

Summary

of **Thematic Public Report**

November 2012

Intercompany occupational health services: a reform in the making

Caution

This summary is intended to facilitate the reading and use of the *Cour des Comptes* report.

The report only commits the *Cour des Comptes*. Responses by the administrations and agencies concerned are given in the follow up to the report.



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Introduction

Almost all (90%) non-agricultural private sector employees are followed, with regard to occupational health, by the intercompany occupational health services (SSTI - services de santé au travail interentreprises) , organized in the non-profit association (created under the 1901 French Act). Business company directors are required to be members due to their responsibility for preserving their employee's health. Only very large companies have the ability to create their own internal service, called autonomous services (civil servants have a special singular system by way of derogation which is not discussed here).

The premiums that companies pay to the inter-company occupational health services are, from a legal standpoint, a payment in settlement of a legal obligation to do so. As such, the Court, under Article L. 111-7 of the Code of Financial Jurisdictions, has jurisdiction to verify them. This point is essential because for over ten years questions about occupational health have attracted repeated attention by public authorities; they are the cause of many reports which have been used as supports for negotiations between social partners; an essential prelude, in this area, to preparing legislative or regulatory reforms. However, with the exception of some scattered data collected by the Inspection General of Social Affairs (IGAS), the operation of the system itself has never been the subject of a comprehensive study.

Therefore, the originality of the report is to report, for the first time, light on the subject of the actual service rendered – or not rendered – to companies and their employees and on the causes of the dysfunctions observed. To this end, documentary audits were conducted in four regions (Centre, Ile-de-France, Midi-Pyrenees and Nord-Pas-de-Calais) where six in-depth reviews were conducted in services with differing size and operations. To this was added the inspection of the General Directorate of Labour and numerous contacts with the Professional Branch, CISME (Interservices Occupational Health Centre), specialist universities and social partners represented on the workplace conditions Steering Committee on Working Conditions (Conseil d'orientation sur les Conditions de travail).

1 Organisation of occupational health

The French organisation of occupational health is unique in Europe : in the United Kingdom, employers are free to choose the means to implement the obligation of safety that they are responsible for; in Scandinavia or Belgium, services are internal to the company while Spain and Germany have retained the principle of external services, entrusted to mutual companies or professional associations.

However, the French system is also distinguished by the place that it traditionally gives to a specialist doctor, the occupational physician, who is responsible for assuring employers, by means of medical examinations at the time of hiring, that «the employee is medically fit for the work position that the employer intends to assign to him» (R. 4624-11 of the Labour Code).

This «insurance related» rationale at the root of the right of ability has always coexisted with a tradition of prevention known as «primary» driven by social security organisations, social partners and professional bodies. These initiatives have enabled the

significant standardisation work undertaken by the public authorities and the labour ministry to be passed on to set preventive measures by risk, sector and occupation.

In addition, since 1970, the public authorities have also wanted to promote this orientation in services then referred to as «occupational medicine» by including, in the duties of occupational physicians, a «workplace activity» and a role of «advisor to the company director or to his representative, employees, staff representatives, social services» (Decree of March 20, 1979).

The fourth Auroux Law, which created Committee on safety and health at work in 1986, then European Directive 90/391/EC led to emphasizing this orientation and introducing, within occupational medicine, a multidisciplinary approach (ergonomics, toxicology, etc.). The comprehensive Law of January 17, 2002, confirmed this choice by transforming occupational medicine and its service into « occupa-

Organisation of occupational health

tional health».

Emotion aroused by the asbestos scandal, the proliferation of occupational cancers and suicide occurring in a professional environment as well as the declining demographics of occupational physicians made implementation of this development more urgent. Negotiations were therefore resumed with the social partners, while some services, with approval from the administration, experimented with new avenues.

The Court's review then intervened in the context of preparation of the Law of July 20, 2011, then the Decrees of February 2012, mainly applicable on July 1, 2012. It therefore

provides an assessment of the situation before the reform but by anticipating certain effects, from experience already acquired by the most innovative services.

Under these conditions, the recommendations arising from the Court's findings have a highly practical character. They could largely be included in the contracting campaign initiated between services, the government and occupational diseases and accidents insurance.

2 Service rendered and tasks set

With the Law of July 20, 2011, providing advice to the employers and employees became the main task of the services. It was no longer the sole responsibility of the occupational physician, but that of a multidisciplinary team. However, implementation of the latter, experimental since 1979 and mandatory since 2002, has been very slow. The only available national study is from 2007 and concludes « can we speak of effective multidisciplinary... when a single person in charge of occupational risks prevention has to assist occupational physicians in 3,592 companies totaling on average 34,279 employees?»

The General Directorate of Labour did not wish to update the figures. Studies carried out by the profession naturally show progress but this is the result of an addition where a licensed engineer is considered equivalent to the occupational health assistant, a new profession whose duties and training are undefined.

Still largely devoid of the necessary resources, the practice of multidisciplinary is not yet immune to the temptation to deploy a part of its activity to large companies, for charged services that are within the competitive sector.

This is why the steering role of the occupational physician must be preserved. However, he faces a shortage of medical time. Occupational physicians rarely achieve the objective, set 30 years ago, of one third of the time spent in advice and activities in the workplace. In most departments, the tasks, also essential, of participating in monitoring health is relegated to this one-third time and therefore compromises the time set aside for companies.

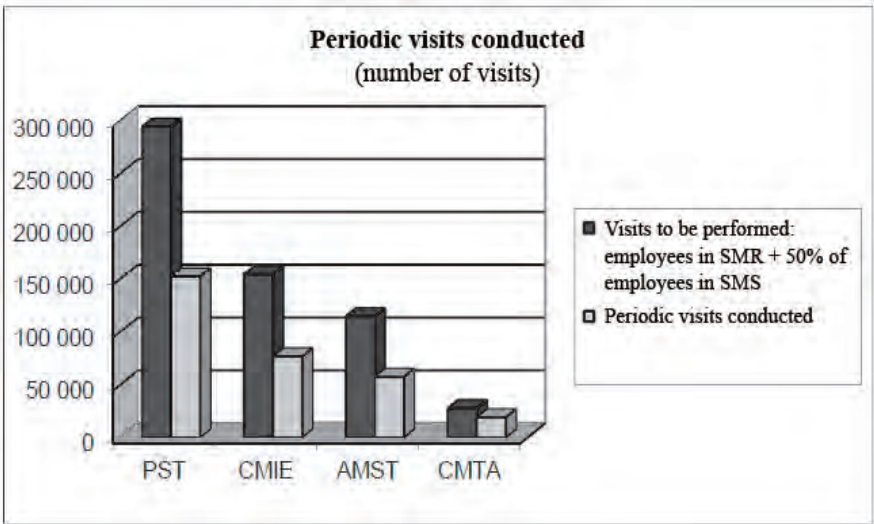
Also, the company record filled out by the physician is completed for less than 30% of companies. Yet, it is a regulatory document that detects risks and which for most of its content can serve as supporting the «single risk assessment document» which each com-

Service rendered and tasks set

pany director must complete. Failing to complete it is criminally sanctionable.

If this minimum service is not rendered, it is due to a very unfavourable medical demography. Despite the efforts deployed and experiments conducted, none of the services that the Court has inspected are able to perform all the sta-

tutory medical examinations that they are bound to perform, including the periodic visit even though its frequency has been reduced.



Source: Cour des comptes according to activity reports - years involved: 2009 and 2010.

PST: Occupational Health Centre [Pôle santé travail]

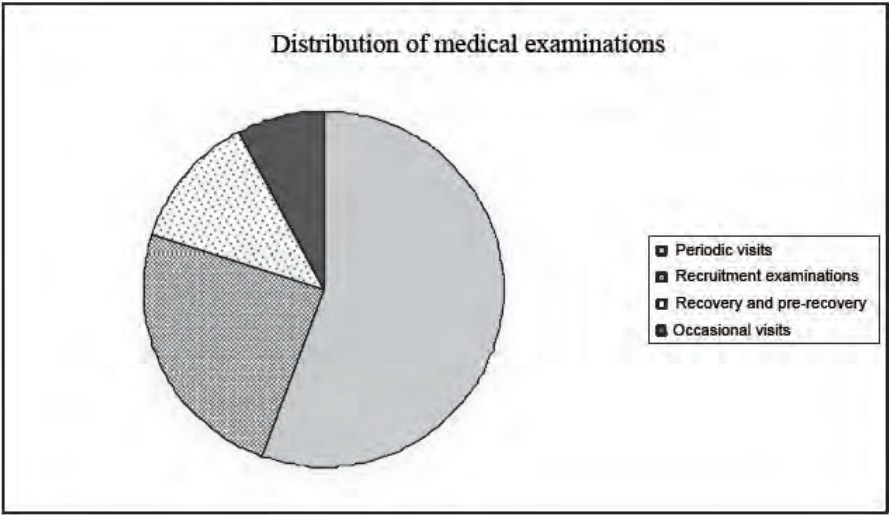
CMIE: European intercompany medical centre [Centre médical interentreprises Europe]

AMST: Occupational health and medicine association [Association de médecine et de santé au travail]

CMTA: Intercompany and trades occupational medical centre [Centre de médecine du travail de l'artisanat et interentreprises]

Service rendered and tasks set

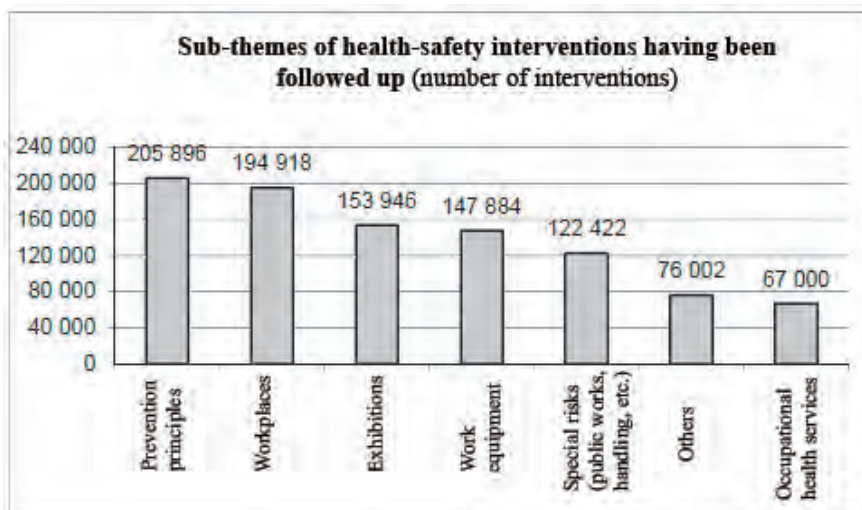
In the near term, this mandatory periodic visit should also be rapidly disappearing, the medical time available being now largely consumed with recruiting examinations, which are essential formalities for labour contract validity.



Source: 2010 Labour conditions - Labour Conditions Council (COCT)

The growth of the labour force automatically multiplies the frequency of recruitment visits, at the expense of other activities which, however, are more important later for the employee's health.

Service rendered and tasks set



Source: *Cour des comptes*, according to the 2010 working conditions report

Small businesses and their employees are the main victims of the various identified deficiencies.

It is in this context that the Law of July 20, 2011 and its implementing decrees propose generalization of a service project, endorsed by public authorities at the time of approval, and related to the priorities that the prevention stakeholders and social partners will have acknowledged, at the

national and local level. Under these conditions and given the context of the medical demography crisis, the activity of the services is expected to greatly differentiate depending on local resources and by type of companies.

The risk of drift exists and this is why the government has an essential role to play, despite the limits of its powers.

3 The reduced powers of the Government

Public policy regarding occupational health and safety is primarily based on a work of animation and awareness of safety and prevention standards and prevention tools. Occupational health plans have focused on this aim; mobilisation of workplace inspection has contributed to it; the themes of occupational health and safety are the main source of follow up given to its actions.

In this overall plan, organisation of workplace health and its management only represents one component of the system. The human resources that the government has dedicated to this specific task, both at the national and local level, are therefore reduced: less than ten agents centrally and, locally, a network of forty regional medical inspectors for labour and manpower, the MIRTMO, set in the regional directorates of companies, competition, consumption, labour and employment (DIRECCTE).

These limited resources are not reinforced by the status of MIRTMO. Since 1947, they have been contracted

under public law. In a context of a shortage of occupational physicians, the lack of career prospects and unattractive compensation results in significant vacancies in positions, 40% as of January 1, 2012.

In addition, the field of recruitment can be problematic, since these are occupational physicians, often from the region's services and called upon to return, who are responsible for advising the regional director of companies, competition, consumption, labour and employment, including service accreditation policy.

The terms of this accreditation constitutes a second aspect of the government's weaknesses. Indeed, contrary to the law in force for other joint bodies, the Minister, in case of refusal of accreditation, is not able to dissolve the service which, in fact, continues to operate. This is true of one of the services audited, which had had no accreditation since 1996.

The Law of July 20, 2011 does not

Reduced State powers

change the situation in this regard but simplifies the procedure, under conditions that deserve attention. It additionally requires that companies using a nonaccredited service are now alerted to the situation, which was not previously the case the human resources are therefore reduced and the sovereign powers weak.

Under these conditions, until very recently the administration had not updated the information system database. Services or occupational physicians must make annual administrative and financial medical reports but the matrix is over 40 years old. The General Inspectorate of Social Affairs (IGAS) pointed out the obsolescence as early as 1990, with no effect.

None of the elements that could attest to the implementation of new objectives set by the legislator, multidisciplinary for example, is taken into account; medical data is not used although it could be an essential reporting base for monitoring developments on the state of employee's health.

In view of these obvious deficiencies, the new arrangement resulting from the 2011 law promotes the deve-

lopment of contracts between the government, the state pension insurance fund and the occupational health (CAR-SAT) and the services. In line with experiments conducted on the first occupational health plan, the contracts envisaged by the administration would only put forward public health goals without trying to change the management of services by adopting measures to effectively monitor services rendered to companies, multidisciplinary for example, or more generally, workplace activities, as evidenced by the creation of a record for the company concerned.

A redesign is all the more urgent in that in terms of governance and management, the Law of July 20, 2011 sets significant challenges for the services.

4 An operation in search of a new equilibrium

Audits performed have shown the frequent inadequacy of associative life, in which, without exception, the leaders of member companies do little. There is consequently a risk of governance being taken over by a small group, family group or joint group from a closed status association.

Faced with these difficulties, the Law of 20 July 2011 opted for a complex system. The board of directors is now mandatorily joint and is presided over by the employer. It is doubled by a control commission that is also joint but presided over by an employee.

Despite the virtual absence of associative life, this law has also maintained the key role of the general assembly which designates employer members, after, however, a notice of the representative organisations.

With regards to employees, it has not favoured participation of employee representatives on the board of directors by a compensation system which would be justified. The result is a system half way between the associative model and joint content system.

This new governance will therefore have to face heavy challenges that weigh on the management of services. These have made significant advances, in terms of ethics, by renouncing in particular the financing of employer representative organisations. Certainly, the prevention of conflict of interests by members of the Board of Directors through regulated agreements is not always exemplary. The temptation exists to outsource training functions and especially advice to businesses in commercial structures.

More generally, the special tax system for services creates an ambiguity: legally, inter-company occupational health services are non-profit organisations but fiscally they are liable for corporate income tax. Some association presidents therefore feel it legitimate to manage them as businesses and be paid accordingly.

At the initiative of the profession, many services have launched a quality approach, proposed by the branch and which should enable the best allocation of resources with regards to the objectives chosen by the legislature.

An operation seeking a new equilibrium

However, these positive elements are not enough. With no change to resources for a number of services, the results can no longer fund the necessary investments and the policy of recruiting new skills that the Law of July 20, 2011, requires. The revision of funding methods, a theme that the Law of July 20, 2011, did not address, is therefore necessary.

In fact, it can be noted that close to half of the services do not comply with the legal basis for establishing the contribution. They determine a payroll rate (capped) and not a contribution per capita, by the number of employees to follow.

The value of the contributions paid would reach € 1.3 million annually, according to the Court's estimates. It is not known to the administration, which does not require communication. However, this mass hides a wide variation in rates in practice for inter-company occupational health services, a variation that is difficult to assess because, depending on the service, the

contribution tables are not comparable, with some providing a somewhat flat fee covering all needs and others multiplying additional contributions. The only value that makes sense is, therefore, as the profession holds, revenue turnover relative to the number of employees followed. In 2009 it stood at about € 90, excluding taxes, per year per employee followed.

This funding project is what is now expected for occupational health.

Conclusion

The recent law of July 20, 2011 and its implementing decrees have intended to draw all the teachings of the movement, committed in accord with the European directives, which grows with the transformation of occupational health medical work: that is, moving from action directed towards the person and curing (secondary and tertiary prevention) to intervention on the causes (primary prevention). As a somewhat fundamental overhaul, the Law of July 20, 2011, seeks to remedy the deficiencies found by reinforcing the responsibility of social partners in governance and monitoring of inter-company occupational health services.

Their operation must now be set on a triple basis, the service project, which employers and employee representatives present to the board of directors for approval, the certification granted by the government and, finally, the contracting which integrates the service, the government, CARSAT and the regional social partners.

In order to overcome the difficulties arising in implementation of the reform, the Court considers it especially necessary to:

- very quickly relaunch consultation with social partners to revise the obligation of the systematic recruitment medical examination;*
- accord to certification the weight which it should have by giving the Minister of Labour, in respect of joint procedures, the ability to dissolve a service or place under the responsibility of a temporary administrator;*
- increase the involvement of social partners by entrusting them with the responsibility to set floors and ceilings for the amount of contributions and other rights which the company must pay to the SSTI in consideration for advice and monitoring of employees.*

Recommendations

1) Provide, when approving services, particular vigilance to the objectives selected in managing companies with less than 50 employees;

2) at the same set specific objectives in terms of establishing company records;

3) prepare a clear doctrine on the consistency of multidisciplinary services expected, their duration, their coordination with funding by contribution, and the boundary with activities of the competitive sector;

4) identify, separately from workplace activities, medical time devoted to health monitoring;

5) relaunch dialogue in view of a revision of the recruitment examination which could be limited to specific cases;

6) quickly open, at the national level, for «employee physicians», the continuing education planned in occupational medicine.

7) study the possibility of exceptional measures for obtaining the title of occupational physician, so as to counteract the risk of non-replacement, eventually, of one occupational

physician out of two; for this purpose, consider including procedures for reconversion of General Practitioner physicians in practice;

8) study the possibility of integrating regional occupational inspector physicians into the body of public health physicians;

9) quickly update not only the administrative and financial reporting model but also the medical activity report, by adapting them to the reforms, including implementation of multidisciplinary teams;

10) align the intercompany services with the laws in force for other joint structures by giving the Minister of Labour, with regards to joint procedures, the possibility of dissolving a service or placing it under the responsibility of a temporary administrator;

11) taking the opportunity for contracting to define, in consultation with all players, quantitative targets relating to the service rendered to companies and their employees, including in terms of initial risk diagnosis, therefore company records and

Recommendations

methods of exercising multidisciplinary;

12) quickly proceed with an initial operational assessment coupled with boards of directors and oversight commissions, including in terms of member absenteeism and planning, as applicable, simplification of the arrangement;

13) align with the existing system for the oversight commissions the right of compensation for members of the board of directors and, in the case of a salaried treasurer member, the rights to training;

14) align the fiscal system for services with the general law of associations;

15) undertake, with the social partners, within the orientation commission on workplace conditions

(COCT), useful discussions for funding reform which would allow them to entrust the power to regulate variations in the contribution and other rights due by companies to the intercompany occupational health services, for comparable services, in return for membership.