the qualifications of professionals and experts. The promotion of working capacity in different stages of the career was a clear priority for the occupational health care services. Labour market organisations are committed to this, too.

To ensure success in this priority goal, the fundamentals of occupational health care services have to be in order. The employer has to organise occupational health care services, the occupational health care services have to be familiar with the conditions of the workplace, the occupational health care services have to be planned and in work that presents a special risk of illness, medical examinations have to be arranged for the workers. The occupational safety and health authority monitors the implementation of these statutory obligations. However, the occupational safety and health authority does not monitor the actual contents of the occupational health care services.

According to the latest Work and health in Finland survey, there were about 1,9 million people covered by occupational health care services on 31.12.2010. 91% of the wage earners are covered by occupational health care services, and 86% of them also had a possibility to nursing that is part of the occupational health care services Akava considers that the obligation to arrange occupational health care services are not implemented as required in the convention.

Under article 5 in the Convention, occupational health care services must take care of identification and evaluation of matters that occur at a workplace and that are harmful or hazardous for health. As to the activities related to workplace conditions, according to the Work and health 2012 survey, during the preceding three years, occupational health care services had inspected working conditions at the workplace of every other (50%) worker covered by occupational health care. Places of business with at least 50 employees clearly had more inspections (59%) than places of business with 2-9 employees (39%). The variation according to industry was great: from 77% in the financial and insurance services, to 29% in the storage industry.

As to the implementation of statutory obligations, during its inspections the occupational safety and health authority has found that the medical examinations in work that presents a special risk of illness have been made appropriately in 86% of the inspected workplaces, and that the workplace analysis is in order in 71% of the inspected workplaces. If these statutory obligations are not performed, it is questionable whether the support for work capacity is implemented at these workplaces, either. Especially small workplaces have coverage deficit in organising occupational health care services.

In addition to absolute coverage deficit, there is relative coverage deficit in organising occupational health care services, which means that the workplace has an agreement on occupational health care services, but in practice, the workplace does not receive the services or the services do not comply with the best practices. For example, according to a report done in Oulu, an occupational disease discovered at a workplace does not lead to any measures at the workplace. Occupational health care services and occupational safety and health authority should react to this when possible, taking the nature of the occupational disease into account. Occupational safety and health authority has instructions related to discovered occupational illnesses, but monitoring data is needed on its effectiveness and applications.

According to Article 8 of the Convention, the employer, workers and the possible representatives elected from among them shall cooperate and equally participate in organisational procedures and other procedures related to occupational health care.

Akava again emphasises that the requirement of Article 8 is not implemented, because all the personnel groups do not have the right to elect their own representatives to the cooperation on occupational safety and health in the workplace. Since Section 8 of the Occupational Health Care Act (1383/2001) refers to the Act on Occupational Safety and Health Enforcement and Cooperation on Occupational Safety and Health at Workplaces (44/2006) as to the parties of cooperation on occupational safety and health on workplaces, higher-ranking salaried employees do not have a statutory right to elect representatives to cooperation on occupational safety and health on workplaces.

Akava considers that since the higher-ranking salaried employees do not have their own representatives in the cooperation on occupational safety and health on workplaces, the strain and risk factors of the work of higher-ranking salaried employers are not sufficiently discussed in the cooperation on occupational safety and health on workplaces.