CERTIFICATION AND QUALITY ASSURANCE IN DUTCH OCCUPATIONAL HEALTH SERVICES

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Abstract. Since 1994, each Dutch enterprise has to be affiliated to an independent occupational health service (OHS), recognized by the government. In addition, each enterprise has to be supported by this occupational health service in its activities for the improvement of working conditions, and in the guidance of employees absent from work. From 1994 to 1998, the government was carrying out the certification and recognition of occupational health services. Since 1998 the certification has been carried out by private certifying institutions, in general consultancy bureaus that also provide ISO certification.

In the Netherlands, the supervision of the quality of occupational safety and health care is twofold. Firstly, the Labor Inspectorate is checking if the enterprises keep to the rules. For example, each enterprise should have a risk assessment report at its disposal. The latter should be approved by the OHS. If an enterprise does not meet these rules, a penalty may be imposed. In practice, this happens rather seldom. Secondly, each OHS unit should be recognized by the Ministry of Social Affairs and Employment. The recognition takes place if the private certifying institution has assessed that the OHS meet a large number of requirements laid down in the “Guideline for the Certification of Occupational Health Services”. This Guideline consists of 50 conditions and about 200 verification points. The requirements deal with the internal organization and the output.

By order of the Dutch government the IVA, a Dutch institute for social research, has recently investigated if this certification leads to a sufficient guarantee for appropriate occupational safety and health care. By means of a large number of discussions and workshops, the IVA has investigated how OHS, employees, employers, insurance companies and others judge the quality management.

In this study, the current method of certification turned out to produce insufficient incentives for quality improvement. None of the involved parties turned out to be satisfied with the current system.

The fundamental problem of this certification system can be summarized as follows. The requirements prescribe a quality management system in conformity with ISO, but they also contain a lot of organization rules, much more than ISO. It is this degree of specification that, if practiced slavishly, leads to an output that is not able to satisfy the needs and demands of employers, employees and government. There are no rules with regard to this output, but only to the process, e.g. the way an advice has been brought about.

In this paper, we show how the current certification system is working, how this system has been evaluated, and what criticisms have been uttered. We also indicate how we might achieve a real improvement of quality management in prescribing much less details about the OHS internal organization, and in demanding employers and employees to make clear agreements about the desired OHS output and to monitor carefully if the agreed output quality has been achieved.

Key words: Occupational health services, Certification, Quality assurance

INTRODUCTION

According to the European Union regulations, all European employers should seek professional support in the field of working conditions and health. In the Netherlands, this rule has been implemented in a way that differs from most other countries. Each Dutch employer is affiliated to an independent occupational health service (OHS), or has his or her own occupational health service...
as an internal department within the enterprise. This obligation has been in force since 1994. The occupational health services support the employer not only in his working conditions policy, but they also play an important role in the guidance of employees absent from work. In the Netherlands, there are about 50 external and 50 internal OHS units, as well as OHS units that are departments of one specific organization. Both the internal and external OHS are self-supporting: they do not receive any funding from the government and are dependent on the contributions of the affiliated employers.

Both types of occupational health services have to be certified. From 1994 to 1998, the Dutch government carried out this certification process. From 1998, the certification has been in the hands of an independent foundation, the Foundation for Management of Certification of Occupational Health Services (SBCA), in which employees, employers and the OHS are represented [1]. Although initiated by the government, the foundation can operate free from any governmental pressure.

The goal of certification is to make the OHS comply with certain quality requirements. In 2001, the IVA, an institute for social scientific research in Tilburg, carried out a study of the effectiveness of the certification process in terms of warranting the desired quality. In this article we first describe the system, and the way the supervision/inspection of the OHS in the Netherlands is currently being organised. Then we present the problem definition, the research method and the results of the evaluation study. We conclude by discussing the consequences of our findings and sketch a possible scenario of the future certification of Dutch occupational health services.

SUPERVISION AND CERTIFICATION

In the Netherlands, the supervision of working conditions and health policy in enterprises is organised in two ways. Firstly, as mentioned above, every occupational health service requires a certificate before being allowed to contract employers. Secondly, the government supervises the working conditions by means of the Labour Inspectorate. This gives rise to a remarkable situation. The employer is obliged to engage OHS in a number of well-defined activities, and if there are problems inside the enterprise with regard to the working conditions, e.g. because of an incomplete or incorrect risk assessment report, it is the employer who is responsible, not the occupational health service. There is no governmental body that directly supervises the OHS activities. The only avenue of quality control is thus an indirect one, i.e. by means of certification.

Certification of OHS is carried out by certification bodies, which are commercial bureaus usually involved in different forms of certification. Also they often carry out ISO audits. The certification bureau checks if the quality manual of the OHS complies with the requirements. This check is carried out on the basis of a document written by the foundation for certification. This document contains about one hundred requirements and “verification points”. The quality manual should reflect how the OHS meet the requirements, which can be divided into three groups. The first group of requirements concerns the OHS structure. For instance: the regulations of the service should stipulate the provision of health services as the main product. Another requirement in this group concerns the necessary level of expertise embodied in the service. The second group of requirements concerns the quality system of the service. Each service should have a quality handbook describing all the products and explaining how the quality of those products is guaranteed. The third group of requirements is directed at actual products by offering a detailed description of the products an OHS unit should deliver.

The approval of the quality manual by the certification bureau is followed by an audit of the internal OHS organisation itself. Finally, some OHS customers are visited. Some elements of the certification are repeated annually. An extensive re-certification takes place every four years.

This procedure has some noteworthy features: First, there is no real direct supervision of the occupational health services. The certification should show that the OHS unit is capable of delivering good products and services for which it is responsible, but no actual quality assessment of those products and services takes place. Ultimate responsibility for a good health and working
conditions policy rests with the employer who may engage any occupational health service that he likes. If the selected OHS unit does not perform well, the employer is free to contract another one. While this leads to strong competition between occupational health services, the key criterion is usually cost (OHS are at liberty to determine their own price lists) rather than the quality of the services.

A second characteristic is that while the certification procedure is very similar to the ISO-9000 quality testing, it does differ: its regulations prescribe much more than the ISO-9000 system. The main distinction between the certification and the ISO-9000 quality system is that an ISO-certified organisation is free to choose the products it will develop and the way they are developed, as long as the (self-made) quality handbook is adhered to. If the certification would be carried out according to the ISO-9000 procedure, OHS would have much more freedom in the way they operate internally and externally, as long as they deliver the services they have to, and as long as the standards are followed as described in the quality handbook. That means that, for instance, the OHS unit could choose to deliver other services for large organisations than for small organisations, and in this way effect a better “fit” between customer and service. According to many employers and employees, this is not possible at present.

A third aspect is the fact that the satisfaction of customers (employers and employees) hardly plays any role in the certification. The type of services to be delivered has been defined and prescribed. The OHS unit receives a certificate on condition that these services can be delivered. Issues like customer compliance, alertness and advisory skills have no influence whatsoever. The products to be delivered are the assessment and evaluation of work risks, the free consultation hour for employees with health and/or working problems, and the periodic health surveillance of workers. Another obligatory service is the guidance of workers absent from their work due to illness. Employers usually emphasise the latter product: for them it is the most important service. During the certification, however, very little attention is paid to guidance during sick leave, with the focus placed on many other products. In consequence, many employers are not satisfied with the service package of the OHS unit: the latter is providing too many products the employers do not demand, and too few products they really need.

The original objective of the certification procedure was to raise the OHS quality. As stated above, the government itself was responsible for certification up to 1998. At the transfer of the certification procedure to private organisations, these organisations and the government agreed to evaluate the new situation after two years. The results of this evaluation are described below.

STUDY OBJECTIVES

For this evaluation study we formulated the following questions:
1. Are the certification requirements an effective guarantee for a good quality occupational health service?
2. Are some requirements superfluous, or are additional requirements necessary?
3. Does the current practice of certification give rise to the revision of the requirements or the certification system as a whole?

RESEARCH METHODS

The methods we applied were discussions and workshops with the lead assessors of all six certification bodies, with quality managers of some 25 OHS units, and representatives of employees and employers who are members of the Central College of Experts. Moreover, we had discussions with representatives of the Council for Accreditation, the Ministry of Social Affairs and Employment, commercial insurance companies and social security institutions. All these contacts helped us to develop an overall image of the experiences of the different parties with regard to the certification practice, what problems occur, and to what extent the certification procedure contributes to the OHS quality. We did not study the quality of the actual services provided by the OHS to their customers (employers) and clients (employees).
RESULTS

The most important finding of this study is the fact that the certification procedure with its current requirements hardly contributes to the level of the OHS quality. We base this conclusion on the following arguments.

- The procedure is a certification of the system. This means that it is certified that the occupational health service has structured its organisation in such a way that a constant quality level of a comprehensive package of services can be achieved. In practice, however, many customers of occupational health services are demanding a more restricted package of services, having not full quality of the full package. The certification does not guarantee the cohesion within the package of services.
- Some of the current requirements are so very detailed that it is practically impossible to provide a “tailor-made” package of services as requested by an individual customer.
- The certification only regards the products that are legally obligatory according to the Working Conditions Act. The requirements laid down by this Act with regard to, e.g. sick leave control and rehabilitation are limited, so they play only a minor role during the certification process. Thus the procedure partially focuses on those services that are largely insignificant with respect to the quality demanded by the customers.
- It is fair to note, however, that the guarantee of the total quality was not the intention of setting up the certification procedure. The main objective of certification was to warrant a basic quality level for those products as prescribed by the Working Conditions Act. In practice, employers, employees and occupational health services have higher expectations of the effects of certification. Moreover, we have to conclude that the current certification procedure does in fact guarantee a certain basic level of provision of services. Before certification was obligatory, there was a surge of newly founded occupational health services. Many of them could not meet the requirements and had to disappear from the scene.

We conclude therefore that a limited adjustment of the current certification system will not contribute much to its improvement. We prefer a discussion about the system itself. The question should be: do we have anything better to replace this system?

RECOMMENDATIONS

Looking at our results we have to conclude that the certification system of 1998 did not exert a desired influence on the quality of occupational health services in the Netherlands. The regulations are so detailed that the managers of occupational health services feel compelled to comply with numerous prescriptions rather than to provide the service requested by their customers. This situation has been partially due to the influence imposed by the employer and employee representatives on the certification system. If one party requires a change or addition, the other party feels obliged to counter with changes and additions of its own. While both parties aspire to a simple certification system, in practice the system only becomes more complicated because of its compromise character.

How might the current system be improved? Looking for improvements in the regulations might be a possibility, but we have signaled an increasing complexity of the system. So the approach of making internal adjustments of the system does not appear to be a good solution. A real improvement might be found in the application of another quality concept to occupational health services. Different concepts and definitions of quality have been described (Fig. 1). One of them is to comply with well-defined requirements made up in advance. The government might try to define what it is good occupational health care and check if this care is actually being provided. This approach requires a supervisory role on the part of the government.

The latter was the case in the Netherlands until 1998, when the policy was realigned to provide the social partners, employers and employees with more freedom in the definition of the desired quality. For this purpose, the ISO-9000 conception of quality has been applied: quality is the delivery of products that meet the demands of customers and the agreements made with them. In this approach, the internal processes of making the products are more important than the products themselves. In the Netherlands, this
Policy has only partially been realized. The government went on to define the OHS products, while testing at the same time, the processes required for these products. So the certification system got "the worst of two worlds": detailed regulations on the products to be delivered, and a quality system that does not effectively test the compliance of these products with the demands of employers and employees. For these reasons, a logical solution should be to continue in line with ISO-9000, and not to prescribe what services and products the OHS should provide, but only to require that they should have a quality system warranting good internal processes. So employers, employees and OHS will have more freedom to negotiate on the services to be provided.

In recent years the ideas about OHS quality have further been developed (Fig. 1). The latest concept is to reach agreement on the effects of the services and to check if the objectives have been realized. In such a system there is no place for a certification by a governmental body. The affiliation obligation is expected to be dropped in a few years. Once this happens, the occupational health services will continue to offer the existing products, but there will be more opportunities to provide more and other services. Quality systems are well suited to this free market situation, but they should enable customers to assess where they can find the products that meet their demands.

The future of certification is closely connected with the future of the occupational health services in the Netherlands. Employers have long sought cancellation of the obligation of being affiliated to an occupational health service unit. If this desire is fulfilled, however, OHS will be forced to compete with each other in providing products the employers are demanding. In such a system there is no place for a certification by a governmental body.

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Fig. 1. Three subsequent concepts of quality of occupational health services.

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In recent years the ideas about OHS quality have further been developed (Fig. 1). The latest concept is to reach agreement on the effects of the services and to check if the objectives have been realized. In such a system, employers, employees, government and occupational health services together define the objectives of care, e.g. the management of sick leave, and qualitative objectives are formulated. The next step is to define parameters for the level of quality achieved. In practice, employers and employees find it easier to agree on the objectives to be achieved (i.e. the desired effects) than on the products needed to achieve these objectives (i.e. the methods to be applied). If the objectives are clear at the enterprise level, employers and employees can together define what is needed to achieve them. In the latter case we could be a step closer to real quality: satisfaction of clients and customers of the contribution of occupational health services in realizing their own objectives.

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