Discussion paper

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A new development for occupational health services in Norway

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Occupational health services (OHS) in Norway are multidisciplinary. The OHS units are quite small, compared to other European countries, with an average of four full-time OHS professionals covering 2000 employees. All are financed by employers. Approximately half of the working population is covered by an OHS. Norwegian work environment legislation sets out which enterprises are obliged to have an OHS, what types of services are to be delivered, and the importance of the impartiality of the OHS. The main focus of an OHS should be to play an expert and advisory role in the health, environmental, and safety policy and activities of the enterprise. A recent governmental report proposed a certification system for OHS in Norway and a further expansion of obligatory OHS to include some new lines of businesses, for example the healthcare and education sectors. The key objectives and tasks for future OHS should be the same as today, but with an increased effort on the reduction of sickness absence and promotion of early return to work.

Key terms legislation; OHS; quality.

The history of occupational health services (OHS) in Norway goes back to the 17th century with the introduction of corporate physicians in the silver mining industry of Kongsberg (1). The first modern OHS, however, is usually regarded as the one founded at the Freia Chocolate Company in Oslo in 1917 by Professor Schiøtz with a public health approach based on prevention by hygienic inspections and health surveillance. It was not until 1977, when the Work Environment Act was passed, that the major expansion of the modern OHS started with the emergence of, in particular, external, multidisciplinary OHS units providing services to many enterprises.

Occupational health services legislation

The Norwegian legislation on environmental health and safety is in accordance with that of the European Union. The specific Norwegian legislation for OHS derives partly from work environment legislation and partly from health legislation. This means that two ministries are involved in the OHS at the present – the Ministry of Labor and Social Inclusion and the Ministry of Health and Welfare.

Under the OHS Regulation (2), the employer is responsible for having an OHS in place and assessing the competencies of the OHS personnel. The Regulation also describes the types of services the employer should require of the OHS and specifies that the OHS should mainly take preventive actions, focusing on certain areas such as (i) the assessment of workplace risk, (ii) the surveillance of the work environment and the health of the workers, (iii) the assessment of work ability, rehabilitation, and workplace adjustment, (iv) the education and training of staff, and (v) the prevention and follow-up of work-related disorders. A separate Regulation specifies which trades and industries are obliged to have an OHS (3).

Occupational health services in Norway today

In Norway today, there are approximately 400–500 OHS units, covering an estimated 20 000 enterprises and one million employees. This is equivalent to 50% of the total workforce. The units are widely distributed all over the country.

The OHS in Norway are multidisciplinary. According to estimated figures from the OHS Registry (4) at the National Institute of Occupational Health (NIOH), they now employ about 2190 full-time employees:

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nurses (660), physicians (340), ergonomists (320), safety engineers (360), psychologists (30), and other professionals (480). Even though the NIOH maintains the OHS Registry, it is virtually impossible to give exact numbers as the registry is based on voluntary reporting. Many units choose not to be registered, and the NIOH has no strict, official criteria of what is needed in terms of resources and competences in order to be called an OHS unit.

A typical OHS unit consists of one each of the following: a physician, a nurse, an ergonomist, and a safety engineer/occupational hygienist. There are specialties within all these areas. Most of the OHS professionals have been through basic training programs, but the amount of training varies a great deal. At present, approximately 30% of the occupational physicians are specialists in occupational medicine, while 25% of the occupational hygienists and approximately 10–15% of the occupational nurses and ergonomists are specialists within their own fields.

The average cost of an OHS amounts to €150 per employee per year, a total cost of €150 million per year for the one million workers who have access to an OHS. The amount of services purchased by enterprises varies considerably, from less than €50 to more than €1000 per employee per year.

The employers cover all the costs of having an OHS. Even though the OHS, according to the legislation, shall have a free and independent professional role in their work, this role is nowadays being challenged by the fact that OHS have to sell their services in a free market characterized by increasing competition between service providers. The lack of public funding may lead to other types of services which are more focused on what is beneficial for the enterprises versus society.

Today about half of the OHS volume consists of non-profit-based internal or external services owned by the enterprises. The rest are profit-based, external services, owned by the OHS employees themselves or private investors. Twenty years ago, only 10% of the OHS were profit-based.

Relationship to public health

As mentioned previously, most of the OHS tasks set out in the legislation are of a preventive character. According to the Regulation, the OHS should not be involved in resolving health problems that are not related to the work environment; this is the responsibility of a general practitioner (GP). Nevertheless, many OHS units also provide some services in non-work-related areas, and get involved in lifestyle questions and the improvement of health behavior. In a 2005 study (5), a large majority of the responding OHS stated they were involved in health promotion activities and gave advice on a number of issues including physical exercise (92%), reduction of alcohol consumption and smoking (87% and 86%, respectively), and nutrition (72%).

However, it may be difficult to differentiate between work- and non-work-related issues, especially when it comes to rehabilitation where the OHS, according to the legislation, should play an important supportive role within the organization. One major challenge therefore, is to improve the cooperation between the OHS and GPs in particular. Major steps to facilitate this relationship are being taken as a part of the national campaign "Inclusive Working Life" which aims to reduce sickness absence, promote early return to work, and prevent early retirement (6). The campaign relies on the involvement of GPs.

Quality in occupational health services

According to Norwegian law, the employer is responsible for ascertaining the quality of its OHS (2). There are no other formal public quality regulations for OHS in Norway. In 1998, the Ministry of Local Government and Regional Development initiated an evaluation of OHS (7). The major findings were: (i) OHS have a good impact on work concerning health, the environment, and safety in the enterprises, but there is room for improvement; (ii) 80% of customers are generally satisfied; (iii) OHS should be more focused on quality issues; (iv) OHS should adjust more to and be more focused on customer needs. As a consequence of these findings, OHS in Norway – together with the NIOH, the social partners, and the Labor Inspectorate – developed a quality system called "Good Occupational Health Services" which is an evaluation tool based on the principles of auditing. This tool is now a part of the basic training program of OHS personnel in Norway and used mainly by the OHS. It was revised in 2007 and is available on the internet (8). In addition, national quality guidelines for OHS are available for Norwegian health personnel as a part of the Norwegian Electronic Medical Handbook (9).

The Labor Inspectorate is responsible for the control of enterprises' own systematic health, environment, and safety activities. Its inspections are, therefore, directed towards the employers and not the OHS. It may sometimes question the work and quality of the OHS, but its attention is focused on the employer. The Health Inspectorate is formally responsible for the assessment of the employer's compliance with the health services legislation of the OHS. So far, the Inspectorate has shown a narrow interest in OHS. Therefore, the public

assessment of the quality of OHS has been limited and most of the quality issues have been left to OHS themselves.

Market developments

Today OHS in Norway function increasingly on a market basis and, therefore, must "sell" their services to enterprises. This means that OHS activities beneficial to the economy of the enterprise may get more attention than those of benefit to society at large. In light of the Inclusive Working Life campaign, this implies that OHS units may be more engaged in the reduction of sickness absence than preventing early retirement and disability pensioning, as recently found in a study (10). The contribution of OHS to public health may, therefore, become limited.

Currently, there is a trend toward the building of larger OHS units. Two new OHS "chains" have emerged, the largest covering more than 200 000 workers. Small OHS units are being bought out by larger ones. Some OHS have responded to increasing competition by constructing various types of formal or informal networks. The situation is very similar to what has been seen in many other European countries. Hopefully the trend towards larger units will also lead to higher quality. On the other hand, the rising competition may result in new types of services not originally intended in the OHS legislation and more beneficial to enterprises than to society.

Many OHS professionals are worried about the future of OHS in Norway due to the current major structural changes and the public authorities' lack of interest. In a survey (11) of 300 OHS professionals in 2004, the following question was asked: "Will you be working in an OHS five years from now?" The responses were: "yes" (30%), "maybe" (50%), and "probably not" (20%). Many highly skilled OHS professionals have left their jobs during the last five years and there is, at present, a pessimistic feeling about the future perspectives for Norwegian OHS. In a small study of OHS personnel who participated in its two-year advanced training program between 1995 and 2006, the NIOH found that half of the participants, who completed the training program before 2000, had left OHS (12). The reasons given for leaving included: (i) outsourcing, (ii) downsizing or restructuring, (iii) poor economy, (iv) lack of professional challenges, and (v) too much focus on general health surveillance in the OHS.

Our experience at the NIOH is that the majority of the enterprises in Norway today are, unfortunately, not able to distinguish between an effective OHS and the "charlatans". Still, as mentioned earlier, these employers have the responsibility to assess the quality of OHS (2). Many OHS therefore feel that it is necessary to have a mandatory certification system. During a survey of OHS in 2004 (11), 91% of the respondents were in favor of such a system.

Another issue on the table today is which types of enterprises should be mandated to have an OHS. The law already regulates which sectors are obliged to have an OHS (3). Such an obligation has been linked to industries with chemical or physical exposures. As a result, many traditional health, environment, and safety problems are better managed than in the past. However, the psychosocial working environment, problems related to the ageing workforce, and rehabilitation and work ability issues are becoming increasingly important. It is therefore more difficult than before to relate the need for an OHS to specific trades and businesses. In the 2004 OHS survey (11), 83% were in favor of requiring OHS coverage for all workers. There is also a growing understanding among Norwegian politicians that OHS should be expanded to cover all workers in the long term and that there is a need for quality control of OHS (13).

New rules for occupational health services

In a report from 2007, the Norwegian government recommended an OHS certification system and an expansion of the types of businesses to be covered by an obligatory OHS (14). According to the proposal, in order to be certified, all OHS must have at least three full-time professionals – or an equivalent number of part-time professionals – and be able to document sufficient competence in occupational medicine, occupational safety and hygiene, ergonomics, the psychosocial/organizational work environment, and systematic health, environment and safety work. Each of the competencies should cover, at least, 30% of a full-time employment. Smaller OHS may still become certified if they have a cooperation agreement with a larger OHS.

The proposed types of businesses that would be required to have an OHS include hairdressers, the healthcare and education sectors, and industries like fish farming, waste and recovery, security, clothing, and hydroelectric power supply. The obligatory OHS coverage is estimated to double from the current 600 000 employees to 1.2 million workers.

In 2008, the Norwegian government also initiated a major expansion and evaluation of the medical departments at the regional and university hospitals and the NIOH. The government proposal on certification and expansion of obligatory OHS may therefore be seen as an increased public effort in the area of occupational health.

Other European countries have come to conclusions different from that of Norway. The Netherlands abandoned their certification system and obligatory OHS a few years ago because the system did not function effectively (15). In Sweden, up to now, OHS have been working on a purely market-driven basis, with no obligatory OHS requirements for business and no certification system. The Swedish government recently proposed financial support for the OHS to enable delivery of rehabilitation and curative services (16). In Denmark, the obligatory OHS for certain lines of businesses has been abandoned and so has, for practical purposes, the question about certification. OHS in Denmark are about to be replaced by advisory services offered by various work environment consulting enterprises (17). Through a screening of the organizational work environment, the Danish Labor Inspectorate may decide that an enterprise with a poor working environment is obliged to receive advisory services from an external advisor, for example an OHS, for a limited period of time.

Norway has decided to take a different approach. The experiences to come should therefore be monitored and evaluated.

Concluding remarks

The increase in the financing of the hospitals' occupational medicine departments, mandatory certification, and the expansion of obligatory OHS all indicate an increased public interest in and commitment to occupational health. This may represent an important turning point for OHS in Norway and stop the downward trend that OHS have been experiencing during the last ten years.

The proposed certification system should be easy to perform at low cost and create as little bureaucracy as possible. Certification, however, only deals with a small part of the quality issues. As mentioned earlier, the NIOH also has various evidence-based quality guidelines that should be followed. These guidelines should be integrated with the expertise of the OHS and the customers' values and expectations (18). Customer orientation in OHS is therefore still key.

Finally, professional ethics is important, but difficult to regulate. Integrity and evaluation of the services is an integral part of both good ethics and evidence-based practice. OHS should refrain from activities that do not meet the professional and ethical standards of good OHS practice. Health, environment, and safety work requires the joint efforts of the employer, the employees, and a professional and multidisciplinary OHS.

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