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New aspects of occupational health services in small workplaces in Finland

A review

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Exactly what is occupational health? Until recently such terms as industrial health, industrial medicine, and industrial hygiene were used to describe the activities concerned constructively with the health of employees in relation to their work, but now such phrases as occupational health, occupational medicine, and occupational hygiene have been adopted, partly because the term "industrial" omits workers in agriculture, construction, education, civil service, business, transportation, etc., while "occupational" encompasses all vocations and self-employed persons, retirees as well, whose work may encounter complex health problems.

In practice the connotation of occupational health varies greatly, even among occupational health professionals. The term is increasingly used in a public health context, and the two overlap conceptually and practically in most countries. Since occupational health cannot be regarded as totally independent of public health, knowledge about national

circumstances in medical care and public health in the country concerned, in this case Finland, is needed for an understanding of the administrative and implemental developments in the field of occupational health.

PUBLIC HEALTH

It is not my intention to provide a thorough account of public health in Finland, but merely to epitomize some recent highlights directly influencing the development of occupational health services within our society. Some of Finland's features are those which have created typical health problems in so-called developed countries, e.g., a relatively high standard of living, an aging population, continuously growing industrialization, increased traffic, urbanization, etc. The effects of environmental pollution are still limited when compared with many other industrialized countries, however, partly because of the relatively low population density (4.7 million people per 337,000 square kilometers), but they are noticeable in some larger cities and in some occupations.

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The state of public health can be characterized by statistical figures. The life expectancy of a newborn child in Finland is 65.6 years for males and 72.5 years for females. The country ranks 21st and 13th, respectively, among countries in Europe in this respect. It occupies a very unfavorable position internationally, however, if the life expectancy of a person aged 40 years is examined, the men being in last place in Europe and the women in 23rd place.

The age structure of the population has been very favorable from the viewpoint of health care. The proportion of children has, until recently, been relatively high, the birth rate in 1970 being 13.9 per 1,000 of the mean population, and the proportion of persons of working age (3.1 million people) is one of the highest in the world. The relatively low number of older persons (14.6 % aged 60 to 100) has meant that the general mortality figure for Finland is small when compared with the figures for other industrialized countries. The overall mortality, standardized for age, is, by contrast, the highest in Europe for both men and women. Moreover, the direction of development is an alarming one. During the period 1957 through 1967 the mortality of women decreased somewhat in all age groups, but the mortality of adult men increased in all age groups from 40 years upwards.

The national mortality figures, e.g., the crude death rate of 9.5 per 1,000 per mean of the population, do not reveal the marked differences within the country or the less favorable figures in the less developed parts of the country, i.e., in eastern and northern Finland. These differences are mostly due to the larger proportion of coronary heart disease in these sections of the country. The reasons are not clearly understood.

The only mortality figures for which Finland may be said to bear international comparison well are those for infant mortality and maternity mortality. These figures (10.1 and 0.12 per 1,000 live births, respectively) and their persistently favorable trend are not only a result of the rising standard of living, but also a consequence of the efficient implementation of maternal and child care, prophylactic health care, and health education and

counseling and the creation of a public organization that covers the whole country and provides services free of charge. Paradoxically, in the light of the foregoing, some of the healthiest children in the world become the sickest workers.

Mortality statistics reveal only part of the disquieting condition of our public health. Morbidity and disability statistics and investigations into public health show that more than one million persons aged 15 to 64 years are reportedly chronically ill, and that disability pensions are drawn by an exceptionally large portion (7.6 %) of the working-age population.

The preceding statistics indicate that the medical care administered in the hospitals will not alone suffice to improve the state of public health and that it will be necessary, in order to improve it, to develop other functions so that the totality of health care required for the efficient performance of public health work will be created. This argument has influenced our nation to the point that new legislation on health care is now in a state of dynamic development and change. The unfortunate public health statistics and the advent of recently enacted public health legislation have also intensified the demands for occupational health services even though the most serious effects on health are seldom directly related to a person's occupation.

Organization and functions

The main responsibility for public health falls on society as a collective entity. Finnish health care in general can be characterized as the "socialized" type. Although the community is considered primarily responsible for health services, there is no monopoly. Especially in the larger cities important private group practices exist. In publicly owned hospitals the physicians are salaried, but outside of work hours they have a right to a private practice on a part-time basis. There are a few private hospitals, and a great number of laboratory services are private.

A compulsory sickness insurance system covers the entire population. It compensates for physician's fees (60 % of standard charges fixed by official rates) and partial or, in most chronic cases, com-

Fig. 1. Organizational chart on occupational safety and health in Finland (— subordinate; --- cooperative).

plete costs of prescribed drugs and travel expenses. It also pays daily allowances; for instance, women receive a maternity allowance for 174 work days. Important exceptions are hospital fees, subsidized by the government so that patients pay only \$ 4.00 per day for comprehensive care, and free (vaccinations, services for communicable diseases, including tuberculosis, and maternity services) or minimally priced primary services in health centers.

The Public Act Health of 1972 introduced a fundamental innovation, a type

of planning which places the responsibility for the provision of health services primarily on the local authorities, i.e., on the communes or municipalities. The central government is limited mainly to legislative and other coordination, control, and financial support.

The small communes have joined voluntarily, or in some cases were even obliged, to form federations for the maintenance of a health center which organizes and delivers all the relevant services. Thus in 1972 the existing 400 communes were

grouped into 200 health center districts. Of these districts about 90 consist of one population center only. The rest are made up of federations of communes with one health center per district. The population in one health center district averages from 15,000 to 20,000 people.

The central Ministry of Social Affairs and Health attends to the major political, legislative, and financial problems, e.g., the budget and new legislation, while the National Board of Health, a subordinate of the Ministry, is responsible for day-to-day administration, technical aspects, central planning, etc. These authorities are required to subsidize communal activity if the services rendered are acceptable both in quality and quantity. The National Board of Health also acts as the licensing bureau and has the right to obtain information on all public health personnel, and every subsidized service unit is required to keep statistical records.

The central administration deals with local authorities through the Provincial Board, but the National Board of Health is also in direct contact with the communes and communal health federations (see fig. 1).

As previously stated, the local authorities have great autonomy, and the primary responsibility for organizing health services rests with them. The new legislation requires the central government to compose and publish annually an official 5-year plan for the nation. The National Board of Health requires from each commune a plan for local activities for the same period, and the Board has to ensure that the local and national plans coordinate. The plans concentrate on major aspects such as manpower, overall costs, and general outlines of programs. The local authorities are relatively free to solve any problems. This type of planning is suited to the markedly decentralized decision process in the country.

Scope within the commune

Within the limits of the national plan of activities the commune must supply the following public health services for its inhabitants (a) health guidance, including informational work in public health, coun-

Table 1. Distribution of the occupationally active Finnish population in 1975.^a

Type of work	Number of workers
Agriculture	300,000
Forestry	65,000
Trade, banking, insurance	440,000
Construction industry	130,000
Industry, mining	540,000
Services	450,000
Transportation	150,000
Road building and water works	60,000
Employed in Sweden	155,000
Total	2,290,000

^a Source: Työvoimakatsaus (Employment report) Nov. 1974, Ministry of Labor.

Fig. 2. Distribution of work force by primary (agriculture, forestry and mining), secondary (industry, construction) and tertiary (trade, banking, education, etc.) production, 1960-1973.

seling on contraception, and general health screening; (b) medical care, including examination and treatment by a doctor, medical rehabilitation, and first-aid services; (c) transportation facilities for patients, excluding the acquisition and maintenance of aircraft but including the main-

tenance of special vehicles for difficult circumstances; (d) dental care, including informational and preventive activities and the examination and treatment of teeth; and (e) health care in schools, including the screening and treatment of students' health in the elementary, secondary, comprehensive, and vocational schools located within the commune.

WORK FORCE AND WORKPLACES

The population of Finland is about 4.7 million, of which 2.2 million form the total work force. About 400,000 persons are self-employed. The distribution of the work force is given in table 1.

The distribution of the work force between the various occupations has been changing continuously since World War II. The number of workers in primary production (agriculture and forestry) has decreased linearly, while the number of employees in industry and service vocations has increased. The trends of these shifts are illustrated by fig. 2. The number of the total work force has not changed throughout the 1960s and 1970s.

The number of workplaces (establishments) totals about 83,000 (table 2); about 7,000 are industrial workplaces. There are only 120 enterprises with more than 1,000 employees, and workplaces with 500 or more employees comprise less than 10 % of the total, about 37 % of the total work force being employed by them. Most of these larger enterprises are located in the southern part of Finland. About 70 % (some 60,000) of the workplaces employ only 1 to 19 workers. Finland is therefore typically a country of small enterprises, a fact which creates problems in organizing occupational health services for most of the workplaces in the country.

OCCUPATIONAL HEALTH SERVICES

Organizational models

Occupational health services can be provided by structurally varying organizations. The selection of the model is dependent on the type and size of the enterprise, the location, the quality and quantity of occupational hazards, the number of employees, the availability of other health services in the area concerned, etc. The following four organizational models are in use at this time in Finland:

1. *Integrated occupational health services organized by private enterprises on their own premises.* About 500 companies employ about 120 full-time physicians, 600 part-time physicians, and 1,000 occupational health nurses in this type of services.

2. *Private occupational health centers established jointly by a number of enterprises, usually 5 to 20.* There exist about 20 such centers, the largest serving 63 firms in the city of Tampere. About 20 to 30 full- or part-time physicians and about 30 occupational health nurses, and a few occupational hygienists or technicians are employed in such centers. In all, the number of workplaces covered by this organizational model is estimated to be about 200 to 300, and they are estimated to employ about 20,000 to 40,000 workers. Expansion of this type of occupational health services is hardly to be expected in Finland.

3. *Occupational health services delivered by private group practices.* About 40 private group practices have been set up in the largest cities and about half of them provide occupational health services in addition to their main function, the provi-

Table 2. Number of enterprises required to pay purchase tax, and their number of establishments and personnel at the end of 1972, according to the number of employees.^a

	Number of employees					Total
	1—19	20—99	100—499	500—999	≥ 1,000	
Enterprises	55,819	3,993	1,050	117	120	61,099
Establishments	59,620	8,506	7,180	2,258	5,215	82,779
Personnel	179,749	164,759	213,429	83,851	386,499	1,280,287

^a Source: Enterprise Register of the Central Statistical Office of Finland.

sion of medical treatment. They have less than 10 full-time, and a few part-time, occupational health physicians, some part-time occupational hygienists, and some tens of occupational health nurses. The group practices serve a few hundred firms, mostly small offices with employees estimated to total about 50,000. The provision of executive and other health examinations and treatment is often the main, and sometimes the only, function of this type of organizational model.

4. *Occupational health services provided by community health centers set up according to the Public Health Act (1972).* These services are discussed in detail in another section.

Although the private group practices of physicians and the private occupational health centers meet the needs of the small workplaces they serve, it must be recognized that, from a national point of view, they have a very limited role within occupational health services as a whole, and this role is unlikely to grow without some organizational changes being made. Occupational health services provided by privately owned organizations (organizational models 1—3) are not fully accepted by the workmen, who regard the occupational physician as the employer's man — a suspicion which in the past was often valid. Such suspicion is known to die hard.

Development

Isolated examples of medical services provided by some larger companies date back to the 19th century, but the real expansion in Finland began as late as the 1960s. Real impetus to the rapid voluntary promotion of occupational health services was provided by an agreement signed in 1971 by the workers' and the employers' organizations. The objectives and scope of the agreement follow the framework of Recommendation No. 112 of the International Labor Conference (1959), which states that the role of occupational health services should be essentially preventive. Medical care should be included only if circumstances of the workplace and the other available medical care facilities of the community make it necessary. This

Fig. 3. Coverage of occupational health services, 1965—1973.

agreement has in recent years greatly influenced the increase in occupational health services, as is discernible from fig. 3.

In 1973, when the latest statistics were available, most of the occupational health services were provided by the larger workplaces. While about 770,000 employees from 1,450 enterprises and 100,000 pensioned workers and family members were covered by these services, 500,000 of the workers were employed by the larger industrial and commercial firms and only about 23,000 were employed in small enterprises (100 workers or less). There were about 2,500 occupational health personnel supplying these services on either a part- or full-time basis.

Today, the in-plant health services provided by large companies follow much the same pattern as that of large firms employing full-time medical staff in most countries. For this reason, and because Finland is a land dominated by the small enterprise, a more detailed description of the services of large workplaces is not included in this review. The remainder of the Finnish work force — more than one million people — is employed by more than 65,000 small undertakings which are incapable of organizing occupational health services without turning to available private group practices or community resources.

According to a rough estimation, in 1973 about 430,000 employees with no access to occupational health services worked in occupations that could be expected to have a number of health hazards. For example, construction and agriculture were excluded from the coverage of preventive occupational health facilities.

Organizing functional occupational health services for small workplaces offers

the greatest challenge for any national health care system. Inasmuch as this is the greatest area of pioneering need in extending occupational health services in our society, it deserves a closer consideration.

It has already been mentioned that little growth is expected in the private sector providing occupational health services to small enterprises. Therefore the following discussion focuses on public facilities.

Community health centers

According to the Public Health Act, the commune or municipality may, with the consent of the Provincial Board, agree to provide occupational health services for employers at the district health center.

Since 1974 the central government has attached great importance to occupational health in the national plans endorsed by the Cabinet. The national plan demands that a considerable portion of the new posts for physicians and public health nurses be used to fill the needs of occupational health services.

The National Board of Health has given directives to the local authorities as regards the priority of different industries, the functions of occupational health services (e.g., preemployment and periodical health examinations), the charge for services, and other details for the specific implementation of the occupational health services. The communes must clarify the needs for occupational health services within their areas and study the priorities involved in planning and negotiating with the employers asking for services. Thereafter they are to make agreements with and supply services to the workplaces which appear to have the greatest health risks or which must provide workers exposed to specific health hazards with special health examinations according to the Labor Safety Act. Such discrimination is necessary as long as the health centers are short of the manpower and facilities needed to provide all interested workplaces with services.

This new type of bargaining with employers for health services may be classified as a peculiar problem which most physicians are not adept at handling, especially if they are new in this field of medi-

cine. Frequently physicians enter this field with little awareness of the policy-making involved. For example, the connotation of occupational health often differs considerably between the negotiating parts, and in addition the workers' delegate may have still another interpretation of the functions of occupational health services.

In the future the routine occupational health practice should be oriented towards the occupational health nurse. For example, health examinations and regular checkups at the workplaces should be conducted to the greatest possible extent by occupational health nurses. The occupational health physician will instruct his nurses and assistants as to what commitments have been made to the various employers. He must therefore familiarize himself with the problems pertaining to the hazards in the particular workplaces and advise his own staff, the labor protection personnel, and the management of the workplace accordingly. He must also cooperate with the labor inspectorate and the Institute of Occupational Health when necessary. In addition, because of his knowledge of job requirements, the occupational health physician will often be a helpful consultant to his colleagues in cases of occupationally disabled employees, rehabilitation programs, and the reemployment of partly disabled workers. It should be recognized that by 1980 the number of doctors in a health center should average 12.

During this system's first full year of operation, in 1975, about 900 employers made agreements with community health centers for the coverage of some 120,000 workers who were primarily employed in occupations with a high degree of health risk.

Personnel

Finland has always experienced a shortage of physicians and concomitantly a shortage of outpatient care. Therefore the occupational health staff of a health center must be regarded as a part of the personnel available for public health work.

In 1974, the first 30 posts for occupational health physicians were established in the community health centers, and

in 1976 there are about 100 occupational health physician's posts.

In 1975 the first posts for occupational health nurses were established when 100 out of the 200 new posts were designated to fill the needs of occupational health services. Unfortunately in 1976 economical reasons reduced the posts of public health nurses to 20 for all the health centers. At present the lack of occupational health nurses seems to be the most serious hindrance to the expansion of occupational health services in the health centers. Table 3 shows the present and planned health center posts of physicians and public health nurses. In addition the staff of a health center includes registered nurses, practical nurses, physiotherapists, laboratory technicians, auxiliary personnel, etc., a total of about 16,000 persons in 1975. A greatly intensified education program for physicians should end the shortage of doctors, which has greatly hindered our public health work, by 1980. Concomitantly the total amount of public health work should increase both qualitatively and quantitatively to the planned level in the early 1980s.

Health centers do not have the technical personnel, e.g., occupational hygienists, safety engineers, etc., needed for the medical supervision of the work environment, but they may make use of the services of public health officers or communal labor inspectors subordinate to the local health board and the services of the six regional institutes of occupational health. In contrast to the private sector, the occupational health staff of a community health center has full professional independence from both employers and workers.

Occupational health functions

If one considers the concepts of public health and occupational health, it is seen that there is an organizational separation of functions. However, the individual worker is treated in the same place, the health center, but the contract between the employer and the commune does not include medical care, health screening (aimed at finding, for example, pulmonary tuberculosis), immunization, or other health programs arranged by the com-

munity. Occupational health services focus on preventive activities concerned with the health and safety hazards in the work environment. In practice the main services are as follows:

1. Recognition, assessment, and control of health hazards and the medical surveillance of planned work conditions as well. In short, the workplace is examined and the health hazards brought to light. After the visit a report indicating the flaws encountered is sent to the enterprise, and demands are made for their correction. Cooperation with the labor inspectorate and the regional institute of occupational health may be useful and even necessary.

2. Preplacement medical examination of young workers and women workers in shift work and the preemployment and periodical health examinations of those workers engaged in operations not generally considered hazardous. Routinely, these examinations are carried out and a fitness certificate is signed by the occupational health nurse unless specific reasons for a doctor's examination are found. The scope of these examinations, recommended by the National Board of Health and the National Board of Labor Protection, can be seen in table 4. There is still some overlap of public health screening programs, e.g., blood pressure, urinary glucose, palpation of breasts, since screening has not yet been fully implemented by the community in regard to blood pressure, diabetes, and breast cancer. The periodical appraisals of the "healthy" subjects are conducted every 5 years for employees under 50 years of age and triennially thereafter.

3. Preplacement and periodical health examinations of workers exposed to special occupational hazards. These examinations are mandatory under the regulations of the Labor Safety Act (1958). They are conducted according to guides issued by the Institute of Occupational Health and approved by the National Board of Labor Protection. These guides specify the scope of the examinations needed for workers exposed to any specific physical or chemical hazard.

Environmental measurements and the threshold limit values (TLVs) adopted by the Ministry of Social Affairs and Health in 1972 are increasingly used as guides for

Table 3. Number of physicians and public health nurses in 1975, and the number of planned new posts for 1976 through 1980, in community health centers and the planned increase and total number of physicians in Finland for 1976 through 1980.^a

	1975	1976	1977	1978	1979	1980	Total by 1980
Physicians in community health centers	1,240	+125	+170	+250	+300	+350	2,435
of these occupational health physicians	67	+30	+30	+30	+30	+30	217
Public health nurses in community health centers	3,700	+20	+30	+30	+30	+30	3,840
Occupational health nurses in community health centers	100	+2	+3	+3	+3	+3	114
Increase in total number of physicians		+445	+580	+825	+565	+560	
Total number of physicians	6,940	7,385	7,965	8,790	9,355	9,915	9,915

^a Source: National plan on public health 1976–1980, Ministry of Social Affairs and Health.

Table 4. Scope of preplacement and periodical health examinations of young persons, women in shift work, and other employees engaged in jobs not considered hazardous.

Age (a) and sex	Inter- val in years	Included in the examination									
		Inter- view	Height and weight	Vision	Blood pres- sure	Intra- ocular pres- sure ^a	Packed cell volume ^a	Gene- ral status	Physi- cal and ment- al devel- opment	Palpa- tion of breasts	Glyco- suria
< 18											
Women		X	X	X	X		X	X	X		
Men		X	X	X	X		X	X	X		
18 to 29											
Women	5	X	X	X	X		X	X			
Men		X	X	X	X			X			
30 to 49											
Women	5	X	X	X	X	X	X	X		X	X
Men		X	X	X	X	X		X			X
> 50											
Women	3	X	X	X	X	X	X	X		X	X
Men		X	X	X	X	X		X			X

^a Examined only for employees aged 40 years or more.

the estimation of the need for such examinations. As a rule of thumb, an examination is called for when the concentration of a specific substance in workroom air exceeds half the TLV. (The Finnish TLV list follows roughly that adopted by the American Conference of Governmental Industrial Hygienists.) This use of hygienic standards has resulted in an increasing demand for environmental measurements

in workplaces. Environmental measurements provided by the occupational health staff of a community health center include those of noise, lighting, thermal conditions, draft, and some simple measurements of airborne contaminants suitable for direct indicators, e.g., detector tubes. These measurements may also be made by local public health officers. Other, more demanding measurements are made by the

six regional institutes of occupational health, situated in the cities of Helsinki, Oulu, Tampere, Turku, Kuopio, and Lappeenranta. Each regional institute operates in two adjacent provinces in close cooperation with the health centers and the provincial labor inspectorate districts.

Expenditures

In 1973 the national average overall cost for occupational health services per employee amounted to about \$ 50. The Social Insurance Institution of Finland supplements the costs by paying the employer 25 to 60 % of his expenditures, depending on the type of services provided. In 1973 the average was 45.1 % (about \$ 15 per employee). The costs subsidized by the State include the salaries of the plant physician and other occupational health staff of a private enterprise and all running costs of the facilities required for occupational health activities (except for those of the establishment of a health station by one or more private enterprises).

All costs of the occupational health services provided by the health centers are subsidized, too. The enterprise pays the health center for actual expenditures only.

Education of personnel

The curriculum of medical undergraduate education is not sufficient to provide all the knowledge needed in occupational health practice. About 20 hours of teaching are provided in the older medical schools of Helsinki, Turku and Oulu; and about 60 hours, in the new medical schools of Kuopio and Tampere. Therefore the occupational health physicians cannot be considered fully qualified to render the service they enter. This deficiency has been recognized by the Institute of Occupational Health, which has organized additional education in this field for many years. Nearly all of the 120 occupational health physicians engaged in occupational health services organized by private enterprises have taken a 3-week postgraduate basic course in occupational health at the Institute. Similarly, the new occupational

health physicians of the community health centers have been offered additional postgraduate training by the Institute. The participation is compulsory since the communes are required to direct an official engaged in public health work to attend supplementary training, approved by the National Board of Health, in his or her line of work, when the Board considers it called for or at least once every 10 years. These courses should be regarded as basic, and continuing education on special occupational hazards in the form of shorter courses and meetings is arranged by the Institute.

The 1,200 occupational health nurses employed by the private sector are basically public health nurses who have also taken a 3-week course in occupational health at the Institute. The public health nurses engaged with occupational health services in the community health centers are also obliged to take a 4-week course in occupational health as additional education. The undergraduate curriculum of the public health nurses includes about 160 hours of occupational health education.

In addition to the previously mentioned groups the Institute offers postgraduate education for specialists in occupational health and for hygienists.

Thus, in general, it may be said that the demand for better educated personnel in occupational medicine and hygiene has grown more rapidly than the resources. As a result, and partly due to the high turnover of doctors in the health centers, the education of many doctors and public health nurses is, unfortunately, limited to "on-the-job" training.

RECENT DEVELOPMENTS IN LABOR PROTECTION

An account of the developments of occupational health services in Finland would be incomplete without reference, however succinct, to the rapid promotion of labor protection in the 1970s. Concomitantly with the agreement promoting occupational health, the workers' and the employers' unions signed a contract with provisions for labor protection. Together they established a Bureau of Occupational Safety

to provide information on health and safety; the Bureau offers administrative courses in occupational health as well.

The new legislation on labor protection enacted in 1972 through 1974 was a fundamental innovation in this field. In organizational terms the entire safety effort of the government belongs to the Ministry of Social Affairs and Health. The labor inspectorate was totally reorganized and a new central administration, the National Board of Labor Protection, was established in 1973 in the city of Tampere. The new legislation greatly increased the effectiveness of labor inspection (although for effective enforcement a great many more inspectors than are presently available would be required), and it also provided a comprehensive and integrated system dealing with safety and health for all workplaces. The workers and the management are obliged to cooperate in safety and health matters.

In general the recent legislation introduced stricter regulations for occupational safety, e.g., safety standards for work equipment and machinery and exposure standards. It also included worker participation in labor protection at the workplace level.

Although the major provisions of the new labor protection legislation are concerned with administration and the control of hazards in the work environment, it also contains elements inevitably influencing the functions of occupational health services. For example, the labor protection committee in a workplace is obliged to follow the occupational health services, and the labor inspectorate oversees the implementation of the health examinations required by the Labor Safety Act.

The legislation created an increasing demand for the education of all the various personnel concerned, the workers, supervisors, management, safety and health personnel in workplaces, hospital and other health service personnel, and administrators, not to mention the personnel of the reorganized labor inspectorate.

The recent progress in occupational safety and health has led to a growth of far reaching demands concerning the renovation of our Labor Safety Act, demands similar to those recently enforced in Sweden.

OUTLOOK FOR OCCUPATIONAL HEALTH SERVICES IN FINLAND

Until now, enterprises have been free to develop voluntarily, or not to develop, the occupational health programs they deemed appropriate for their needs and available resources. Despite the good coverage of occupational health services in bigger industries, the present situation is by no means satisfactory. Most of the small workplaces are still outside the sphere of occupational health services, but the main limiting factor has been the shortage of services available.

An increasing awareness of the importance of occupational health services among the workers, trade unions, administrators, and employers has created great pressure for further development. Especially the trade unions have exerted an increasing influence by pressing for improvements in the legislation of this field.

In view of the many defects in the present system of occupational health services a departure from past thought and practice is necessary. Legislation concerning the organization of occupational health services has been prepared for many years; e.g., in 1971 a national committee examined the matter in depth and worked out a proposition for an Occupational Health Act. It was not approved by the Ministry, however, and the major question of development has revolved around the drafting of occupational health service legislation ever since.

The latest proposition of the Ministry was published for open discussion in 1975. The proposition is formulated in general terms with a few specific requirements which are bound to change as time goes by, but which empower the government to issue regulations on a number of specific subjects. The proposition represents a radical departure from past practice in that all employers would become mandatorily involved in occupational health services. The employer would be able to choose any of the four organizational models presented earlier, and their responsibilities would equal those discussed in the context of occupational health services provided by the community health centers. The proposition also demands that the community fund the necessary

resources for effective occupational health services. In addition, the employer, e.g., in a big establishment, would be permitted to organize other health care facilities even though they are elsewhere stipulated as a responsibility of the commune. These activities would have to coordinate with the public health plan of the commune, however.

The proposed legislation is likely to introduce many advantages when compared to the prevailing voluntary system. Because occupational health services must depend upon real needs and the available national resources, both personnel and financial, they must be integrated into the national health planning process. With this mind, the following points may be considered. First, the legislation would provide the authorities (National Board of Health and National Board of Labor Protection) with better means with which to guide the future expansion of occupational health services to the workplaces which need it the most. Second, in concordance with this expansion, the authorities could allocate the necessary medical and financial resources to the relevant areas by means of the national public health plans discussed previously. Third, the scope of the occupational health services would be clearly specified, and the authorities could better guide and super-

vise their functions and coordinate them with developing public health work.

A new occupational health program is planned that will, it is hoped, result in the reduction of specific risk-related health problems. Whether this ambitious goal can be met is, at this point, far from certain. The program faces many severe problems of strategy, design, manpower, education, financing, etc. Since the inauguration of a national occupational health service has not yet been dealt with by the national planning mechanism, a pilot program has been started by the Institute of Occupational Health. The project offers the nation a welcome opportunity to learn about the problems involved. The primary goal is structural information collection and analysis of the present situation in the small workplaces within a health center district. The study aims not only at defining problems and discovering potential solutions, but it is also oriented towards the future targeted amounts of services, both hygienic and medical, and required changes and additions to the occupational health system. Building on the body of the data that will be collected during the next two years, the authorities hope to introduce rationality into the planning and implementation of occupational health services for small workplaces.

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