

Practice and position of occupational physicians in France and Finland

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1. Introduction

This document describes the position of the occupational physician in France and Finland. Based on the document *Review of regulations governing the position of occupational physicians in the Netherlands, France and Finland* [*Overzicht Regeling positie bedrijfsarts in Nederland, Frankrijk en Finland*], we submitted questions to Dutch occupational physicians working in the relevant countries about their practice. We used the information received from them in the following sections.

Before describing the practice of the occupational physician in detail, we provide a brief sketch of the statutory context. The position of the occupational physician is influenced not only by health and safety legislation but also – if the physician is involved in sickness absenteeism or in establishing occupational disability or monitoring employees with an occupational disability – by legislation in these areas as well.

The focus then shifts to the occupational physician's practice. Which of the statutory occupational health and safety obligations are actually met? And what about those aspects of the occupational physician's position that are regarded as problematical in the Netherlands?

The present document immediately zooms in on the practice of occupational physicians in each country without first describing the actual duties and authority of such physicians or of the occupational health service there. That information can be found in the *Review of regulations governing the position of occupational physicians in the Netherlands, France and Finland*.

2. France

We received answers to our questions and additional information from four Dutch occupational physicians who have been working in France for several years. They are Steven Verbeek (since 1999), Frits Peters (in France since 2009), Karin Kroon-Renaudon (has worked for an occupational health service on behalf of local government since 1994) and Laurentiu Enuica (in France since January 2012).

2.1 Statutory context

2.1.1 Obligations of employer: occupational health and safety (OHS)

Occupational health and safety (OHS) rules are set out in the following legislation:

- *Code du Travail*: a body of laws, bye-laws and decisions by the French Ministry of Labour. The Code identifies mandatory targets. Some are very precisely defined (for example the occupational exposure limits for a substance used on the job), and some only generally.

The *Code* obliges the employer to:

- install a *Comité d'hygiène et de sécurité des conditions de travail* (CHSCT): a committee of employee representatives who concern themselves with all OHS matters.
- call in legally designated types of assistance (a specialist employee or an external service) when monitoring OHS.
- call in an occupational health service (*services de santé du travail* or SST) to conduct compulsory routine check-ups (usually every other year) and to draw up a risk inventory and evaluation (RI&E).

In July 2011, the *Code du Travail* was amended and further rules adopted concerning the duties and organisation of SSTs and the duties of occupational physicians. The rules generally concern the structure of the occupational health services, for example a governing board based on parity, provision of multidisciplinary services, and recognition of the role of occupational nurses in conducting routine employee check-ups.

The July 2011 amendment did not mean major changes in terms of the employers' obligations.

- It did, however, give occupational physicians a *droit d'alerte*, meaning that they may raise the alarm if they suspect serious damage to individual or collective health (or a high risk of such damage occurring). Employers are then obliged to respond to such warnings (in writing); in other words, they cannot ignore the.
- Another new factor is that the *Code* now charges occupational physicians with advising employers on their alcohol and drugs policy.

Employers were, however, given an important new obligation on 30 January 2012.

- The employer must draw up an individual RI&E for each employee, known as a *fiche de prévention des expositions aux facteurs de risques professionnels*. The *fiche* must be sent to the occupational physician whenever an employee comes in for a medical (*visite médicale*).
- Failure on the part of the employer to produce a *fiche* may lead to a fine of EUR 1500 or EUR 3000 in the case of a repeat offence (or if several employees are found not to have a *fiche*).

It is notable that the French occupational health system consists of differing systems for agriculture, the private sector and government. The working methods also differ from one region to the next. There are no plans to change this.

2.1.2 Employer's obligations: sickness absenteeism and occupational disability

Occupational physicians in France play no role in assessing or monitoring employees who are off sick; that is the job of the physicians treating them and *Sécurité Sociale*, the social security agency. Occupational physicians may examine an employee who is off sick or returning to work after an illness. It is their job to evaluate whether a returning employee will need to take any restrictions into account at work (after inspecting the workplace) and to advise on any necessary adjustments or modifications. The occupational physician is authorised by law to compel employers to make adjustments to the workplace.

Employers are not obliged to continue paying a sick employee's wages. The employee's employment contract is suspended during illness; wages are then paid by the social security agency. All Frenchmen are covered by *Sécurité Sociale*, which not only provides compulsory health insurance but also disburses sick pay. This is paid out for a limited period (no more than three years) and depends on the employee's work history. Employees who are fully disabled then receive a benefit amounting to approximately 50 percent of their original pay.

Employers are only responsible for employees who become ill or disabled if their case involves an occupational disease or industrial accident. If the employee so requests, *Sécurité Sociale* will evaluate this based on a list of occupational diseases. If the evaluation is positive, the employer must pay the difference between the benefit the employee would receive for a *risque social* and the higher benefit he receives for a *risque professionnel* (up to 100 percent of his pay).

2.2 Practice in France

2.2.1 Employer's obligations regarding OHS and the occupational physician's role

How do the employer's statutory obligations with respect to occupational health and safety turn out in actual practice? And what is the occupational physician's role in this context?

2.2.1.1 CHSCT (Comité d'hygiène et de sécurité des conditions de travail)

At all firms with more than fifty employees, the CHSCT must meet four times a year. The meetings give occupational physicians a good opportunity to raise issues. Some firms do not have a CHSCT because they are unable to find employees willing to join.

The labour inspectorate and health insurer (*Caisses d'Assurance Retraite et de la Santé au Travail* or CARSAT) are always invited to attend meetings (with the exception of CHSCTs in government), but they are unlikely to send representatives. The CHSCT is often involved in investigating industrial accidents and in drawing up the RI&E. The quality of the CHSCT's performance differs from one firm to the next. They appear to have more power than the VGW (safety, health and work) committees in the Netherlands. For example, the CHSCT can insist that external expertise be called in.

That is otherwise for the CSHTs that operate in local government. The mayor (an elected official) is the employer in such cases, and the law stipulates that he or she must take whatever measures are necessary to safeguard and protect employees' physical and mental health. The mayor actually does have a great deal of power and can do more or less what he or she wants, until the next election. That power is set to be curtailed in

future, however, as regional institutions gain momentum (various municipalities converging with various political interests).

In theory, the occupational physician has a great deal of influence on the CHSCT because it consists of employee representatives (these are often trade unionists, but not always; any employee can stand for election). The committee also pays frequent workplace visits and discusses solutions to work-related problems.

2.2.1.2 SST (services de santé au travail)

All firms are obliged to join an occupational health service, and in fact most firms do. Large companies can hire their own occupational physician or join a group service. There are no occupational physicians who run their own practice (independent physicians); they must have a permanent employment contract either with a company or with an occupational health service.

Companies that have more than 200 employees in industry or 600 employees in the service sector must hire an occupational nurse (that is not the case for local government). The nurse serves as a sort of extension of the occupational physician and deals with minor injuries, routine medical examinations or workplace visits. In addition, the nurse has other tasks, often administrative in nature. The occupational health services for local government have only recently begun to consider deploying nurses for 'routine duties'. The new *décret* of 30 January 2012 stipulates that nurses at firms, like nurses at occupational health services, must complete an advanced course (*formation qualifiante*) before they can qualify. This is a new requirement.

Since 2004, occupational health services have been obliged to offer multidisciplinary services. That means that in theory, a member firm has access to different disciplines through its occupational health service. The *Code du Travail* does not describe mandatory core disciplines. It is usually the occupational physician who decides whether multidisciplinary services should be called in. The CHSCT – which discusses working conditions in the broadest sense – may also request consultation with a representative of another discipline, for example a workplace expert or IRPR (*Intervenant en Prévention des Risques Professionnels*: safety expert, ergonomist, toxicologist, etc.). This does not give rise to extra costs: the cost of calling in an expert is generally included in the fee, but that differs from one service to the next.

2.2.1.3 Routine employee check-ups and RI&E

The law basically dictates the frequency with which routine employee check-ups are carried out, depending on the risks of the job or whether an employee belongs to a particular risk category. Individual firms may make special arrangements, but this is not customary. In practice, the occupational physician and his personal secretary – who acts as his assistant – decide how and when the check-ups should be carried out. Everyone basically has a check-up every other year; risk groups have annual check-ups or more frequently, as determined by the occupational physician. The shortage of occupational physicians means that they are often unable to examine everyone every other year, as required by law. That is another reason for having nurses carry out the routine check-ups.

Occupational physicians are obliged to draft a *fiche d'entreprise* (FdE) for the companies entrusted to their care. Sometimes, the companies themselves request an FdE, often because they have been paid a visit by the labour inspectorate.

The occupational physician uses the FdE to document his or her assessment of the health risks at the company. It is document with limitations, however, because it disregards many of the safety risks and pays very little attention to how OHS is organised. The occupational physician must submit the FdE to the employer and the CHSCT and make it available to the labour inspectorate and CARSAT inspectors. This is a long-standing obligation but many occupational physicians do not have enough time to comply with it (each physician is responsible for hundreds of companies). They have the option of selecting high-risk companies and calling in workplace experts. Occupational physicians differ considerably in the way they deal with the FdE, and neither their management nor the labour inspectorate provide clear instructions.

The *Document Unique d'évaluation des risques* (DUER) is an RI&E that companies must draw up themselves. The SST is supposed to help them do this, primarily by providing workplace experts to assist them (IPRPs). SSTs are now rapidly hiring many IPRPs for this reason. SSTs are not obliged to check that a company has a DUER. Local governments are also obliged to have the DUER, but the vast majority do not. Once again, no monitoring procedure is in place.

In theory, an employer can blame the occupational physician if he or she has failed to produce a satisfactory FdE, has neglected to warn the employer about a particular occupational risk, or has failed to advise on how to avoid it. This does not happen in actual practice, however, or at least not officially. Occupational physicians at asbestos-processing firms were recently charged with neglecting to issue sufficient warning and with downplaying the effects of exposure to asbestos. The lawsuits are pending.

2.2.1.4 Monitoring compliance with obligations

The labour inspectorate (*Inspection du Travail*, IdT) is charged with monitoring and enforcing the statutory rules (not at the local government), but it is severely understaffed. On top of this, non-OHS issues such as dismissal cases, labour conflicts, wage disputes and illegal labour demand a great deal of its attention.

Forty physicians work for the IdT. These medical inspectors (*médecins-inspecteurs régionaux du travail*, MITs) are in constant contact with the occupational health services and represent an important link between occupational physicians and government. They continue to play a key role in the certification of occupational health services. They monitor matters by responding to warning signs (especially in appeal cases and during disablement procedures), by analysing the individual annual reports of occupational physicians (although not systematically), and by encouraging regional meetings and training. Unfortunately, there are too few MITs; every *département* in France (there are 95 in all) should have at least one.

2.2.2 Employer's obligations regarding sickness absenteeism and occupational disability, and the occupational physician's role

2.2.2.1 Medicals

It is rare for an occupational physician to examine an employee already on sick leave, or to confirm that a sick employee is fit for work again (these account for only 1 to 3 percent of all the medicals that they carry out). Most of the examinations performed by occupational physicians are pre-appointment medicals. Absence medicals, known as *visites de pre-reprise*, are increasing in number, however. Only the sick employee, his or her physician or the social service's *médecin-controlleur* may ask the occupational physician to perform a medical of this kind – and not the employer. Occupational

physicians therefore perceive very little pressure from employers in cases of sickness absenteeism.

When an employee is ill, the physician providing treatment decides whether he or she is fit for work. Most occupational physicians believe that GPs and specialists tend to wait too long before reporting an employee fit for work again.

It is the occupational physician's job to evaluate whether a recovered employee is fit to do his or her own work after returning to work. In order to assess this, the occupational physician carries out a *visite de reprise* one week after the employee resumes work. The *visite* can result in one of four different assessments: fit to do own work, temporarily unfit, fit but with restrictions, and permanently unfit.

The procedure is different for civil servants. After six months on sick leave, a *comité médical* must be asked to decide whether the employee is occupationally disabled. The *comité médical* is an advisory body consisting of physicians (GPs and specialists) officially appointed by the *Prefect* of the *département*. The employee only sees the occupational physician after the *comité* judges him or her to be fit for work. The *comité's* assessment takes precedence over that of the occupational physician.

2.2.2.2 Workplace inspection

If an employee has *restrictions*, the employer must investigate whether his or her work can be modified or whether he or she can be given other work. As mentioned above, the occupational physician has the legal authority to require that adjustments be made, but will usually adopt a more strategic approach to the employer.

After a workplace inspection, the occupational physician can decide whether and, if so, what 'adjusted' work will be possible. Whether the physician in fact conducts an inspection depends on his or her experience and familiarity with the company and contacts there, and the amount of pressure he or she wishes to place on the company to make the necessary workplace adjustments. Large companies are often prepared to make the necessary arrangements based on professional considerations. Occupational physicians often have a more stable relationship with large companies, meaning that they can accomplish more. Small firms often have little understanding of OHS and are irritated by the occupational physician's 'intrusion'.

Employers usually welcome workplace inspections by the occupational physician. They are eager to show him or her how reasonable or unreasonable the adjustments are. Whether the inspection leads to a dispute between the two depends on the occupational physician's attitude and other factors (for example the economic circumstances of the company). If the issue is critical enough, a dispute may ensue, but both French employers and employees tend to avoid conflict.

Unfortunately, in actual practice occupational physicians rarely have time for workplace inspections. Other reasons why they avoid such inspections are the tension that arises between them and the employer and the fact that they do not feel sufficiently competent when it comes to workplace adjustments.

In cases of a *permanent disability* (in the employee's existing job), a disablement procedure commences. Prior to that procedure, the occupational physician always conducts a workplace inspection to see whether the work cannot be adjusted in some way or whether there might be other work that the employee can do. The procedure takes two weeks and often ends with the employee being entitled to an unemployment benefit. The employee is then obliged to look for other work, bearing in mind his or her

restrictions. For the first month after the occupational physician deems the employee unfit for his or her work, the employer must make an effort to reintegrate the employee into the workforce.

If the employee's restrictions cause him or her to be recognised as 'occupationally disabled' (something that is not decided by the occupational physician), then an independent agency will assist the employee in finding other work.

The disablement procedure for civil servants is initiated not by the occupational physician but by the *comité médical*. The occupational physician can refer the employee to the *comité* for a medical examination and is obliged to submit his own opinion on the case in writing, as he is the only one who is familiar with the relevant working conditions.

2.2.2.3 Occupational disease or not

Employees must themselves ask *Sécurité Sociale* to assess whether their disorder or illness is an 'occupational disease' (often at the suggestion of the physician treating them). The occupational physician is not involved in this. He or she may offer an opinion on the matter, if asked. This means that while the employee is off sick, the relationship between him or her, the occupational physician and the employer is not 'strained' by any differences of opinion as to whether the employee's illness is an occupational disease. *Sécurité Sociale* issues an independent ruling on the matter. There is strain if the occupational physician takes steps to report an occupational disease. This is often preceded by a discussion between the occupational physician and the employer, with the former attempting in vain to force the latter to adjust the work.

Nowhere in the law does it state that an occupational physician must report an occupational disease. Every physician may draw up a *certificat médical* to report an occupational disease, but it is the employee who must decide to report this to *Sécurité Sociale*. Such reports are often submitted by GPs and specialists (especially ENT specialists in the case of noise-related deafness and pulmonary specialists in the case of occupational lung diseases). GPs are more likely to report RSI (*troubles musculoskélétiques* or TMS), which accounts for 75 to 80 percent of all occupational diseases, in particular tendonitis and carpal tunnel syndrome.

There is virtually no chance of having a psychological complaint classified as an 'occupational disease'. Decompensation (a sharp deterioration in mental health) at or because of work is regularly reported as an *accident de travail* and has a good chance of being accepted as such if the relationship with the employee's job is demonstrable (for example the suicide cases at Renault, La Poste, and France Télécom). Accusations of *harcèlement* (harassment/bullying) are first turned over to the labour inspectorate (which tends not to take action) and then to the courts, which regularly dissolve the employment contract. The occupational physician's role – if the case involves an incident and the damage is minor – is to support the employee and to work strategically to 'repair' matters.

Stress prevention is in its infancy in French firms. The obligation (imposed under EU law) to pursue a policy of stress prevention was introduced in France two years ago, but companies are still struggling to master the basics. In fact, employers believe that psychological complaints, if they exist at all, should be repressed, or that such complaints are not their responsibility because they are caused by the employee's personal circumstances or by 'psychological vulnerability' (*fragilité psychique*).

2.3 Problems

2.3.1 Confidentiality/professional secrecy

The fact that the occupational physician's work in France consists mainly of routine check-ups and pre-appointment medicals does not prevent a relationship of confidentiality from developing between him/her and the employee. Employees often regard the occupational physician as a confidant with whom they can discuss everything, from problems on the job to difficulties at home. Sometimes the occupational physician even knows more about the employee than the latter's GP. The occupational physician also functions as a complaints desk for work-related problems.

Confidentiality is never an issue because the law governing medical examinations and check-ups is designed specifically to protect employees. The routine check-up is meant to describe the relationship between health and work. The pre-appointment medical is not intended to weed out high-risk employees but mainly to establish a reference value for the employee's state of health in relation to his work.

The occupational physician does report the results of the routine check-up to the employer, but not of the specific medical findings (which are regarded as a *secret medical*). Instead, the report focuses on any individual employee restrictions. That can be troublesome if the restrictions are psychological ones. Such situations generally turn out well if the occupational physician and employee discuss in advance what information will be shared with the employer and in what form. Another method is for the occupational physician, the employer and the employee to hold a meeting at which the employee tells the employer about his or her restrictions. This is a method rarely chosen by French occupational physicians, who are careful to avoid accusations that they have violated medical professional secrecy.

Generally speaking, occupational physicians do not draft reports on aggregate employee data. The Dutch physicians who provided the information for this report generally do, and employers and works councils are very appreciative.

2.3.2 Finances and independence of occupational physician

French SSTs are financed exclusively by contributions from member companies. Occupational physicians are employed by an SST (compulsory permanent employment contract). There are two types of SSTs: the *unilateral service*, which has only occupational physicians and nurses (larger services may have other disciplines such as ergonomists and psychologists) and the *group services* of occupational physicians and nurses, occupational health specialists, psychologists, social workers and toxicologists. Employers pay a standard fee per employee for a routine (annual or biennial) employee check-up (an average of 0.2 to 0.5 percent of the total wage bill for companies with more than ten employees). In most cases, employers pay a fixed percentage of the wage bill for the entire range of services (occupational physician, nurse and IPRP), with the actual number of routine check-ups and other medicals no longer being a factor.

Every company theoretically has the right to all of an SST's services, but in reality large companies tend to require more time and attention than smaller ones (and they get it too). There is no option in France to select a particular package of services or to pay extra for more time (as in the Netherlands), but the services themselves are now considering charging extra for the time-consuming, supplementary work, especially the tasks carried out by the IRPRs (i.e. the workplace experts, for example safety specialists, ergonomists and toxicologists).

Our interviewees say that occupational health care is not a political priority and must certainly not cost more money now that elections are pending. That means that occupational physicians do not expect to be given more obligations or duties. At the same time, it would be political suicide to reduce the level of worker protection, so major cuts in occupational health care are not expected. Harmonisation of fees is likely to come up for review, however.

French occupational physicians work fairly independently and their profession is well protected. They are given permanent employment contracts and it is very difficult for companies to change physicians. Companies also have no say in which occupational physician they are assigned from a group occupational health service. That decision is taken by the management of the service, although some negotiating naturally goes on behind the scenes.

If the occupational physician is put under pressure, then he or she can always turn to the labour inspectorate, which goes to great lengths to protect the occupational physician's position. Other evidence of their autonomy is the fact that occupational health service managements regularly complain how little influence they have on physicians' working methods.

Occupational physicians who work for a company – in other words in a *service autonome* – enjoy somewhat less autonomy. They are under greater pressure because they are employed directly by the company. They essentially enjoy the same protection under the law, but their position is still somewhat weaker. They do earn more than the physicians working in group services, and they have fewer employees in their care, generally between 1500 and 2000. In a group service, occupational physicians may be responsible for anywhere from 3500 to 6000 employees. In local government (*fonction publique territoriale*), occupational physicians are appointed to a special service that works only for local governments. Each one is responsible for even more employees than his or her group service counterpart, i.e. between 4000 and 6000.

2.3.3 Access to occupational physician

Occupational physicians are guaranteed unrestricted access to the workplace (under the law) and are entitled to meet (separately if needed) with an employer, an employee or a consultative body. He or she must have access to all data (safety information, reports on tests and so forth) that could be important. Businesses that have more than 200 employees must set up a consulting room for their occupational physician.

Employees are making greater use of the occupational physician's services. They can do so in a number of ways, for example while off sick for a *visite de pré-reprise* (at the request of the employee, the physician treating him or her, or the *Sécurité Sociale* medical adviser). In addition, every employee may request an appointment, as may the employee's own physician. Employees working in high-risk jobs tend to consult the occupational physician more often than others.

Although occupational physicians deal more haphazardly with employees in small companies (fewer than ten employees) – they do not have enough time to pay these companies regular visits – when problems arise, usually related to employee illness, there are no barriers to consulting them. Small companies of less than ten employees are not obliged (as larger ones are) to spend a particular percentage of their wage bill on occupational health care.

2.3.4 Shortage of occupational physicians

Access to an occupational physician depends on his or her availability. Very few French physicians choose a career in occupational health: occupational physicians do not have a good reputation. Many of the 124 training places available in 2011 remained unfilled. As a result, there is a shortage of occupational physicians, meaning that, in reality, access to the occupational physician is limited.

A full-time occupational physician in France is assigned some 3000 to 5000 employees. The actual figures vary considerably from region to region; depending on the region, an occupational physician may be assigned 5000 to 6000 employees or even 10,000 employees in sparsely populated regions. There is a shortage of occupational physicians of about 30 to 40 percent; that figure is expected to rise quickly. Various campaigns have been launched to recruit physicians abroad.

2.3.5 Occupational nurses

The French government and/or professional associations of occupational physicians are attempting to alleviate the shortage by having nurses take over the routine check-ups and simpler workplace-related activities. To employers, the important thing is that the check-ups and medicals are actually carried out; if there is no other way, then they would rather have an occupational nurse perform them than not have them performed at all. The SSTs are now hiring large numbers of nurses and training them in occupational health.

It is not really difficult to find nurses who are interested in this work. Many of them prefer a quieter life than in hospitals, where they work odd shifts and under enormous pressure. After some initial hesitation among the existing occupational physicians (French physicians have trouble delegating), the occupational nurses are slowly gaining acceptance everywhere. It is important that their work should be clearly defined, and that is not always the case according to our interviewees.

2.3.6 Training and expertise of occupational physician/protection of title

Occupational physicians differ considerably in their level of expertise. Those who received basic medical training before 1980 were able to obtain a *Certificat d'études spécialisées* (CES) after completing an additional six-month course. Some 75-80 percent of all existing occupational physicians have done so. There are also younger physicians who have completed a four-year programme (comparable to the Dutch occupational physician programme). They are awarded a *Diplôme d'études supérieures* (DES) at the end. There is also a shorter programme (two to four years) for experienced physicians, the *concours européen*. This programme also leads to a DES. The shortage of occupational physicians has led to a new trend in which older GPs are invited to be 'retrained' to receive a DES. It is not really a popular career switch, however, because it requires a long-term investment for a job that in the end pays much less than that of GP.

Compulsory continuous professional development (*formation médicale continue*), which involves obtaining points for peer supervision, courses and symposiums, had been cancelled (for financial reasons and because the system was unwieldy), but reinstated in early 2012.

According to our interviewees, French occupational physicians focus much more on individual medical issues than their Dutch counterparts, and are often weak when it comes to providing medical advice on a collective or company-specific basis. Their

medical (somatic) knowledge is generally good to very good. They are clearly much weaker when it comes to psychological complaints.

It is prohibited in France to appraise physicians who have a permanent employment contract for their quantitative output. That means that occupational physicians have no incentive to do more than a certain 'customary output'. They look for quality primarily by 'instigate' OHS in companies (for example by taking individual results to the collective level). Nevertheless, this does not happen very often, and in any event much less than in the Netherlands.

2.3.7 Cooperation with mainstream health care/departmentalisation

GPs and specialists pay little attention to the relationship between illness and work; occupational physicians, on the other hand, do not hesitate to consult GPs and specialists. They share the same principle of medical secrecy and employers and employees respect this. Contact with GPs and specialists is easy because French occupational physicians do not monitor employees on sick leave. Conversely, GPs and specialists only rarely consult occupational physicians. When and if this does occur, it is because the physicians know one another. Medical data is always shared free of charge and it is usually the patient who provides the information, as they keep their own records (reports on medical examinations, notes from specialists, x-rays, laboratory reports). Employees take their records with them when they see their occupational physician. French GPs and specialists are much less computer-savvy than their Dutch counterparts. They tend to communicate in writing, with the patient as the messenger, or by telephone. Employers have very little contact with GPs and specialists; the latter do not appreciate being approached by employers.

2.3.8 Prevention

The French occupational physician's most important task lies in the area of prevention. The law describes this as follows: 'prevention of every form of damage to employee health owing to work'. If the occupational physician takes an active approach to companies (by paying visits, drafting reports and contacting the CHSCT), he or she can exercise considerable influence. Whether the workplace inspection leads to a prevention advisory report depends very much on the particular occupational physician.

The employers' associations and the unions pay lip service to prevention, but in actual practice there are very few agreements about prevention at industry level (with the exception of very large companies and the construction industry). This is very different to the situation in the Netherlands. Sometimes the interest taken in prevention increases if the industry or sector finds it there are many work-related disorders (for example RSI).

'Life-style interventions' play a much bigger role in the Netherlands than in France. There is one exception, however: since 20 July 2011 (the latest amendment of the *Code du Travail*), the occupational physician must specifically advise employers and employees about alcohol and drugs use.

3. Finland

We received answers to our questions and additional information about Finland from Jos Verbeek, associate professor at the Coronel Institute/AMC in Amsterdam and senior researcher at the Finnish Institute of Occupational Health (FIOH) in Finland.

3.1 Statutory context

3.1.1 Employer's obligations: occupational health and safety

The employer's OHS obligations are specified in the Occupational Health Care Act. The Act focuses on:

- preventing work-related disorders and industrial accidents;
- ensuring health and safety at work and in the working environment.

The Act also aims to support:

- employee health, capacity for work and job-related ability in the various phases of their careers;
- effective performance by the workforce.

The employer is obliged to offer preventive occupational health care. He can also offer curative health care, on a voluntary basis. The Act also provides for cooperation between employers and employees in order to ultimately achieve the aims.

3.1.2 Employer's obligations: sickness absenteeism and occupational disability

Employers are not obliged to continue paying a sick employee's wages. Sick pay and disability benefits are paid by Kela, Finland's social security agency. After a ten-day waiting period, employees on sick leave collect sick pay for a maximum of 300 days (the amount comes to 70 percent of their wages up to a certain annual income, and a lower percentage for higher incomes). Anyone who has not recovered by then may qualify for a disability pension. Sick employees who return to work part time after several months on sick leave may qualify for partial sick pay.

Employers are required to insure employees against industrial injuries and occupational diseases. They take out coverage with private accident insurers. The premium is a certain percentage of the wage bill, with allowance being made for the specific accident risk of the relevant occupational group. An employee who suffers an industrial accident or an occupational disease can claim benefits from the accident insurer that are higher than the standard benefits paid by Kela.

3.2 Practice in Finland

3.2.1 Employer's obligations regarding OHS and the occupational physician's role

The labour inspectorate monitors the employer's compliance with its obligations. The law interprets 'prevention of work-related disorders' broadly; this includes preventing excessive psychosocial stress.

Two notable features of the system in Finland is that there are no GPs and that general practice is an underdeveloped area of specialisation. In Finland, occupational physicians also play the role of GPs or – to put it another way– an employee's occupational physician is, first and foremost, his GP. It is an arrangement that evolved gradually from the early days of Finland's health care system. The fact that occupational physicians offer curative medical care is a kind of fringe benefit for employees. Everyone is used to

this arrangement and it applies to virtually all employees. Only about 10 percent of smaller firms do not offer it. Unemployed persons go to a municipal health service for primary care. The care provided by an occupational physician is generally better organised and there are more services on offer. Working people are therefore 'better off' in this regard.

So far, Finnish employers have not been responsible for monitoring sick employees (or for organising such monitoring). The employee's physician – which may well be his or her occupational physician – writes a 'disability note' stating how long the employee will be absent. That is all there is to it. The employee is not monitored; there is not thought to be a need for this. Recently, it was decided that if an employee is off sick for 90 days, he or she should meet with the employer and occupational physician to draw up an action plan, in order to prevent long-term occupational disability.

3.2.2 Employer's obligations regarding sickness absenteeism and occupational disability, and the occupational physician's role

3.2.2.1 Occupational disease or not

Whether or not an employee is suffering an occupational disease or industrial injury makes no difference to the award (or size) of the benefit paid out by Kela. That does not mean that the issue of 'occupational disease or not' is irrelevant to the employee (and his/her benefit); in cases of occupational disease or industrial injury, the employee can claim benefits under the employer's private occupational disability insurance. That insurance often entitles the employee to a larger benefit than that paid by Kela.

The company's occupational physician can establish that the employee has an 'occupational disease' and refer the employee to the FIOH or university outpatient clinic for occupational diseases for an official, specialist diagnosis by an independent occupational physician working there. These physicians are put under some pressure by employees to qualify a disorder as an occupational disease (for example a diagnosis of fungal-induced asthma). The diagnosis matters less to employers, as the benefit is paid out by the occupational disability insurer.

If the employee is not diagnosed with an occupational disease or industrial injury, other insurance may be relevant. For example, if an employee is unable to work owing to a traffic accident, then the personal injury insurance will also cover the employee's absence and occupational disability. Insurance companies are very keen to recover the costs associated with employee absence and disability from one another.

The higher the rate of absence in a company, the higher the premium that the employer pays for private occupational disability insurance. This is not a major issue in Finland, however. Does this mean that employers are unconcerned about employees recovering from non-work-related illnesses? Not entirely. They indeed take little interest in this group, but mainly for reasons of privacy than a lack of concern. Their customary reasoning is: 'The employee is sick and the doctor will cure him or her; as the employer it's none of my business'. The doctor's note 'prescribing' absence is rarely questioned.

3.3 Problems

3.3.1 Confidentiality/professional secrecy

Medical files are regarded as confidential information in Finland, as elsewhere.

Because sick employees are hardly ever monitored, there is less communication between the occupational physician and the employer about individual cases. The occupational physician or other physician providing treatment gives the sick employee a statement of occupational disability indicating the diagnosis and length of time he or she will be off work. There has been some discussion of this statement of diagnosis, with some parties arguing that it violates doctor-patient confidentiality.

The occupational physician in Finland is mainly a GP; within the context of occupational health, he performs routine employee check-ups (more than a million a year for slightly more than two million employees). The routine check-up is indicated by work-related exposure; for example, if an employee is exposed to noise, then his hearing would be tested routinely. The Work Ability Index (WAI), a multidimensional work capacity test, is not carried out universally, but only in individual cases. The results of the WAI are not shared with the employer.

If a routine check-up reveals that an employee is unable to do his/her work without putting health or safety at risk, then the occupational physician notifies the employer.

The occupational physician is a trusted professional whose position is never called into question in Finland. He or she is regarded as the employee's 'family doctor', and everyone knows that doctors are there to heal.

3.3.2 Finances and independence of occupational physician

Employers are reimbursed for 60 percent of the cost of compulsory (preventive) occupational health care under the National Health Insurance (NHI) scheme. Kela reimburses 50 percent of the occupational physician's curative care. In 2009, the costs were EUR 324 per employee for occupational health and curative care together (EUR 120 and EUR 204 respectively). The NHI reimbursement was EUR 64 and EUR 84 respectively. There is no debate about these amounts in Finland; the arrangements are simply taken for granted by politicians and the public.

Although employers pay some of the costs of the occupational physician, and almost all occupational health services have become part of for-profit companies owing to a series of mergers, there is no question that occupational physicians are entirely autonomous vis-à-vis employers. They are perceived as GPs and no one doubts that their main intention is to heal the sick.

3.3.3 Access to occupational physician

There are almost no barriers to occupational physicians in Finland, with almost 90 percent of employees being offered occupational health care. Access is also well organised in the agricultural sector thanks to the social insurance scheme for farmers. The figures are lower in the SME sector. In 2007, only 55 percent of the employees in micro-firms (fewer than ten employees) had access to occupational health care (Leino, *Barents Newsletter on Occupational Health and Safety 2009*; 12:79–81). Small businesses, like all employers, are obliged to offer preventive occupational health care, but they sometimes neglect to do so. According to Leino, that is because they have

limited resources. In addition, the labour inspectorate rarely pays a visit, so the risk of a non-compliant employer 'getting caught' is minimal.

Alongside employees, the self employed can also make use of occupational health services. They only do so to a limited extent so far, although they are entitled to the same reimbursement that employers receive for their employees: 60 percent of the cost of compulsory (preventive) occupational health care under the NHI (Leino, *Barents Newsletter on Occupational Health and Safety 2009*;12:79–81).

3.3.4 Shortage of occupational physicians; deployment of occupational nurses

Finland is also experiencing a shortage of occupational physicians, but this simultaneously means a shortage of GPs because the work of the former focuses on curative care. There are vast differences between municipal health centres (for non-employees) and occupational health services. Physicians employed by the municipal centres work under enormous pressure and for low pay. Occupational physicians employed by the occupational health services have a lighter work load and are well paid. According to our interviewee, the OECD believes that this system is widening the gap in care provision.

The number of training places for occupational physicians has been increased and occupational nurses are now being deployed for routine check-ups and workplace inspections. The division of responsibilities has been positively received. The nurses are regarded as fully-fledged occupational health professionals and they have an active and flourishing professional association. No thought is being given to dividing the responsibilities further, for example with the occupational physician concentrating on work-related physical impairments.

3.3.5 Quality, training and expertise of occupational physician/protection of title

Physicians who work part time as occupational physicians are qualified to do so after taking a seven-week course leading to certification. Continuing professional development is recommended but not compulsory, and those who do not pursue it are not subject to sanctions. Once registered, an occupational physician retains his or her qualification for life.

A full-time occupational physician/specialist in occupational medicine has completed a six-year specialist programme. Both types of physician work in occupational health services and both do the same type of work. However, every occupational health care unit must have at least one specialist occupational physician. These physicians during their training spend six months at the Finnish Institute of Occupational Health (FIOH), the multidisciplinary research and expertise centre. That is one of the problems when it comes to increasing the number of occupational physicians: there are only a limited number of trainee places available. Increasingly, psychologists are being called in to deal with psychosocial health risks.

3.3.6 Cooperation with mainstream health care/decompartmentalisation

The various professionals employed at the occupational health services work closely with one another. Because occupational physicians are regarded as an employed person's GP, there is no cause for occupational physicians and GPs or primary care to work together. Both Finnish GPs and municipal health services (for non-employees) apply the same rule as Dutch GPs: they do not, as a matter of course, investigate whether an illness or disorder has been caused or is being aggravated by the patient's work. Occupational physicians frequently refer patients to specialists working within the same service or at a hospital.

3.3.7 Prevention

Prevention and wider risks (including psychosocial risks and risks arising from the way work is organised) are most certainly points of concern in Finland. For occupational physicians, however, prevention takes a back seat to medical care. Prevention work consists mainly of the routine check-up, tailored to the employee's specific case (work-related risks). If the routine check-up is done properly, it produces relevant information for the organisation: a report with health data on the workforce that also provides a frame of reference for improvement. Based on this report, an occupational physician can propose extra preventive measures to reduce or prevent risks. According to our interviewee, such measures are just as rare in Finland as in the Netherlands, however.

Finland differs from the Netherlands in that its occupational health services perform very limited OHS tests and inspections, and when they are performed, they are usually entrusted to the occupational nurse (and not the occupational physician). More specialist services – such as testing the level of noise or of a chemical substance – are offered by the Finnish Institute of Occupational Health (FIOH) through its regional departments. These services are therefore often based on and associated with scientific research and are of excellent quality.

Individual employees may take a WAI test, the multidimensional test of the employee's work capacity. The results of the routine check-up or WAI are never used as an excuse to discuss the employee's lifestyle with him or her (either by the occupational physician or the employer).

In general, it is companies that are expected to maintain their employee's fitness for work, more so in Finland than in the Netherlands. They do this by organising such activities as sports afternoons or lectures on such topics as burnout. The FIOH plays an important role in publicising these activities, although most of them take place outside the regular occupational health services.