International OH systems

Part 2: occupational health delivery in the Netherlands

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In the second in a series of articles exploring different national occupational health systems, Carel Hulshof and Monique Frings-Dresen explain how OH is coordinated and delivered in the Netherlands, and the changes that are now emerging to ensure a modern, evidence-based approach to OH provision.

THE Netherlands has a working population of about 7 million employees served by a near-comprehensive system of occupational health delivery. As part of the Working Conditions Act of 1994, the Dutch government passed legislation that required all employers to contract certified multidisciplinary occupational health services (OHSs) to assist them with occupational health and safety and with sickness absence management. In 2002, the coverage of the working population by OHSs reached almost 100%. The total volume of trade by OHSs in that year accounted for 1 billion Euros[1].

Since 2004, due to deregulation and tailoring of protective legislation, the size of the market has decreased. Employers are now free to contract either a certified OHS or hire a board-certified occupational health and safety expert for specified tasks. Employers

Occupational health delivery in the Netherlands

The Dutch occupational health system has changed over the years to a state in which:

- employers are free in their choice of contracting either a certified OH service (OHS) or hiring a board-certified occupational health and safety expert for specified tasks
- for many years, the Dutch OHSs hardly contributed at all to the prevention of occupational ill health. Over 90% of the contracts of companies with OHSs consisted either entirely or largely of sickness absence guidance
- the quality and evidence-based foundation of many of the OHS programmes can be questioned and should be improved
- practice guidelines are being developed to assist practitioner decisions about appropriate occupational healthcare for specific clinical circumstances.

are obliged to seek advice from a certified occupational physician (OP) if an employee's sickness absence exceeds a period of six weeks. In 2008, more than 85% of all companies had a contract with an OHS or with an individual expert[2].

In total, about 2,000 occupational physicians, 550 occupational hygienists, 2,000 safety engineers, 200 organisational experts, and 250 occupational health nurses are now delivering occupational healthcare in the Netherlands. Of the OPs, 61% are employed by the five largest OHSs, 22% by 69 smaller OHS organisations, and 18% are working on a freelance basis. The number of self-employed OPs has almost doubled over the past three years[3].

HISTORY AND ORGANISATION

The beginning: in-house services

The history of occupational health delivery in the Netherlands dates back to the beginning of the 20th century. In 1908, a few years after the first physician was appointed as a medical inspector for the Labour Inspectorate, a large shipyard and a railway construction firm were the first Dutch companies to employ a physician for their employees[4]. In the first decades of the 20th century, only a few large industrial enterprises, such as the Dutch State Mines, Philips, Stork, and the Royal Dutch Airlines, followed this example and started their own in-house medical services. These services were directed mostly toward prevention and treatment of occupational injuries and inflammatory diseases, in particular tuberculosis.

Joint and multidisciplinary services

After the Second World War, awareness of the importance of occupational safety and health in industry was growing. While large organisations often established their own OH departments, medium-sized companies were not able to hire their own medical staff and consequently formed associations of companies within a region to set up a joint OHS organisation[5]. In the 1970s, the number of joint OHSs increased rapidly. A pivotal role in this development was played by the OH branch organisation of the construction industry, Arbouw, which contracted a comprehensive countrywide network of these services. However, the Act on Occupational Health Services, which was implemented in the Dutch legislation in 1962, was still obligatory only for companies with at least 750 employees (office workers excluded) or companies with special risks, such as lead producing or processing firms[6]. Thus, in spite of this countrywide spread of services, the actual coverage of the working population by all OHSs was only 40%.

Also in this period, the nature of the OHSs gradually changed toward multidisciplinary services. While the first OHSs were staffed mainly by occupational physicians and occupational health nurses, between 1980 and 1994 other professionals joined: occupational hygienists, safety engineers, occupational physiotherapists, ergonomists, psychologists, occupational social workers, and organisational experts. An important incentive for this process was the introduction of the Working Conditions Act in 1983, requiring OHSs to employ members of at least four different board-certified professions: occupational physicians, safety engineers, occupational hygienists, and organisational advisers. Strangely enough, and in contrast with many other European countries, occupational health nurses and ergonomists were overlooked as core professions in this Act.

After 1994: rapid growth, privatisation and commercialisation

At the end of the 1980s, the Netherlands was suffering from high work disability figures, which were thought to be caused in part by the specific features of the social insurance system, in particular the Disability Insurance Act 1967, which provided financial compensation for wage loss of disabled employees irrespective of the cause of the disease ('risque social'). These high figures led to fierce political debates. This ultimately resulted in fundamental revisions of the Disability Insurance Act, including privatisation of part of the social insurance system and an increase of the financial responsibility and accountability of employers (and partly also employees) for sickness absence and work disability. This was intended to be an incentive for employers to invest in the prevention of sickness absence and disability, as well as the adoption of a more active return-to-work policy.

In conjunction with this rather drastic change in social insurance legislation, an important reform of the OHS system was introduced in 1994. In this reform, the Working Conditions Act was revised. All employers

became obliged to establish or hire certified OHSs for the following tasks:

➤ advice on sickness absence management and prognosis of recovery
➤ check and approve the company's occupational health and safety risk assessment
➤ occupational health surveillance of employees in cases of work-related risks
➤ a free accessible consulting hour for employees with questions about work and health.

At the same time, a ban on OHS profits was withdrawn to stimulate a competitive market. These two developments created enormous potential for rapid growth of the occupational health and safety market. Many new players entered the field. Former social insurance organisations and commercially oriented companies, such as private insurance organisations, founded new OHSs, often on a large national scale. A fierce competition in price and content of the services began, and radio and TV commercials for large OHSs were common. Sometimes the activities of OHSs and insurance companies were difficult to disentangle, such as cases of OHSs playing a role in offering a package of 'employee benefits' to companies on behalf of an insurance company or referring employees for special care to healthcare providers contracted or founded by insurance companies.

As a consequence of this competition, the market for occupational healthcare changed from a supplier-centred to a customer-centred one[7]. Because of the rapid growth of the number of OHSs and the demand for OPs, many former social insurance physicians were re-educated as OPs but often retained the 'insurance physician attitude', which in general is not focused on preventive tasks and guidance.

Although employers were obliged to hire OHSs for at least the four aforementioned tasks, sickness absence management was by far the dominant activity performed by OHSs. In a large questionnaire survey of OPs and insurance physicians in 1998 regarding the effects of the new legislation, a substantial proportion of the respondents complained about a lack of time or possibilities for prevention and about a serious threat to their independent position[8]. The European Trade Union Institute has also been critical of the Dutch OH system. In 2007, Laurent Vogel, director of its health and safety department, commented: 'In practice, the Dutch OHSs hardly contribute to prevention at all. Over 90% of contracts with the OHSs consist either entirely or for their major part of sickness absence guidance'[9].

Deregulation and new orientation

The most recent years can be characterised as a period of deregulation. Additional legislation from 2002 (the Improved Gatekeeper Act) mandated, by imposing fines, that employers, employees, and occupational health professionals take responsibility in the management of sickness absence starting in the first six weeks has contributed to a significant decrease in sickness absence and disability[10]. However, in particular the government and employers' organisations increasingly expressed the view that in the fields of social security and occupational health and safety, over-regulation had been created. Self-regulation by the social partners became the new paradigm. For the OHSs, this process was accelerated by a 2003 ruling by the European Court of Justice wherein the obligation for all employers to contract an OHS was judged to be in conflict with the European Framework Directive. Therefore, the legislation was partly altered in 2005. If an employer is able to manage the legally required preventive activities related to OH by its own in-house staff or by hired experts, then there is no further obligation to contract an OH service. Furthermore, the obligation to arrange a freely accessible consulting hour was removed, in spite of protests from OPs and trade unions.

In 2007, 79% of the employers still had a contract with an OHS[2]. However, it is expected that this percentage will decrease further over time. Many OH professionals have since lost their jobs in the OHSs. Some of them became self-employed as a consequence of this job loss, while others voluntarily made this change because of the perceived potential of this new 'market'.

Because the high sickness absence rates and disability figures in most companies have been substantially reduced, many OHSs are currently in a process of re-orientation. Having ignored for many years their preventive duties, OHSs are now seeking new possibilities to show their added value with regard to prevention. One of the new areas in the OH market is the increased attention to the lifestyle and vitality of the employees. While the obligation to offer occupational health surveillance for specific risks to the employees is carried out in only 10% of the companies (which violates the law), two-thirds of the large companies consider general health checks as an important instrument 'to maintain the vitality of the employee and the organisation'[11]. Many OHSs have tried to anticipate this and offer different types of health checks. However, the quality and evidence-based foundation of many of these programmes is questionable.

QUALITY OF OH AND PRACTICE GUIDELINES

Although the development of occupational healthcare for (almost) all employees can be considered a sign of substantial progress, the quality of the care provided did not, and does not, always meet professional

standards, partly as a result of the commercial approach that many OHSs have adopted to survive in a rapidly changing market. Moreover, the direct influence of 'third parties' (for example, insurance companies or commercial providers of certain aspects of care) on the content of the work of OPs and other professionals is growing. To address these issues, and to improve the professional quality and independence of professionals within the OHSs, the scientific basis of OH practice needed improving. One of the tools for this improvement has been the development, implementation, and evaluation of clinical practice guidelines.

Practice guidelines are 'systematically developed statements designed to assist practitioner decisions about appropriate healthcare for specific clinical circumstances'[12]. In 1998, the Netherlands Society of Occupational Medicine (NVAB) – the professional association of OPs with more than 2,000 members – started a programme for the development and implementation of evidence-based practice guidelines[12].

The NVAB guidelines are based on scientific evidence – with the level of evidence presented for each important recommendation in the guideline – peer-group consensus, professional or ethical principles, and best practice. So far, 12 NVAB guidelines have been published: low back pain; mental health; visual acuity; sheltered workshops; complaints related to the arms, neck, or shoulders; asthma/COPD; contact dermatitis; noise-induced hearing loss; ischaemic heart disorders; influenza prevention; pregnancy and work; and cancer and work. Four others are in development.

Not only are the guidelines for use by individual practitioners, but they may also improve the quality of healthcare overall, by enhancing professionalism, accountability, and efficiency. Scientific evaluation of some of the NVAB guidelines in randomised controlled trials confirmed their effectiveness and cost-effectiveness with regard to sick leave and disability prevention[13–15].

The professional societies of other health professionals have embraced this idea and are now starting to develop guidelines as well, partly in conjunction with the NVAB. With the increasing evidence that work and working conditions have a large impact on health in general, the NVAB has also become actively involved in developing multidisciplinary guidelines in collaboration with other (para)medical professionals. To be eligible for funding of clinical guideline development, the Dutch Ministry of Health has incorporated in its latest programme the inclusion of work-related aspects as an obligatory requirement and a guidance document was recently developed[16]. Part of the existing gap between general healthcare and occupational health may be bridged by the integration of work and health issues and guidance on return-to-work interventions in relevant multidisciplinary clinical guidelines.

THE WAY AHEAD

In the previous two decades, occupational healthcare in the Netherlands was focused mainly on sickness absence and disability for work and, particularly after the start of the commercialisation, employers had a strong influence on the content of the occupational care because they paid for it. The development and implementation of practice guidelines for OPs has improved care; it has become more evidence-based and more oriented toward preventive actions to improve participation at work.

Occupational healthcare is and should be aimed at:

1 safe work for the employees
2 prevention of work-related diseases
3 participation of employees with and without limitations
4 improvement of functioning at work.

OPs will remain key actors in these activities, but the broad orientation of OH delivery requires a multidisciplinary approach involving collaboration with other OH professionals, general practitioners, and (para)medical specialists. OH professionals in the Netherlands will be more involved in preventive activities, such as implementation of evidence-based measures at the workplace to prevent occupational or work-related diseases, and less involved in sickness absence management. The focus on development and implementation of lifestyle programmes will increase. Examples are stimulation of physical activities and fitness, as well as changing diet and smoking behaviour to decrease obesity and cardiovascular diseases.

Due to demographic changes in the working population, general practitioners and medical specialists will be faced with employees with chronic diseases who want to participate in and sustain their work as much as possible. Thus, occupational healthcare will have to be integrated early in the treatment process to increase participation of employees with (chronic) diseases. This underscores a need for better collaboration between occupational and general healthcare.

In the Netherlands, other ways of organising OH delivery are emerging. Several 'clinical occupational health professionals' are now employed in hospitals and primary care centres. These professionals, mostly medical doctors but also some occupational health nurses, are working in multidisciplinary teams with the goal of bridging healthcare and occupational health at an early stage of the disease process in cases of work-related or work-relevant diseases.

In the future, the number of OH services and occupational physicians may decrease in the Netherlands; large companies are likely to retain well-developed occupational healthcare in their organisations, but in small enterprises occupational healthcare could be organised at the branch level, perhaps partly delivered in a primary care setting. To maintain the quality of occupational healthcare at a sufficient level, training in occupational health must be developed and integrated into courses for other health professionals. Multidisciplinary guidelines oriented toward work participation are currently being developed and implemented in practice. Participation in work is increasingly seen as an important outcome parameter for good healthcare. This necessitates training in using these guidelines in practice, as well as training in working in multidisciplinary teams focused on work participation during medical treatment. It must be hoped that the insurance companies are similarly convinced of this and will support and encourage employers, general healthcare professionals, and occupational health and safety specialists to improve occupational healthcare for the individual employee. ■

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CONCLUSIONS

- **In** the previous two decades, occupational healthcare in the Netherlands was mainly focused on sickness absence and disability for work
- **The** development and implementation of practice guidelines for occupational physicians in the past few years has improved the quality of care, becoming increasingly oriented toward preventive actions to improve participation at work
- **Occupational** physicians remain key players, but the broad orientation of OH delivery also implicates a multidisciplinary approach and collaboration with other OH professionals, general practitioners and (para)medical specialists
- **The** focus on development and implementation of lifestyle programmes will increase
- **Participation** in work is seen as an important outcome parameter for good healthcare

Notes

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