IT SIMPLY HAS TO BE COMMERCIAL

perceptions of Dutch occupational health physicians on the consequences of the commercialisation of Dutch occupational health services

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SUMMARY

In this thesis you will find the results of a study that was intended to collect information about the dilemmas occupational health physicians or bedrijfsartsen experience in their job. A job that formerly was part of a non-profit, mainly public health driven institution and now belongs in a commercialised setting. The laws introduced since 1994 were meant to change the part of the social security system that directs the payment of sick employees. All companies are now obliged to pay for the sick-leave of their employees for up to one year of absenteeism or ziekteverzuim. The companies also have to be attached to an occupational health(OH) service or arbodienst for their ziekteverzuim- and arbo-policy. Arbo means arbeidsomstandigheden or working conditions. The new commercial arbodiensten mainly originated from the still existing bedrijfswerenigingen, organisations for the control and payment of sick employees. As a consequence of new legislation, the former internal and former external OH services or bedrijfsgezondheid diensten and the new ‘real’ commercial arbodiensten emphasise on a client(employer) oriented approach and are also expected to reduce the ziekteverzuim-percentages of the companies. The new commercial approach of the arbodiensten lead to undesired changes in the position and the type of work of the bedrijfsartsen. It was the researcher’s objective to become informed about the perceptions of the bedrijfsartsen where it concerned these undesired changes.

The information of this study mainly comes from one ‘real’ commercial arbodienst. This type is believed to be successful with the new commercial formula, but at the same time controversial comments are heard in relation to this type. In order to give the results a more general value also bedrijfsartsen of other types of arbodiensten were interviewed. Since occupational health or bedrijfsgesondheidszorg(BGZ) involves three parties, also two employers and one group of employees were consulted for reactions to the latest changes in BGZ.

The information from the study of the literature, observation and transcribed interviews was analysed and is reproduced in the form of five chapters in the findings of this thesis. Chapter 3.1 is a reflection on the perceptions of the three parties involved on the changes in their position within BGZ. Existing literature on this topic showed that 40% of the bedrijfsartsen believe that their position has worsened. The same literature make us believe that the position of the employees also changed in a negative sense, but the employers were believed to have profited from the new situation. The author of this study especially describes the noteworthy changes in the position of the bedrijfsartsen, like there are the more curative
oriented tasks, being connected to a wider variety of company-sectors and the position of the *bedrijfsarts* next to other specialists or *kerndeskundigen* in the field of *BGZ*.

Chapter 3.2 is a reflection on the perceptions of the parties involved on illness and fitness-for-work. Since the changes started off with the preoccupation of the government with the *ziekteverzuim* figures, a lot has been set up in relation to this aspect. Curative methods got special attention because of two reasons. First they are believed to be tougher products and second they give an attractive cost-benefit balance for the employer. Some *bedrijfsartsen* are concerned about this development, because the analyses and solutions of the real causes of work related problems are put to the background.

Chapter 3.3 is a reflection on the perceptions of the parties involved about the services provided by the *arbodienst*. The *bedrijfsartsen* of the 'real' commercial *arbodiensten* show their discontent especially with the quantity-first-policy. The *bedrijfsartsen* of the other types of *arbodiensten* realise that they also are confronted with the side effects of commercialisation.

Chapter 3.4 is a reproduction of the similarities found within four groups of *bedrijfsartsen*: the former *verzekeringsgeneeskundigen*, the *bedrijfsartsen* of a former internal *BGD*, the *bedrijfsartsen* of a former external *BGD* and the young general medical doctors, who are in training to become a *bedrijfsarts*. Many of the similarities are linked to the organisation of a *arbodienst* and to the type of company you work for. Training turned out to be a very important determinant for being critical about the latest developments. Being critical meant looking for alternatives that try to combine the advantages of commercialised *BGZ* with the ideology as preserved by the training institutions, the professional organisation (*NVAB*) and the former external *BGDs*.

Chapter 3.5 is a reproduction of the thirteen elements of ambiguity as perceived by *bedrijfsartsen* in the actual job description. Five weren’t recognised as such in the existing literature. They are: uncertainty about the future, impoverishment of the mutual contacts, 'working on an island', the participation in routine work and 'class-justice'.

Commercialisation changed the *BGZ*-culture, but the introduction of other *BGZ*-specialists and the democratisation and individualisation processes of Dutch society in general also contributed to these changes.
1. INTRODUCTION

The topic of this study on occupational health physicians or bedrijfsartsen and the occupational health service or arbodienst they work for, is an issue for about 35% of the Dutch population (Horst 1988:20), because in fact it concerns all working people. Occupational Health (OH) or bedrijfsgezondheidszorg (BGZ) has been an issue since more than 100 years, but it is only since January 1998 that all of the Dutch working population is officially linked to an arbodienst. Arbo means arbeidsomstandigheden, which literally translated means working conditions. It are those arbodiensten that with the use of a group of specialists or kerndeskundigen, and a specific package of BGZ or arbozorg will control the health and well being of the employees.

Although I have never been professionally active in the field of BGZ, nor did I ever actively use these services as an employee, I could easily feel the tension between some contradicting aspects in this field. For example it is believed that Dutch companies have rather good working conditions, but still the Netherlands has an absence-due-to-illness or ziekteverzuim percentage twice as high as some neighboring countries. It was the Department of Social Medicine of the Free University that invited me to do a study on the topic as defined in the title. Mr. N. Plomp, already active for more than 20 years as a researcher in the field of occupational health and safety (OHS) or arbeids- en bedrijfsgeneeskunde (ABG), introduced me into the different aspects of BGZ. He, as a trainer of bedrijfsartsen, is especially interested in the experiences of Dutch physicians with the effects of commercialization in the sector of BGZ.

1.1 Background Information

Socio-economic, political and cultural characteristics influencing health and health care in the Netherlands

The Netherlands, with its 15 million people, is a densely populated country. It has a high level of economic development. This has positively affected the health status of the Dutch population as well as the quality and technical level of health care. The Netherlands is also a so called ‘strong state’, where the different political parties are able to guarantee a more or less stable line of development. However, political changes have influenced the health policy: the Christian and Social Democratic parties that ruled before 1989 were in favor of a strong governmental influence. Since 1989 the Coalition of the Conservative-Liberal and Social
Democratic parties lead to a more deregulated and market oriented climate. In health care we may speak of a managed or planned market, because the government tries to keep a tight control over the fees for medical treatment (v.d. Veen 1997:11).

The favorable health status of the Dutch is reflected in a high life expectancy (77.1 years), a low infant mortality rate (6.3/1000) and a low maternal mortality rate (8.2/100,000) (v.d. Veen 1997:23-28).

In the Netherlands everybody has the right to some kind of social security if (s)he cannot support him or herself. Through this system everybody is also assured of a health insurance. The state involvement will ensure that discrepancies in health care won’t be too big between publicly and privately insured people.

The good health status of the Dutch is for a major part a consequence of the central role of our ‘family doctor’ or general practitioner (GP), who represents the first line health care together with the preventive health care services, which are mainly controlled by municipalities. The GP through his or her gatekeeping position will control the number of referrals to the secondary and tertiary levels of the Dutch health care system. Because of the GP’s familiarity with the families and the community, the GP is supposed to work more effectively, which is also believed to lead to the relatively low prescription rate of treatment for only 56% of diagnosed cases (v.d. Veen 1997:23).

In this study I would like to concentrate on occupational health and safety or arbeids- en bedrijfsgeneeskunde, which by the arbodiensten and the companies is practiced as BGZ. This health sector falls under Social Medicine in the Netherlands and deals with ‘the health and well-being of the individual employee and the collective of employees’ (v. Damme 1995:1).

BGZ came into being at the end of the last century, when the industries rapidly grew and abuses with respect to laborers safety were registered on an ever greater scale. Occupational health services or bedrijfsgedondheidsdiensten (BGD) at that time were either directly linked, the so called internal BGD, or independent of the company they worked with, the so called external BGD. In the first decades of this century BGZ was mainly related to safety aspects of working conditions. It was only in the late sixties and seventies that humanization of work was taken into account and immaterial aspects of work got attention. Since then the well-being of employees became the main target (Willems and Croon 1995: 19). In 1983 the new Arbo law definitively substituted the ‘law on safety’ of 1895, which already underwent some adaptations in 1959. This Arbo law especially regulated the preventive aspects of BGZ, the
expertise and the independent position of BGZ personnel and most important of all the increased influence of the employees and the works council or ondernemingsraad(OR) on BGZ related matters. Initially there was no special attention for the approach to ziekteverzuim, but with the growing numbers of the unfit-for-work or arbeidsongeschikten, and the growing ziekteverzuim percentages it became a necessity for the Dutch government to deal specifically with this aspect. In the beginning of the 90's a median of 7.8% of the Dutch working population was absent due to an illness. With a range from 4.5 to 11 (Willems 1995:21). The preoccupation with this high figure together with the already mentioned change in the line of policy making, formed the basis for the coming into being of a number of new laws since 1994. According to Plomp's description (1999: 1375) there are:

2) Wet TZ/Arbo (1994) : terugdringing ziekteverzuim/herziening van de arbeidsomstandighedenwet
3) WULBZ (1996) : uitbreiding loondoorbetalingsplicht bij ziekte
4) Arbobesluit (1997)
5) Wet REA (1998) : (re)integratie arbeidsgehandicapten
6) Wet op de Medische Keuringen (1998)

See also annex IV.

Since 1994 the arbodiensten officially work on a commercial basis and compete with one another in order to obtain the contracts with the companies. Until 1994 only 40% of the employees and only 10% of all companies were attached to an BGD (Plomp 1999: 1379) After 1998 more than 90% of all employees and companies have been attached to an arbodienst.

Specific for the specialization arbeids- en bedrijfs geneeskunde is the involvement of three parties in stead of two in the traditional medical setting. The three parties are the bedrijfsarts, the employee and the employer. It is not only the number of parties involved that is different, but also the activities and perspectives to be dealt with in the specific 'relationships' are different. This quite unusual context of medical care hasn't been studied, as far as I could trace it, by a medical anthropologist. By the use of certain concepts from medical anthropology I hope to be able to get a clear picture of the perceptions of bedrijfsartsen.

1.1.1 Bedrijfsartsen: their training and their work
According to the professional regulations of the professional organization, the NVAB, all physicians, working in the function of bedrijsarts, should be registered as either bedrijsarts, controlling physician or verzekeringsgeneeskundige (VG) with the necessary extra training or if not yet specialized should be allowed to participate in the official training within a period of 2 years (NVAB 1997: 6.3.2-6.3.3).

The training institutions give priority to preventive care, which is mainly oriented towards care of the working situation and as such deals with the arbeidsomstandigheden (Doctor 1992: 16). The high cost spent on health care in the Netherlands and the high cost paid for ziekteverzuim and arbeidsongeschiktheid actually strengthen the idea of taking care of prevention first, but it seems that arbodiensten tend to solve this problem in a more curative way.

'Considerations of ethical standards in OHS arises largely because doctors may find themselves in a position where conflicts of interest and loyalty from the different roles they are required to play' (Philipp a.o. 1996:351). This was the basis for a qualitative study in England in order to investigate the views of specialists in OHS about business ethics in OHS. What Plomp and Willems fear for in BGZ in the Netherlands is argued on in this article: the shift from a professional to a business ethic is partly responsible for radically altering the medical profession world-wide. Market forces now often determine the types of services to be given (Philipp a.o. 1996:351). It remains to be seen if the bedrijsartsen consider the professional and business ethics as ambiguous. To Plomp it seems obvious that they are, because the market mechanism takes the need of the clients (employers) as the starting point, while the ‘real’ professionals still tend to give priority to the public health norm of ‘health and well-being for the employees’ (1999:1380). Willems adds to this that bedrijsartsen tend to interpret the changes after 1994 as more negative than positive where it concerns their own job: there is less attention for preventive matters, there is more bureaucracy and there is much pressure on production (1998: 99). Concerning this ambiguity it is imaginable that bedrijsartsen know when business ethics prevail and when professional ethics have to be given priority. On this aspect we find some useful remarks by Ewing in her article on ‘the illusion of wholeness; culture, self, and the experience of inconsistency’. She argues:

*in all cultures people can be observed to project multiple, inconsistent self-experiences that are context-dependent and may shift rapidly. At any particular moment a person usually experiences his or her articulated self as a symbolic, timeless whole, but this may quickly be displaced by another. quite different ‘self’, which is based on a different definition of the situation (1998:296)*
1.1.2 *Arbodiensten* where do they come from?

<table>
<thead>
<tr>
<th>type of <em>arbodiensten</em></th>
<th>no. of employees cared for</th>
<th>no. of <em>bedrijfsartsen</em></th>
<th>no. of <em>arbodiensten</em></th>
<th>no. of employees per <em>bedrijfsarts</em></th>
<th><em>bedrijfsartsen</em> as percentage from total personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>former BGD's</td>
<td>3.138.000</td>
<td>1.015</td>
<td>111</td>
<td>3.091</td>
<td>22.6%</td>
</tr>
<tr>
<td><em>arbodiensten</em> coming from a <em>bedrijfsvereniging</em> (see page 22)</td>
<td>2.228.000</td>
<td>427</td>
<td>5</td>
<td>5.218</td>
<td>23.5%</td>
</tr>
<tr>
<td>newly formed commercial <em>arbodiensten</em></td>
<td>570.000</td>
<td>147</td>
<td>26</td>
<td>3.877</td>
<td>20.2%</td>
</tr>
</tbody>
</table>

Plomp 1999: A4-2/4: figures from 1997

The *arbodiensten* have a specific image as well within society as within health care. All Dutch working people are familiar with the institution. The *BGD*‘s from before 1994 got only limited attention in the media, because public relation wasn’t important and their functioning wasn’t that controversial. A company either was legally obliged or voluntarily choose to be attached to a *BGD*. The *arbodiensten*, even more than the *BGD*‘s in the past, became part of society and as such have specific social and cultural aspects. Helman says about this:

*Beside the official health care system, there are smaller ‘systems’, which might be termed health care sub-cultures. Each have their own way of explaining ill-health, and the healers in these groups are organized into professional associations, with rules of entry, codes of conduct and ways of relating to patients* (1994:64).

This concept fits well to the group of *bedrijfsartsen*. It remains to be seen if the *bedrijfsartsen* form a subculture as well towards outsiders as within the *arbodienst*. Koot describes the aspects of having one or more subcultures in a company. The positive aspect is the feeling of being a unity. The negative aspect is that it is difficult for two subcultures, present within one company, to work together(1990:62). Having taken these concepts as the basis for my study, I paid special attention to sub-cultural or ethnomedical characteristics.

So far quality aspects of *arbodiensten* have been strictly controlled every 5 to 10 years. In the beginning this was done by an governmental institution, but lately an independent organization, working by order of the Ministry of Social Affairs and Labor is performing the (re)-certification control. *Arbodiensten* have a quality handbook, which serves as the basis for their
mainly procedural quality. It is especially this quality handbook that guides the controlling organization.

1.1.3 The other parties involved

The new laws have given the main responsibility of how to guarantee good working conditions and how to control ziekteverzuim to the employers. The results of Willems’ questionnaire actually admit that employers are more active in the field, but where does this perception come from:
1) are they really interested in creating a good working environment?
2) are they interested, because they want to limit the cost for ziekteverzuim as much as possible?
3) have they started to do something under the legal pressure, and are they not really willing or convinced to do something about arbeidsomstandigheden?

So far it seems that the national organizations of employers are happy with the changes. The trade unions like the idea that all employees now officially fall under BGZ, but they are having a close watch on how the BGZ is performed in the different arbodiensten. The employees themselves expressed their grievances over the new type of BGZ on a especially for that purpose introduced telephone line. General discontent is not heard so far, probably because the social security system in the Netherlands still guarantees good basic needs.

1.1.4 Perceptions of illness and fitness-for-work

Willems in his dissertation makes clear that in the new era of a ‘humanized’ BGZ, it becomes difficult to speak of clear-cut occupational diseases. ‘Work related diseases are multifactorial diseases in which the work environment plays a partial role in the causation’(1987:19). At some other place in the dissertation Willems cites Collings in order to look at the employees’ illness from another perspective:

The simple truth is that there is no such thing as a non-occupational disease in a worker, if one accepts the definition of occupational as being a condition that was aggravated by or contributed to by work. There is no medical condition that is not influenced by eight hours of daily work. Or, for that matter, by eight hours daily of anything else.(1987:17)
Illness representation and explanatory model (EM) are closely linked to one another. The classical definition of EM by Kleinman is: 'the process by which illness is patterned, interpreted and treated as well by the patient as the practitioner' (Helman 1994: 111). In the BGZ there is an extra dimension to the EM, because it not always serves to describe the simple fact of being ill. It regularly deals with a justification for being absent from work. The EM of the employee will be interpreted and also, especially under the actual circumstances, judged by the bedrijfsarts and employer. This judgment leads to Doctor's interpretation of the existence of 'white, gray and black absence of work' (1992: 44-45). Because limiting or terugdringen of the ziekteverzuim (TZ) has become such a hot item in BGZ, the training institutions, as well as the arbodiensten have tried to grasp the phenomenon. Basically, ziekteverzuim occurs when there is a imbalance between the burden and dutiability, de belasting en de belastbaarheid, of an individual. The burden is mainly defined by one's workload. Personal characteristics, amongst others, will define the dutiability. Other factors influencing ziekteverzuim are the threshold for a person reporting him or herself ill and the opinions of society of how to go about reporting ill under certain circumstances (Willems and Croon 1995: 18).

1.1.5 A market mechanism within health care

Commercialization of health care isn't new, but doing this on a profit basis and with a strong competition element is new for the Dutch situation. Allowing the market mechanism to influence the BGZ, created new forms of BGZ that were partly meant and are partly unwanted effects. At this moment there are supporters and opponents of the new situation. Kool described the urgent need for the development of a market system within health care: *The excessive regulation and collectivization of the actual Dutch health care system is based on behavioural suppositions, which don't fit anymore to todays citizen and consumer of medical care. His desire to be free is expressed in the individualization and democratization proces of the western society* (1995:171).

Kool then continues by saying that there is a need for some moral conditions that will guide the market economy. It especially presupposes a market-ethic where the enterprises and the individual citizen have a high level of responsibility (1995:178). Plomp mentions about the ever growing commercial influence:
The impairment of the professional integrity in fact leads to the predomination of other interests above the professional ones. As a consequence one might have an attractive commercial offer, but professionally it falls short (Plomp 1999:1381).

Quality of care becomes an issue here. A transparent quality policy is ‘een hoog goed’ in medicine, but on the other hand physicians are the pre-eminent professionals that defend self-regulation in many aspects of their work (v Herk 1997:49)

The arbodiensten coming from the bedrijfsverenigingen and the newly formed ones are considered the ‘real’ commercial arbodiensten. They use a management, guided by the so-called marketing and sales department, that gives attention to the image or public relations of the arbodienst involved. The question is if this ‘impression management’ fits with the professional standards of the arbeids- en bedrijfsgeneeskunde.

The commercialization process has lead to the taking over of smaller arbodiensten by bigger ones, who have more financial and management back-up.

So far many journalists and scientists have described a trend, but it has been difficult to convincingly show, through qualitative data, what really has changed for the bedrijfsartsen and if job-dissatisfaction is only the result of law changes or maybe also an effect of other factors like:

1) individualism
2) short contracts
3) the growing emphasis on being highly qualified in the field of technical and social skills
4) the constant extra training on specific topics and on the use of new computer programs
5) the need to be adaptive and flexible where the reorganization and economy measures are concerned (Willems and Croon 1995:22). Even certain background variables may influence somebody’s job-perception and satisfaction (Willems 1998:101). For a long time it was believed that the bedrijfsartsen still had to adapt to the rapidly changing outlines of their work as a consequence of the new laws. Five years after the introduction of the first laws, the most important steps have been taken and a clearer picture must be visible.

1.2 The general objective
To get a clear picture about the dilemmas as perceived by bedrijfsartsen, resulted from the introduction of new laws in the field of occupational health or bedrijfsgezondheidszorg since 1994. The laws were meant to stimulate the market mechanism for the arbodiensten.

1.3 The research questions

1) How do the different parties involved (arbodiensten/bedrijfsartsen, employees and employers) describe their position in the field of BGZ before and after 1994?
2) How are illness and fitness-for-work perceived by the different parties involved? Are there conflicts about the different perceptions?
3) To what extent are the bedrijfsartsen, the employees and the employers satisfied with the functioning of the arbodiensten?
4) Are there differences in perception of job satisfaction between the different bedrijfsartsen working in the same or different arbodienst(en). How do the perceptions of the bedrijfsartsen influence their views on job-conception and -satisfaction?
5) How do bedrijfsartsen deal with a perceived 'role-ambiguity', which has its basis in the contradicting views on BGZ. On the one hand there is the public health founded principle and on the other hand the demands of the commercially guided 'real' carrying out of tasks.

2. METHODOLOGY

2.1 The study design

It is a qualitative study which focused on the situation of bedrijfsartsen in a arbodienst in Amsterdam. To give it a more general value, relevant information from outside this situation has been dealt with. This information came from an extensive literature review, interviews with key-informants and with two bedrijfsartsen from outside this arbodienst. This study has tried to link the micro-level with the meso-level and where possible even with the macro-level.

It has been a retrospective study that looked at the period from the introduction of the arbo-law in 1983 up to the actual situation of 1999. This time period and especially the specific influences of the changes in law from 1994 onwards, were supposed to have an impact on the job-conception and the job-satisfaction of bedrijfsartsen.
Although comparison between the perceptions of the different groups involved should have been interesting, I had decided to concentrate only on the physicians. The study hoped to come up with some distinguishing differences of perceived dilemmas among different groups of bedrijfsartsen.

The set up of the study was participatory in the sense that before the observation and interviewing started, a meeting with all the bedrijfsartsen involved was planned in order to give additional information and where comments on what they want to investigate could be heard. If the bedrijfsartsen wanted it, they even could form a ‘sounding board’ for the whole group, which should keep regular contact with the researcher. Participating bedrijfsartsen were allowed to read the first draft of the thesis and comment on it.

2.2 The process of data collection

To become acquainted with the topic I first did an extensive literature review on as well information about ABG and BGZ as on some related medical anthropological aspects. In order to have an idea where to place Dutch BGZ I also looked at some information from other European countries.

The place of the fieldwork was a suggestion from one of my supervisors, N. Plomp. He was interested in this particular arbodienst, because it seemed to be successful in the new strategy of offering a commercial product to the employers. Other secondary reasons for choosing this arbodienst have been the facts that there had been already some contact with the director of this arbodienst and the location was within acceptable distance for the researcher. A previsit was planned and realized in order to come to an agreement about the set up of the fieldwork.

One week of (participant)-observation was planned and realized. In this week I visited 3 units or vestigingen of the so called business-unit in Amsterdam and participated in a one day program of 3 bedrijfsartsen of the three different units. The main unit has all the supportive services present, like there are: marketing and sales, financial affairs, quality management and computerization control. One of the vestigingen one year ago was still part of another arbodienst, which formerly was a internal BGD of a big national company. A third vestiging started as an independent business unit in 1994, but as a result of different circumstances became part of the above mentioned one. The 3 vestigingen now all belong to a national arbodienst which has its origin in a specific so called bedrijfsvereniging, which these days are called uitvoerende instantie(UVI). The one day programs of the different bedrijfsartsen gave
me the opportunity to participate in 3 consultation hours for employees on ziekteverzuim. Beside this I participated in 2 social-medical-teams (SMT’s) or bedrijfsbezoeken. On the other weekdays of the observation I joined a senior teamsecretary and the receptionist who receives all the employees visiting the arbodienst. I also joined the mobile controller or arbomedewerker of recently reported sick employees on his tour around the houses of these employees. In this very one week a presentation about the arbodienst was performed by the senior marketing and sales manager for the co-assistenten of the faculty of medicine, which I was allowed to join.

After the observation period followed a 5 week period of interviewing:
- 9 bedrijfsartsen of the one arbodienst, which was a mixture of ex-VG’s, bedrijfsartsen from a former internal BGD and basisartsen in training for bedrijfsartsen. The sampling was realized by the arbodienst on the researcher’s orientations, which were: a more or less equal representation of the first 2 groups, because of the more extensive experience and a lesser representation of the last one. Beside this I asked for a representative representation of men an women and if possible a representative representation of the different political orientations. The location manager, responsible for the final selection tried to offer me an as varied ‘population’ of bedrijfsartsen as possible.
- 2 bedrijfsartsen from outside this arbodienst. One was from a former external and one from a former internal BGD. The first arbodienst was suggested to me by the supervisor and I myself selected the particular bedrijfsarts for his long-standing experience in the field of BGZ. The other one was suggested to me by a friend bedrijfsarts, whom I also interviewed as a key-informant.
- 3 key-informants. One is a friend bedrijfsarts, having worked for 13 years for a former internal BGD and recently changed to a former external BGD. The second is a bedrijfsarts, who now holds a position in a national institute for Prevention and Health. He is also the author of the articles, that resulted from the questionnaire responses from bedrijfsartsen and VG’s. The third is a representative from the trade union FNV and there holds a position as advisor on CAO-policy and as projectleader for the control over the services of the arbodiensten.
- 2 employers, one who’s company is linked to a former external BGD and one who’s company is linked to a former internal BGD. This sample was chosen because of the largeness of the
companies and because they have a long history of cooperation with a BGD which is now called the arbodienst.

- 1 focus group discussion (FGD) with a group of 6 employees working at a large company, linked to a former internal BGD. I selected this company for the FGD, because I had participated in a SMT here and also profited from a tour around the work place at that time with the bedrijfsarts I accompanied that day. A small questionnaire (see annex V) about the quality aspects of the arbodienst and bedrijfsartsen was used here.

A pretest of how to perform, process and analyze an interview was realized during the module ‘research methods in medical anthropology’ of the AMMA course.

All interviews, inclusive the FGD, were taped and transcribed completely.

Beside this I was invited by my supervisor to a colloquium with the title ‘Dilemmas in the practice of arboservices’. Since I was asked to make the report of this meeting, I was obliged to listen carefully. The information I got out of this meeting in a way sounded familiar, but also gave me a lot of new insights, especially where it concerned specific problems, like

* the involvement of the insurance companies
* the 'unwilling' employers
* the heterogeneity among the bedrijfsartsen

And I learned more about the position of other group involved in the BGZ, whom I didn’t have the opportunity and time to interview officially. There were

* the NVAB
* the employers organization
* the factory inspection or arbeids inspectie, a department from the Ministry of Social Affairs and Labor

2.3 Data processing and analysis

The transcripts were labeled according to the medical background of the interviewees, which meant that an interviewee either belonged to the ex-VG's, the combi-bedrijfsartsen from the former internal BGD, the bedrijfsartsen of the former external BGD or the basisartsen in training for bedrijfsarts. After this the individual transcripts were manually processed according to the variables defined in the research proposal:

- the bedrijfsarts related aspects: education, tasks, position and role(-ambiguity)
- the arbodienst related aspects: management, quality, commercialization and administration.
- employer related aspects, which also included the position and activities of the OR and ziekteverzuim-related aspects.
- employee related aspects, which also included the perceptions on illness and fitness-for work.
- aspects of the steering institutions: trade unions, NVAB, the Dutch government, the BOA, the insurance companies, etc.

Next, the 5 research questions were answered by a cross-sectional use of the processed individual information. Beside this a table was made with the (background) variables of the 11 interviewed bedrijfsartsen in order to detect corresponding elements and the reasons for similarity or difference. This table will not be presented as an annex in order to protect the privacy aspects of the interviewees. A comparable procedure was followed for the FGD.

The consultations of the 25 employees observed in the consultationroom of 4 bedrijfsartsen were also listed in order to detect some basic figures, like the locomotor, psychic and other diagnosis ratio, the male/ female ratio, the first/repetitive visit ratio and the verzuim/voluntary or open consultation ratio (annex VI).

An analysis of the 6 completed and returned questionnaires was made. The questionnaire in the first place was meant to direct the participating employees towards the subject BGZ. Of course no far-reaching conclusions can be made on the basis of only 6 questionnaires in a company with more than 200 employees. Still it is interesting to know what those 6 representatives consider as first quality priorities of a arbodienst and of bedrijfsartsen. And what they consider as weak and strong quality elements of a arbodienst and of bedrijfsartsen.

2.4 Debriefing activities

As well during the period of writing the research proposal as during the period of fieldwork and while writing the thesis regular contacts were held with both supervisors. During the fieldwork there were some debriefing moments with the director and the location manager of the business unit. The first draft of the findings was presented to the interviewed bedrijfsartsen and to 1 key-informant. A dissemination meeting (annex VIII) was held with 3 of the interviewed bedrijfsartsen in order to respond the researcher’s 3 questions:

1) Did you recognize your arbodienst, in other words are the findings a good description of
reality?
2) Are the positive as well as the negative elements of your work well described?
3) Are there categorical errors in the description?
Of course any other type of remark was welcomed.
Also the supervisors were asked to comment on the first draft of the findings and on the set up of the thesis.

2.5 Ethical considerations

In the meeting with the director of the *arbodienst*, we agreed on the assurance of anonymity towards as well the *arbodienst* as the interviewees. A similar unofficial procedure was followed towards the key-informants, employers and employees. Before every interview this point was repeated in order to allow the interviewees to speak as frankly as possible.
Dissemination of the draft of the findings has been limited to the one *arbodienst* in Amsterdam, the supervisors and the most important key-informant.
The final thesis will go to the same *arbodienst* and supervisors. Other participants will only get a copy if this *arbodienst* agrees on it. The information as presented in the thesis can only be transformed in a publication if this *arbodienst* gives her permission.

2.6 Limitations of the study and changes in the data collection procedures

In general very few adaptations have been applied to the original set up of the fieldwork and to the processing of the data.
The participation of the *bedrijfsartsen* in the set up and in the performance of the study have been very limited, because of time pressure and other priorities on the side of the *bedrijfsartsen*. It were especially the director and the location manager, who discussed specific matters with me. In the observation period there was no opportunity to participate in one of the meetings in between the *bedrijfsartsen*, but they were very frank in allowing me to listen to their informal discussions.
The number of *bedrijfsartsen* interviewed finally was less than planned and a smaller number was collected outside the 'target' *arbodienst*. The main reason for this shift was the fact that quite a variety was present within the one *arbodienst*. This was the result of a recent take over
of a big national internal BGD by the 'target' arbodienst. The process of complete incorporation is taking place very slowly.

The FGD, according to the researcher's opinion, was well prepared, but still worked out somewhat differently. Having asked for about 6 'real' employees, I finally held a FGD with 5 'real' employees of whom 3 also had another function in the company, like being member of the OR or the arbo workgroup. The 6th person was the manager himself, with whom I had planned to talk separately, but because of unforeseen circumstances in the company had decided to participate in the FGD. After some rethinking I decided not to leave out the information obtained here, because I felt I dealt with a homogeneous group, where even the manager fitted in very well. This was probably due to the fact that they all shared the same middle class of the Amsterdam society. They also shared a long-standing experience in the same company, which offered me valuable information for the topic of the study.

The participation in the colloquium wasn't planned, but offered me very good extra information after all.

The transcription of the taped interviews and the processing of the transcribed information absorbed much more time than I expected, which resulted in an adaptation of my workplan and finally delayed the official finishing time.
3. FINDINGS

In the description of the findings, because of reasons of convenience, I will only use the male form when referring to the bedrijfsartsen. Beside this reason I also follow the line of authors of articles on this subject and of the bedrijfsartsen themselves, who almost only use the male form, including the females. And a last reason is that the males are still in the majority within this profession.

In the first 2 main chapters of the findings I use the arbodienst and the bedrijfsarts almost as synonymous. Although not absolutely correct, the reader has to consider the one as representative for the other in those chapters. It is in the last three main chapters of the findings that the bedrijfsartsen completely speak for themselves.

3.1 Perceptions of the parties involved (arbodiensten, bedrijfsartsen, employees and employers) on their position in occupational health/ BGZ before and after 1994.

3.1.1 The position of the arbodiensten and bedrijfsartsen

3.1.1.1 The significance of a ‘real’ commercial arbodienst in contrast to a ‘non’ commercial arbodienst has to be explained first. It is believed that those arbodiensten who started with the introduction of the new laws in 1994 worked very hard on their public relation activities and openly admitted their negotiation activities on price and product quality with the employers. Although in the past the former BGDs also were private enterprises, they never emphasised the mentioned activities, because it was a matter of mutual necessity and understanding. This attitude of the former internal and external BGDs to a large extent is still present and as such they are considered non-commercial.

The ‘real’ commercial arbodiensten still are very much linked to the so called ‘GAK-culture’. The fact that they still are talking of their rayon or area is typical. The controlling physician, verzekeringsgeneeskundige(VG) or GAK-physician, was linked to a specific rayon, where the companies with a postal code belonging to this rayon were part of. Since many of the ‘real’ commercial arbodiensten originate from one or another bedrijfsvereniging¹ their first clients also

¹ Until 1994 all companies were linked obligatory to a bedrijfsvereniging and paid per employee a certain contribution as a form of social security in case the employee should fall ill. Since in 1994 the payment for ziekteverzuim became privatised, the bedrijfsverenigingen lost this task almost completely. The
originate either from the ‘GAK-circuit’ or some other bedrijfsvereniging. The main tasks of the GAK-physician were ziekteverzuim-control and -attendance. Since the arbodiensten have taken over a mayor part of the tasks of the former bedrijfsverenigingen, 80 to 90% of the activities of the bedrijfsartsen deal with these aspects. Even arbodiensten that originate from the long existing occupational health services or bedrijfsgezondheidsdiensten (BGDs), against their will, changed to this direction:

"...because of the changes since 1994 ‘bedrijfsartsen’ were sent back to their consultation rooms. That is very obvious. I don’t like this change.... I think we spend 1 ½ or 2 times as much time on consultation.........In the past we were more or less considered as physicians that worked in the interest of the patient.......Nowadays we are involved in the absence control, which can be considered as the judgement of a claim...... GPs nowadays also take into account this new element in the functioning of bedrijfsartsen and it puts pressure on the relationship.

The staff members of a ‘real’ commercial arbodienst admit the emphasis on ziekteverzuim-control and -attendance in their work. Some see it as an inevitable and commercially most important part of their work, while others believe that the emphasis has to change:

Absenteeism-control, -attendance and reintegration is the cork that we float on.....

If you look at the companies that in the past were linked to the GAK, I believe those have to change their policy from an emphasis on ‘ziekteverzuim’ to an emphasis on ‘arbo’.

For the so called (ex)combi-physicians of the internal BGDs it is different. For them things haven’t changed much. Before 1994 they already had to do the ziekteverzuim-control and -attendance, because the big companies they were linked to, were obliged to pay for the sick-leave of their employees. These were activities beside the ordinary guidance and check on the working conditions. Those bedrijfsartsen didn’t see the necessity to change their attitude. Those internal BGDs in a way were ahead of their time, because many had already started to adapt to some sort

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 bedrijfsverenigingen were organised according to the type of companies they worked with. The GAK was exceptional in the sense that different types of companies were linked to it. Since the function of the bedrijfsverenigingen has changed, they also changed their name in uitvoerende instantie (UVT) or an institution that has specific executing duties.
of commercialisation, partially as a consequence of changes in the big company and partially as a consequence of changes in society.

I have to admit that the whole privatisation of the law on sick-leave or the 'ziektewet' didn't affect me. The company I work for always paid for the sick-leave of its employees. For me nothing has changed ....... We always agreed on what to do with the client or employer on the basis of realistic expectations and if those turned out to be wrong we adapted them for the next year.

3.1.1.2 One striking fact with regard to the position of the bedrijfsarts is that they all choose their own attitude towards the sick employee. Officially 3 elements can be distinguished from the task of the bedrijfsarts (Plomp 1992: 607):

1. the expert, who is in control of specific medical problems, a task most closely linked to that of the curative physician.
2. the advisor or advocate for health and well-being. This task especially fits the ziekteverzuim-attendance. In this role the bedrijfsarts does not want to pretend to have the one and only solution, but simply contributes to it.
3. a person with quite some knowledge of the organisation of a company, but is not the ultimate expert in this field.

All bedrijfsartsen recognise these aspects of their function, but they all have different priorities. One bedrijfsarts expressed it very clearly:

If you present the extremes of two visions in a black and white manner, you get on the one side a vision of a 'bedrijfsarts' who is not very much interested in one's medical diagnosis.......and he will start to talk with the employer about a less heavy workload. The other vision is from a 'bedrijfsarts' who in his position of physician will try to put his own diagnosis. After a consultation with the GP, he will come up with advice on how to get back to work again....... When you put your own diagnosis it gives you the opportunity to keep up your medical skills and at the same time it allows you to validate a specific intervention as useful or not.

A bedrijfsarts as representative of the first vision, puts it in the following way:

When I consider what I actually have to do, I am in the first place some sort of medical advisor with some medical knowledge, instead of a physician with some advisory skills. All the time you must be aware of how to present the facts. That is very important. It is a soft type of job.......
believe much attention must be given to one's skills in communication. If you are not in control of this skill you better forget the rest.

During observation only 1 in 25 patients underwent a physical examination. An explanation for this reality can be found in the facts that 35 to 50% of the patients is absent with psychogenetic problems and 17 of the 25 observed consultations were with patients seen before (see annex VI). Also considered must be the fact that patients with severe physical or psychogenetic problems will only consult the bedrijfsarts in a very late phase of their sickness or maybe not at all.

3.1.1.3 Although it seems to be an individual choice to use the medical curative attitude towards patients, it is a generally accepted attitude to advise on the ziekteverzuim and arbo policy. To be able to work adequately and more specifically on certain matters many bedrijfsartsen prefer to be connected only to a specific type of company. The differences between the companies are expressed in:

1. the branch or sector, like there are the metal-, wood-, graphical-, and chemical industries, but also education, office work, etc.
2. the size of the company. The organisation of a small company is completely different from a big one with over 100 employees.
3. a company being familiar or not with occupational health and safety.

Within the 'real' commercial arbodiensten it is not common that a bedrijfsarts works as a 'specialist' in a specific sector. It is especially a privilege of the more senior bedrijfsartsen, but even they often have to accept a mixture of companies, because there is such a wide variety of companies contracted by the arbodienst. In the former internal and external BGDs it was more likely that one works as a 'specialist', because only specific sectors were obliged to or voluntarily choose to have BGZ. However a minority of the bedrijfsartsen let me know that a mixture of types of companies guarantees the necessary variety.

The bedrijfsartsen expressed themselves in the next way:

The sector determines what type of clients you have.....There are different mentalities.....Before 1996 all companies had to become affiliated with one or another arbodienst. Some since long were connected to Arbounie². Those ones were used to communicate in the sense of this is what

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² Arbounie is considered a 'non' commercial arbodienst, because they still express their mentality of being a former external BGD.
we want and can you offer this to us? The new ones don't even realise the necessity of it. They don't see the surplus value, because of lack of experience.

A trainer of a training institute for bedrijfsartsen mentioned:

A lot is linked to the type of 'bedrijfsarts' and the type of company. How does the arbodienst go about a newly contracted company nowadays: does the youngest 'bedrijfsarts' get it or the one who still has some space left. The 'arbodiensten' actually have to consider seriously matching the 'bedrijfsarts' and the company.

3.1.1.4 The powerful position of the bedrijfsartsen is still guaranteed within BGZ. The bedrijfsarts is called the 'spider in the web' of all persons concerned with the reduction of the ziekteverzuim and the creation of good working conditions (arbo), as well within the arbodienst as within the company. For the employees, the bedrijfsarts is the case-manager, the one responsible for their ziekteverzuim-claim and -attendance. For the employer, the bedrijfsarts is the relation-manager, the one who keeps the communication going between the arbodienst and the company. The bedrijfsarts is the teamleader of a team that assists a company in its ziekteverzuim- and arbo policy. Yet are there bedrijfsartsen who disagree with this picture or who believe things will change in the near future.

Very often I am not in the position to change working conditions. I can only advise......I often realise that we are believed to have more power than we really have.

Dutch people have long since given up placing the physician on a pedestal. The implication is that we nowadays come to a mutual agreement with the patient....in the sense of 'I believe that within a couple of weeks you will be fit-for-work again'.

It is very possible that the legislation after 5 years will say that the 'bedrijfsarts' will not pass judgement. He will be replaced by a specialist in occupation and organisation, often a psychologist, who knows everything about interhuman behaviour, because it is no longer believed to be a medical problem but a behaviour problem. This might be a solution and at least it solves the problem of the shortage of 'bedrijfsartsen'.
Many bedrijfsartsen have an idea what BGZ should be like ideally and what their position should be in such a setting. Many are not able to realise this ideal, because of the commercial demands of the arbodienst or because of complicating factors within the company. The ideal picture of BGZ is to be found in the international definition, which was nearly met in the content of the arbolaw of 1983. The ones in favour of this type of BGZ are the training institutions of bedrijfsartsen, the former BGDs and the organisation of the professionals (NVAB). Bedrijfsartsen from a 'real' commercial arbodienst expressed themselves in the following way:

Isn't it fair to expect from the employer some sort of an intention-declaration, in which he declares to perform according to the proposed advice, unless he has good reason not to do so.

I believe that companies will adapt to a situation in which they themselves will perform and if necessary ask the advice of a arbodienst. At the moment many prefer to put out to contract in order not to be bothered with any troubles. It is my opinion that companies in the future have to start to deal with the difficult matters and no longer leave them to us. My opinion also is that one has to tackle the source of the problem first. When somebody is working under a heavy workload, you have to deal with that first, before you can expect an surplus value.

Unfortunately the reality of today is still different. This reality is created by the government, the individual 'real' commercial arbodiensten and the supporting insurance companies. BGZ nowadays is defined by a market mechanism, where all the attention goes to the primary client, the employer.

At this moment the 'arbodiensten' use some sort of survival strategy which started in the turbulent first years after 1994. The strongest are becoming visible now and it was presented to us that we had to collaborate to this mission. I only hope that soon we will have to work less on quantity and more on quality('bedrijfsarts').

There is a discrepancy between the control of arbodiensten and bedrijfsartsen on the one side and the control of companies on the other side. The functioning of the arbodiensten is regularly and intensively controlled through a re-certification process and the bedrijfsartsen are controlled by re-registration standards. The training institutions for bedrijfsartsen recognise this problem and want the individual and collective arbodiensten(BOA) to protect the bedrijfsartsen from conflict situations arising from this poor organisation.
Because the labour inspection doesn’t regularly control the employers on if and how they are realising their arbo-policy, it seems as if we have to sell all kinds of products to the employers, because we are so commercial. But the reality is that we are advising all kinds of things to the employers that are not essential elements of a good ‘arbo’-policy(‘bedrijfsarts’).

Beside the influence of the new laws in the field of BGZ another development is taking place within trade and industry. There is an almost general trend of companies to produce more with less manpower. Within this process of small financial margins it is difficult for the bedrijfsartsen and arbodiensten to sell their arbo-products.

3.1.1.6 Bedrijfsartsen try to protect as much as possible their independent position with regard to the employers as well as the employees, but still now and then they are confronted with situations where in the mediationprocess one party feels prejudiced.

You operate in situations where tension easily arises and as ‘bedrijfsarts’ you have to find the best way in between.

When you look at the situation superficially, the employer wants him back as soon as possible, and the employee wants to profit from his absence as long as possible. We, ‘bedrijfsartsen’, have to find a balance between the two parties and this demands a lot.

You simply are a service-hatch.....and when you don’t manage to do that well....they will let you down and consider you as useless and want another bedrijfsarts.

When the conflict concerns a judgement of the bedrijfsarts on the ziekteverzuim of an employee, the employer as well as the employee have the right and possibility to consult a UVI for a second opinion. Employees regularly use this opportunity. According to a verzekeringsgeneeskundige working at the GAK: it has increased from a few times a month to a few times a week. According to the point of view of many bedrijfsartsen the majority of second-opinion cases is won by the patient, because the verzekeringsgeneeskundige prefers to give the benefit of doubt. Official figures show, that both patients and bedrijfsartsen win in 50% of the second-opinion cases. As a conclusion one might say that many bedrijfsartsen have a distorted image of what happens at the UVIs.
For the employers and employees it is very valuable to have the opportunity to go for a second opinion, but *bedrijfsartsen* come up with some sensible criticism against it:

In general a 'bedrijfsarts' is well informed about a particular employee and he won't draw his conclusions too easily....... You have your reasons why somebody is fit-for-work again. I believe a 'verzekeringsgeneeskundige' has to consider the opinion of a 'bedrijfsarts' above the one of a GP.

It is surprising that employers hardly ever request a second opinion. Do they always agree with the opinion of the *bedrijfsarts*? Or are the consequences of either the request or the possible result different for the employer as for the employee? See annex VIII.

3.1.2 The position of the employees within *BGZ*

3.1.2.1 In the new situation of the privatised *ziektewet* you get the impression that only two parties are involved in *BGZ* and that the employee is some sort of passive participant. To a large extent this image is an illusion, because the employees and their supportive organisations already before 1994 started an *awakening and democratisation process*, that continued to develop after.

The law for the works council or *ondernemingsraden* (ORs) was already introduced in 1983 and since then the labour unions have started to train these ORs. As a consequence of the growing *individualisation* of the Dutch society the individual person or patient gets more respect. Another consequence of the mentioned processes are the fact that employees or patients ask for a transparent *arbo* - and *ziekteverzuim* policy. Employees, and especially the middle management have been brought into action for activities like the development and implementation of these policies.

A *bedrijfsarts* talked about this aspect:

*You have to reckon with two customers. There is the very powerful client, that is the employee and the powerful client, that is the employer.....Employers know that if the employee is unwilling, nowadays the last one has more rights supporting his case. He can go for a second opinion amongst many other rights.*

A *bedrijfsarts*, working in a research institute, mentioned:

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3 A law that describes the obligations and competencies of the works council. Amongst others they have the authority to check if the company is living up to the instructions concerning the terms of employment and the safety, health and well-being of employees.
All 'bedrijfsartsen' have taken their oath and as a consequence of that you primarily work in the interest of the employees. But this has been put in the context of an insurance-system. Both the employee and employer have to realise that. If one effects an insurance, the insurer has the right to check if one lives up to the conditions of the policy.

The key-informant of the labour union FNV said:

The employee is the client and member of the target group of the 'arbodienst'. The employee spends 8 hours of his daily time on the workflow, which a employer doesn’t do.......If an 'arbodienst' doesn't do its job well, only one is suffering and that is the employee.

The employee on the other hand has his own responsibilities:

concerning 'ziekteverzuim' an employee has to take a responsible attitude and one has to take care that everybody in the company behaves in a similar way.

One employee mentions:

Last year I had my leg in plaster and I got the idea that I could decide myself when to start working again. I mean, I didn’t visit a 'bedrijfsarts', everything was arranged by telephone.

An employer mentions:

I believe that nowadays there is more attention for the employees in a company......The actual 'arbo'-policy fits well within this idea of more attention. It is probably also part of a combination of factors present in the society of today. We are much more occupied with the personal development of people.

Even though employees speak more openly about and participate more actively in the BGZ, this also has its down side. Because these activities are often additional to the regular job of the middle management, they are often overloaded concerning the number of activities as well as their knowledge and understanding of the reasons for ziekteverzuim. In fact the OR must be able to give some positive input on the arbo-policy, but in general its functioning depends on the organisation of a company. Even a well functioning OR in a sense is fragile, because of the turnover of employees participating in it. Besides, the OR in confrontation with the employer always has to be aware of its individual position and the position of all employees. When the OR demands too strongly, the relationship with the employer is easily damaged.

A bedrijfsarts mentions:

Many don’t know what input an 'OR' can give, even if they are well trained by a labour union. But often a trained 'OR' doesn’t give surplus value, because in those companies things are
already well organised. It is especially in those places where you believe an ‘OR’ is of value that it is very weak or even never established.

3.1.2.2 Not withstanding the development as mentioned under 3.1.2.1 we still have to consider the political-economic vision on the relationship of the 3 involved parties. Even in a modern society the employer and physician hold a powerposition, because of their autonomous position and professional status. The employee is the one who keeps the production process going. On the very extreme side of this vision, expressed by Lupton, the bedrijfsarts has the power to certify whether a person is physically able to work. Thus the doctor-patient interaction may reinforce the definition of health as the ability to work, for the healthy person is the person who produces (1994: 108). Different interviewees expressed themselves in this direction:

If you ask me what has been a negative effect of the commercialisation process within 'BGZ', I believe it is the exaggerated attention the 'ziekteverzuim' has received. Because of all this attention employers especially have turned out to be very smart in finding administrative tricks. ('FNV')

It all started in the Hague with the idea of loosening the control on the 'arbowet'. It is believed that nowadays the 'OR' is a balanced partner for the employer, but in general this is not true. ('Bedrijfsarts')

3.1.2.3 Certain ideas and images about the sick employee are circulating as well within the companies as within the arbodiensten. These ideas and images are especially linked to the fact that many sick or absent employees simulate and as a consequence cannot be trusted. The new ziekteverzuim reduction policy is aimed at reducing the very existence of this idea. The employers, because of the privatisation of the payment for sick employees, were believed to be stimulated to work on this aspect. So far this turned out to be very complicated, because of so many different factors involved. As a consequence it seems that many employers opted for the above mentioned administrative tricks in order to keep the ziekteverzuim and the linked costs low.

Regularly also the option of a financial sanction in the form of reducing the employee’s wage during absenteeism was considered, but under the pressure of the labour union and certain political groups it was rejected.
The majority of the interviewed bedrijfsartsen told that in their job they are not guided by the idea of 'you cannot trust absent employees'. But the fact is that stories about incorrect treatment of employees easily spread. On the other hand also employees judge amongst each other a colleague's justifiable or unjustifiable absenteeism or the validity of his complaints about the services of the arbdienst.

An employee talks about these matters:

*What you hear generally has to do with long-term absent employees and those tend to be involved in a different process. These people grumble, because they believe nobody is willing to listen anymore to their stories. I myself cannot judge if their complaint is valid or not.......I actually mean to say that you only hear the extremely negative stories.*

The representative of the labour union says:

*Even when it only concerns 10 people, who believe they are underprivileged, this is unacceptable, especially in a professional institution like a 'arbodienst'......They have to take every sign seriously........Because consequently those 10 people inform 10 other colleagues about it and it starts to work as an oilstain......In fact one doesn't need to be preoccupied with the one in a hundred who does something in halves. If a good culture exists within the company, this person disappears by himself.*

Exceptionally mistrust still exists, which the researcher experienced during the observation period. The bedrijfsarts was alarmed by a patient's behaviour during consultation, but couldn't confirm his mistrust. It was only when the patient had already walked outside that the bedrijfsarts saw his ideas confirmed:

*It will be recorded in the patient's file that he deceived me. I can not allow this, I have passed this stage. I believe a patient and a physician must be straight with one another.*

3.1.3 The position of the employers within BGZ

3.1.3.1 As already mentioned in the paragraph about the employees, employers give more attention to aspects related to the employees as a consequence of the growing democratisation and individualisation. This includes the policy on ziekteverzuim and arbo. Before 1994 only specific, most of the time high risk companies were involved in some sort of BGZ. Those companies easily adapted to the new type of BGZ, but the newly affiliated companies still have to
get used to the idea and don't know what kind of policy to choose. An employer in the construction sector expressed his ideas about the recent adaptations in the next way:

*Because of the attention of the government and the media in the last few years on BGZ, new measures have been introduced in the companies: the introduction and realisation of absenteeism instructions, the appointment of a 'arbo'-coordinator, the introduction of a 'arbo'-care-system......Because of the attention, the policy is also formalised on paper.....What probably existed in a brief way in the past has become much more professional.*

3.1.3.2 The political-economic vision on the health of an employee deserves some more attention under this paragraph as well. It is not only because of an adapted legislation that the employer is forced to be preoccupied with *ziekteverzuim* and *arbo*, but also in order to keep the production process going. The existence of a shortage of personnel, either because of an increased *ziekteverzuim*-problem can be solved easily in the following ways:

1. to contract employees through an office for temporary labour (*uitzendburo*), because then the government will pay for the *ziekteverzuim*.
2. to follow out a riskselection during a reorganisation-phase or during a application-procedure.

Reactions to the new situation are:

*Look, employers are more aware of what kind of problems an employee can give. The risk-profile of an employee is carefully looked at.* ('Bedrijfsarts')

*When I make a tour within that company I don’t see any employee above 50 years of age. They are gone because of a reorganisation. And this is what other employees tell me: they simply applied a strong selection. This is happening in other companies in their admittance policy.* ('FNV')

The employers don't like to be criticised in this way on the application of the new *arbowet* of 1994. That is why the organisation of employers remark that these are only exemptions:

*Unwilling employers don’t exist and especially not in the Netherlands. In general employers are themselves well aware of the strategic significance of healthy and motivated employees. The legislation contains enough stimuli to act accordingly. I believe that it is more likely that a
unwilling employer is the victim of a bad advice. When exceptionally there really is a
unwilling employer, you better drop him as a client.

One bedrijfsarts mentions that in a way the legislation around ziekteverzuim and arbo created
false expectations, but probably also wasn’t well understood at the time of the introduction:
At the time of the development of the new legislation all attention went to the reduction of the
ziekteverzuim. I believe that many employers at that time thought that with the introduction of
the new legislation the ziekteverzuim automatically should drop. I believe that the double
meaning in the sense of by creating good working conditions the 'ziekteverzuim' will drop, hasn’t
always been clearly put forward.

CONCLUSIONS in relation to the first research question: How do the different parties
involved, describe their position in the field of BGZ before and after 1994?

I take as a starting point the results of Willems’ questionnaire and Plomp’s analysis about what
has changed in the position of respectively the bedrijfsartsen, the employees and the employers in
the BGZ since 1994. In Willems’ article we can read that 40% of the bedrijfsartsen believe that
their position has worsened in the sense that they are more directed by outside forces than before,
that they have to work under time pressure and they no longer can work from a pure humane
medical view point. In the same article we also find the belief that the position of employees has
worsened in the sense that they are regularly offered only a temporary contract, that there is more
risk-selection and there is more conflict between employees and employers (Willems 1998 (TB V):
99). On the contrary both authors believe that the position of the employers has changed in a
positive sense, because they worked hard on a ziekteverzuim- and arbo-policy. My conclusions in
relation to this topic agree to a large extent with the findings of both authors, but there is more to
say about the position of the bedrijfsartsen. The position of the employees seemed to have a less
negative influence from the new legislation as mentioned by the authors and the employers truly
worked on a ziekteverzuim and arbo-policy, but most of the time not as seriously as the authors
make us believe.

A bedrijfsarts working for a specific arbodienst and being in charge of the BGZ of different
companies has been confronted with different adaptations in 'culture'. In the first place physicians
in their professional and scientific training are used to working with individual patients and their
diseases and they have to find an individual, though biomedical supported, solution or treatment.
Within BGZ officially there is no place for treatment or therapy and preferably one has to place
the employee’s problem in a social context instead of an individual context. The health and well-
being of the employees-collective is at stake. It is not only difficult for a physician to make the
change, but to a certain extent it also leads to a loss in status. This is one of the reasons why some
bedrijfsartsen stick to the individual biomedical way. Another reason is that biomedical therapies
are considered ‘tough’ and therefore sell well.

Another adaptation in ‘culture’ a bedrijfsarts can be confronted with, is when he changes from
one company sector to another. The internal organisation and also the occupational diseases differ
from one to another company sector. It is believed that a good match-up between a bedrijfsarts
and a company is very important. So far neither the employers nor the arbodiensten have been
very selective. The first ones were guided by the obligation to consult a arbodienst for the
ziekteverzuim and arbo-policy within their company. The last ones were occupied with new tough
rules of the new market-mechanism.

The BGZ in the Netherlands underwent a lot of changes in its 100 years existence, but the
development never went so quickly as in the last 20 years. Before 1994 the bedrijfsarts, besides a
nurse and sometimes a social worker, was the only functionary within BGZ. In the actual setting
there are 4 so called specialists or kerndeskundigen in the field of occupational health, hygiene,
safety and organisation. They all have their own different perspective. So far the bedrijfsarts is
still the most important kerndeskundige, but it remains to be seen if somewhere in the future a
specialist in occupation and organisation will take over.

BGZ started off with the primary target of creating a workplace, where the well-being and safety
of all employees was guaranteed. A second function was the guidance of an individual sick
employee in order to return as healthy as possible to the company. This second and actually
secondary function has become the primary target within BGZ after 1994 and two dimensions
have been added to it: first the bedrijfsarts has to control or check the ziekteverzuim-claim and
second he has to try to guide the sick employee as quickly as possible back to his workplace. As a
consequence the bedrijfsarts has been drawn back to his consultation room for about 80% of his
time. Another consequence of the new tasks is that the bedrijfsarts gets involved much more
easily in a mediator-role, which if he fails has the consequence that one of the parties will consult
the *bedrijfsvereniging* for a second opinion. This combination of tasks and its possible consequences isn’t new for the *bedrijfsartsen* of the former internal BGDs.

The changes within *BGZ* aren’t the sole result of a new legislation, but are also a consequence of changes within society as there are the democratisation and individualisation processes. These processes have lead to the organisation of employees in the sense of creating works councils or *ORs* within bigger companies and more powerful labour unions. Another change in society is the fact that employees have a higher education and are more self-assured. In fact this gives the *arbodienst* and *bedrijfsarts* the opportunity to work on a more balanced *ziekteverzuim* and *arbo-*policy, but in the actual setting this idea hardly gets a chance. The employers are the ones who choose and pay the *arbodienst* and on the basis of this fact seem to claim certain rights. The *arbodienst* on the other side is guided by its ‘roots’ and either belongs to the ‘real’ or ‘non’ commercial *arbodiensten*. The latter are moving in the direction of the ‘real’ ones and as a consequence *bedrijfsartsen* of both types of *arbodiensten* will be confronted sooner or later with the next considerations:

- the biomedical oriented therapy sells well, but does it belong to *BGZ*?
- the *arbo*-policy deserves first priority within *BGZ*, but nowadays all attention goes to the absent employee.
- as a legacy from the past, the *bedrijfsarts* likes to be involved in all aspects of the *BGZ*, but the commercially guided principles of efficiency and effectivey forces him to dispose of certain tasks.
- can the most important rule of commercialisation be adapted from: the client (employer) is king to the clients (employee and employer) are king.
3.2 Perceptions of the parties involved (arbodiensten, bedrijfsartsen, employees and employers) on illness and fitness-for-work.

3.2.1 The perceptions of the arbodiensten and bedrijfsartsen

3.2.1.1 As already mentioned one of the aims of the new legislation was to reduce the ziekteverzuim-percentages, which were considered to be very high in the Netherlands in the late 1980's. The national social security system and the 'culture' existing among the Dutch employees weren't able to reduce it to an acceptable figure. Something had to be done and the Dutch Government believed that it had established a useful tool in the law on TZ/Arbo. It wasn't foreseen that this new legislation could be interpreted in different ways and could lead to different ways of execution. The new commercial arbodiensten started off very energetically but now had to admit that it wasn't an easy task and responsibilities aren't equally divided between the parties involved.

The following comments were made in the interviews with the bedrijfsartsen:

I believe we are squared up for the 'ziekteverzuim', but the 'ziekteverzuim' is the only thing we can't influence.

In general an employer knows his employees better than I do. And if the relationship between those two is okay, then the 'ziekteverzuim' will drop automatically. Look, if people are really ill, you can't influence it. The only possible aspect that might be influenced here takes place in the relationship of the employer with his employee. A 'bedrijfsarts' can only act as an advisor here.

If the 'verzuim'-percentage is high several consecutive years, you can expect it to be a 'normal' figure for that company. It doesn't mean that you don't have to put an effort on reducing it anyway........ The 'verzuim'-percentage is a guideline, and nothing more than that.

This is in contrast with the image the 'real' commercial arbodiensten sell to the outside world:

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4 Fitness-for-work or arbeidsongeschiktheid signifies two things in BGZ. The first meaning is to be found at the moment when an employee falls ill and the bedrijfsarts decides whether this person is not, partially or totally fit-for-work, with or without a period of recovery. The second meaning is to be found in relation to the law on unfitness-for-work or the WAO. A person who falls under this law is either completely or partially exempted from the labour-duty, because of a physical or mental inability.
The target of a commercial approach is an effective 'ziekteverzuim' control and in this effort the 'arbodienst' is willing to play the role of social-accountant for her clients, in order to be able to solve as many problems as possible that are linked to the employee, his occupation and his health (the words of a marketing and sales professional).

3.2.1.2 Even when a bedrijfsarts believes he can't influence the ziekteverzuim, he still is confronted with the sick employee and has to help him in one or another way back to work. In the first chapter it was mentioned that different bedrijfsartsen had a different point of view towards the medical curative approach. It is obvious that the majority of the complaints a bedrijfsarts is confronted with, either has its origin in the locomotor system of the body or is psychogenetic in origin (see annex VI). All the other complaints fall into a third category. Also obvious is the fact that a specific company-sector creates specific health problems. Responsibility in and motivation for one's job also have their impact on the ziekteverzuim, but to what extent is not clear. One bedrijfsarts believed that motivation is of marginal importance only, because the majority of the people in the Netherlands choose their own job and automatically are more or less motivated. Another bedrijfsarts had a very clear picture of his task:

*In my job as 'bedrijfsarts' everything is linked to the fact if the patient is fit or unfit for his job. We have to find out how dutiable or 'belastbaar' a person is, especially in relationship to his own job.*

Beside this core reality of the function of a bedrijfsarts, there is quite some room for a personal approach towards the most common health problems. The more complex medical-social problems aren't easy to deal with and also need the personal interest and dedication of a specific bedrijfsarts in order to be solved successfully.

*I spend a lot of time treating psychogenetic problems. I believe that as a 'bedrijfsarts' you can be quite successful in this type of problem....... Beside this I always had preference for the locomotor system of the body...... In fact there is less surplus value on the latter type of medical problem, because beside a good physical observation there is not much left to do for a 'bedrijfsarts'. You can only advise.*
The people from the 'Melkert' group took on a heavy load in their new jobs and actually they didn't profit much from participating in the labour-process. They were people who had lived on their social security money for a long time and had incurred debts. Besides, they also come from a community where bad experiences are common and this undermines a lot.

3.2.1.3 The way bedrijfsartsen fill in their work-time isn’t dependent whether or not you work for a 'real' commercial arbodienst or a former BGD. They all spend 50% of their time on consultation, and another 20 to 30% on contacting the curative health sector, the employer and the UVIs. The last 20 to 30% of their time is spent on participating in the so called Social Medical Team (SMT) or company visit. During this visit the bedrijfsarts and the employer talk especially about the long-term absent employees. Beside this, more general ziekteverzuim- and arbo-related aspects should be discussed, but both the employer and bedrijfsarts aren't yet very familiar with the new intention of the SMT.

The consultation-hour is meant for sick employees as well as for 'healthy' employees who like to consult their bedrijfsarts on some aspect of their work that might threaten their health in the future. Employees belonging to the last category are scarce. During observation only 2 out of 25 employees visited the so called 'open' consultation-hour. The arbodiensten don’t put much effort in the promotion of this type of consultation-hour. Much more attention goes to the 'social-accountant'-role of the arbodienst. Through connections with the so called Gezonde Zaak or 'Healthy Business' it is believed that one can offer tougher methods for the control of the ziekteverzuim. Many bedrijfsartsen expressed enthusiasm towards the development of those tough methods. In order to get a better picture of what are soft and what are tough methods the following opinions of bedrijfsartsen are cited here:

In relation to the soft methods:

5 Minister Melkert introduced in 199. a new system for the long-term unemployed people. He tried to reduce the threshold that existed for employers to admit these kind of people for a job. The Minister was temporarily willing to pay the minimum wage of these people and the company only added a small amount of money.

6 De Gezonde Zaak is an independent institution, created by some (para)medical and other specialists on occupation and organisation. They hope to build up good connections with the arbodiensten, who are expected to refer patients with certain locomotor and psychogenetic problems. So far it are mainly the employers who are paying for this kind of treatment for their employees, but one hopes that in the near future the assurance company will take over this payment.
In collaboration with the patient you always have to try to formulate a joint target and work towards it. This almost always gives a 100% score. You always have to opt for a win-win situation. It also means that you constantly compromise and use different target values for different patient.

You have to try to get somebody back to work if only for half days or in some adapted labour. In this way you bring an employee back to the daily routine and he is in contact with his colleagues again. Through this you keep the threshold to return to work low.

In relation to the tough methods:
I am not against the commercial 'arbodiensten', but I can't see only the advantages. I actually believe that their products sell much better to the client. Their products are tougher. We sell a soft product in the sense of a judgement of a 'ziekteverzuim'-claim or a reintegration. I consider a pure judicial advice and an advice on occupation and organisation tougher products.

I think it is great that they are doing it, but officially it is not their task. Their core-task is to trace and to control the causes of 'ziekteverzuim' and of potential safety risks........ I don't want to say beforehand that training one's back always is nonsense. But I mean that things are turned upside down here, because it doesn't make sense to train one's back and not pay attention to the working conditions('FNV').

3.2.1.4 Prevention of illness and unfitness-for-work officially have first priority within occupational health internationally, but as already mentioned in the former 'curative' BGZ is keeping the bedrijfsarts busy for more than 80% of his time. If we take into account the secondary preventive effect in the sense of giving advice in order to prevent another period of ziekteverzuim, the overall time spent on prevention probably lies near to 30%.

The real primary preventive activities are to be found in the so called risk inventarization(RI) and in the general periodical health check-up or periodiek algemeen geneeskundig onderzoek(PAGO). The first one is considered the basis for a good ziekteverzuim- and arbo-policy and often is carried out by one or more of the other kerndeskundigen. In a PAGO a particular group of employees within a company will be controlled in order to find out if and to what extent they suffered from a
specific negative effect in their job. It is difficult for the bedrijfsartsen to simply explain the usefulness of the PAGO. It is considered a routine health check-up, which in fact can be done as well by an occupational health nurse. They also believe it is difficult to convincingly link an assessed health problem to one or another problem in the working conditions.

A bedrijfsarts from a 'real' commercial arbodienst said:

Many 'PAGOs' are fully dealt with by an occupational health nurse. I don't agree with this idea, because most of the time when you get the results you simply agree. When fill-in-forms are used the 'bedrijfsarts' must be willing to participate and especially look after the employees that score higher on the number of complaints. It is important to be involved in this activity, because it helps you to be better equipped to advise the employer.

There is also a commercial aspect linked to the PAGO. If a bedrijfsarts is capable of selling a lot of PAGOs to the different companies he is linked to, his sales are increasing. As a consequence he doesn't need to make as many sales on the ziekteverzuim consultations and might reduce the number of employees he is looking after.

3.2.1.5 The second opinion is used regularly by employees, to ensure fair treatment and a just decision. The verzekeringsgeneeskundige mentioned earlier, added that in Amsterdam the majority of employees requesting a second opinion, are of foreign origin. This fact shows that on the one hand bedrijfsartsen have more difficulties coming to an acceptable collective target here and on the other hand this group of employees is much quicker to use the tool of a second opinion. One bedrijfsarts expressed it in the following way:

It is true that more often I have a conflict with foreign people about the judgement of fitness-for-work. Look, it is really a matter of communication. In fact it is not so much a pure language problem, it especially has to do with how people experience the fact they are absent from work and how they deal with it. And of course people from other cultures go differently about it.

The conflict arising from the situation where an employee doesn't agree with the judgement of full recovery and being fit-for-work again, more or less can be easily solved with a second opinion. Much more complicated are the cases where the employee is involved in a job-conflict with his employer. This is believed to happen more often after introduction of new legislation, because the employers are putting more effort in a risk-selection, which the better educated and more self-assured employees don't accept. Although it is not the responsibility of a bedrijfsarts to
handle such a conflict, he easily gets involved, because very often the employee tries to avoid the conflict by pretending to be ill. One bedrijfsarts explained how he went about such a conflict:

I wanted to avoid the man from staying at home for one year and then being confronted with 'WAO' examination. It was obvious that there was no medical problem. The solution had to be found in either solving the conflict or leaving the job. My action was as follows: a limited period of unfitness-for-work on medical grounds and after that simply unfit-for-work, because of the conflict-situation. In the second period he was medically fit and as a consequence the job of the 'bedrijfsarts'is done. If the situation of unfitness-for-work still continues, it is a result of the work-situation and that has to be solved between the employer and employee.

3.2.2 The perceptions of the employees on illness and fitness-for-work.

3.2.2.1 The fact that a group of employees believe that bedrijfsartsen lack expertise, is very much linked to the fact that they still hold the central position within BGZ. Because of this position the bedrijfsartsen are confronted with all kinds of problems, which they can’t solve adequately, because they are not trained for it as for example in the field of occupation and organisation. On the other hand they are believed to have quite some knowledge on the epidemiology aspects of occupational diseases, but they regularly fail to recognise a structural problem in a certain workplace. In the last 10 years new occupational diseases have been recognised, like there are the burn-out-syndrome, the organo-psycho-syndrome(OPS) and the repetitive-strain-injury(RSI), but still some bedrijfsartsen are not familiar with those diseases. The meldlijn\(^7\) of the FNV reported a number of the failures of bedrijfsartsen:

One 'bedrijfsarts' said he had never heard of OPS. I don’t expect a GP to be familiar with this diagnosis, because he has another specialism, but a 'bedrijfsarts' nowadays must know it is an occupational disease. A secretary working at a medical centre for the ambulatory care of people with psychiatric diseases once was the 7th in a row of colleagues who fell ill with symptoms of stress. The reaction of the 'bedrijfsarts' in this particular case was: why don’t you look for another job.

Criticism is also heard in relation to the soft type of solutions for absenteeism. The bedrijfsarts frequently uses a temporary adaptation in the function or a temporary reduction in the work-time

\(^7\) This is a telephone line that has been installed by the FNV in 1998 in order to register the complaints that existed on the functioning of the commercialised arbodensten and the bedrijfsartsen.
pain most of the time is temporary. This in contrast to loud noise and fine dust, which in the long run give permanent damage.

Every employer will decide for himself on either financial, legal or moral grounds what will be done about the 'good care' of the employees in his company. If even with general measures the ziekteverzuim isn't acceptable, other measures have to be taken, in the eyes of the employer:

In the beginning the 'bedrijfsarts' checked the absent employees only after two weeks, but with this policy the 'ziekteverzuim' still went up. In order to have better control over the people who frequently use a short 'ziekteverzuim' period, we introduced a control after only one week of absenteeism.

CONCLUSIONS in relation to the second research question:
How are illness and fitness-for-work perceived by the different parties involved?

Plomp made some noteworthy statements in relation to the changed attitude towards illness and fitness-for-work since the introduction of the new legislation. He says that since 1994 illness and health in the BGZ have become commercial articles, because they represent an economic value. He also mentions that because of the extra attention for ziekteverzuim-control and -attendance the companies ask for specific measures in the sense of ready available curative care for the most common occupational diseases. This leads to the establishment of specific institutions (De gezonde zaak) for the diagnosis and recovery of especially locomotor and psychogenetic problems (Plomp 1999: 1374, 1377).

The preoccupation with the high ziekteverzuim figures, which started in the late 1980's, hasn't been solved yet. It is believed that the new approach hasn't been effective enough, but probably also cultural elements and the effects of the democratisation and individualisation processes play a role. As a consequence of these processes an employee expresses his opinion more easily and if necessary defends it by the use of a second opinion. Element of criticism, amongst others, is a lack of expertise of the bedrijfsarts. Also the employer is criticised, but this sometimes ends up in an unjust procedure via the ziektewet.
The sickness-pattern *bedrijfsartsen* are confronted with, is mainly restricted to problems of the locomotor system and of psychogenetic origin. The remainder is a mixture of physical problems. In all these cases, even when it concerns a conflict between the employee and employer, the *bedrijfsarts* is expected to make a quick assessment on somebody's ability to work. In case of (partial) unfitness-for-work he has to start a return-to-work schedule. For the individual unfitness-for-work and the collective absenteeism problem, the 'real' commercial *arbodiensten* offer products that must lead to a tangible result. Besides, these solutions complement an attractive cost-profit picture. Both the employer and the *arbodienst* are the entrepreneurs in this context, because they are trying to negotiate a fair deal, while the employee might only hope that his health and well-being will be furthered by the product. The role of the *bedrijfsarts* here is one of pointing out the problem and formulating advice for it. If he does this well, three parties profit from it: 1. the *Gezonde Zaak* and the linked *arbodienst* will get their financial share; 2. the employer can save on the payment for sick-leave, when indeed the employee undergoes a faster recovery; 3. the employee gets a quick and free treatment.

Although curative matters are more prominent nowadays within *BGZ*, preventive activities officially also are fixed elements. *Bedrijfsartsen* admit the importance of them, but the physician is believed to be too expensive to do routine work as in the *PAGO*, and also because they don't have the specific training to do for example a risk-inventarization in a company, the main part of prevention is done by others. Although understandable, this meant a big shift in the responsibilities of the *bedrijfsarts*.

### 3.3 The perceptions of the parties involved ( the *bedrijfsartsen*, the employees and the employers) on the services provided by the *arbodienst*.

#### 3.3.1 The perceptions of the *bedrijfsartsen*

3.3.1.1 As mentioned before the *bedrijfsartsen* of the 'real' commercial *arbodiensten* are waiting for a turning-point in their work. They hope that soon the management of their *arbodiensten* will change the emphasis on quantity to a more quality orientated work-attitude. The only problem is how to define quality within *BGZ*. Even if certain aspects are believed to be representative for quality, it is hard to measure them. How for example can you measure the client's satisfaction?
And which client actually deserves priority in quality-service? Is it the employer, who has a contract with the *arbodienst* or the employee, who has to stay in optimal condition to ensure a good functioning of the company or organisation? It is difficult to solve this *client-dilemma*. In the Dutch language at least there doesn’t need to be confusion about the word client, because there is the word *klant* or client, who represents the regular buyer of a product. Besides, there is the word *client* or client, who represents a person who asks for assistance and within health care is equal to the patient. Of course it is specific to BGZ that there are two clients, the employee and the employer, but under a market-mechanism there tends to be an unbalanced relationship with those two clients. The articles of the *Professional Statuut of the NVAB*, are not very helpful, in the sense that they don’t give priority to one or the other client:

- *article 2.3* says: *the employer is the 'klant' of the 'arbodienst'*
- *article 2.5* says: *the employee or 'client' is the person who works for the 'klant' of the 'arbodienst'*

3.3.1.2 A similar *dilemma* is felt by the *bedrijfsartsen* in relation to the growing attention for *ziekteverzuim*-control and *ziekteverzuim*-attendance. This is felt at the cost of a preventive approach of the working conditions. An American ethicist in the field of occupational health expressed it in the following way:

> To me it seems that absenteeism control is such a big issue in the Netherlands, for the employer as well as for the 'arbodiensten'. So if this is priority, then develop a policy here. The 'arbodiensten' must take a leadership role in this issue. Maybe they can discuss more extensively with the clients on this issue, because if the 'bedrijfsartsen' are very unhappy with this absenteeism policy, how can the workers be happy with it.

Surprisingly most of the *bedrijfsartsen* interviewed didn’t object to doing the *ziekteverzuim*-control, which according to themselves is similar to the judgement of a claim. In article number 9.3 of the *Professional Statuut of the NVAB*, we can read that this task is unacceptable:

> In case of 'ziekteverzuim' the 'bedrijfsarts' has to attend the employee. Judgement of the degree of unfitness-for-work and giving advice on how to get back to work are part of this attendance, but the judgement of a claim or 'ziekteverzuim'-control is not.

Although the *bedrijfsartsen* don’t object doing *ziekteverzuim*-control, they do object to the amount of time spent on it.
If it were up to me they would abolish the whole reintegration path. It didn't add anything to my services. Even the employees and employers didn't profit at all from the new RIP. It is only a bureaucratic measure, that waste your time and energy and also create irritation. And what really should happen already exists.... We as the former internal BGD had a clear policy here. We believe that it is the employer's responsibility together with the employee to fill in the RIP-form. We as 'bedrijfsartsen' add our medical advice to it. But the 'real' commercial 'arbodiensten' took over this formality completely from the employer. This probably is a consequence of the fact that the 'real' commercial 'arbodiensten' originally were linked to the smaller companies, who weren't familiar with those activities. But this way of handling things is wrong, because you miss the opportunity to let the employer and employee solve it for themselves.

Not withstanding the negative or side effects of the quantity-first-policy, there is also a positive effect. Every arbodienst under the pressure of a market mechanism has to do its best and this makes them creative and work hard on good products and a friendly face.

3.3.1.4 The bedrijfsartsen are quite satisfied about the existing feedback-moments and meetings and they are cautiously optimistic about the future of these activities. The informal meetings in the corridor and during lunch-time are frequently used and considered very useful. Besides, there is a formal monthly meeting where organisational as well as BGZ-related medical aspects are discussed. A third type of meeting, the personal assessment of colleagues or the intercollegiale toetsing (ICT), has recently been started as a consequence of the obligation to fulfil certain conditions in order to guarantee one's registration as a professional bedrijfsarts. The meeting that hasn't been very successful so far is the one with the other kerndeskundigen. As a consequence of the computerisation the bedrijfsarts communicates predominantly through this medium with the other kerndeskundigen. They admit that this can't be a substitute for the meeting, where the RI has to be evaluated and a new arbo-policy suggested.

A type of meeting exists with the other 'kerndeskundigen', which is called the interdisciplinary meeting. Officially this has to be realised once every year for each company, but it is very difficult to meet this requirement. Since last year I haven't participated in one and there is no plan for this year as far as I know. Officially it is part of our job, but the reality is different.

The key-informant of the FNV gives his opinion in this way:
If the 'arbodienst' could interweave the activities of the other 'kerndeskundigen' with the activities of the 'bedrijfsarts', good communication between them could be guaranteed automatically. This should be perfect. But at the moment I perceive a division in labour relation and safeguarding of one's position. This has a negative impact on the employee.

3.3.1.5 There is a difference in perception between the bedrijfsartsen from the 'real' and 'non' commercial arbodiensten on the type of communication they have with the employer. The first ones purposelly use an open and informal way of communication, which means that they use first-name terms with the employer. In this way they hope to ensure a good negotiation. The advantage of an informal type of communication with your client is that there is more direct contact. It isn't especially a result of the commercialisation, but simply is a result of our style of working. With this style you can achieve more with your client. In this way it is also easy to approach the employer.

A contradicting point of view comes from a bedrijfsarts from a former external BGD:
In the past you were part of the company and you were familiar with the personnel. When they wanted your opinion on a particular matter, they immediately contacted you. This has changed.

3.3.1.6 The contracts of the 'real' commercial arbodiensten are framed, offered and sold by the department of marketing and sales. The employer can choose between different types of contracts, which in general leave space for other elements of BGZ when necessary or wanted. This is in contrast with the 'non' commercial arbodiensten, which in general sell a so called total package of BGZ-services. Criticism on the first type of contracts is especially linked to the fact that they hardly put any conditions or presuppositions on the part of the employer. A bedrijfsarts mentions on this point:
If you offer contracts to employers that simply don't demand too much, you create an image as if this is an acceptable way to set up an 'arbo'-policy.

3.3.1.7 Different bedrijfsartsen showed their concern about the future of the new type of commercial arbodiensten. So far many have put a great effort in the success of the commercial formula, but it is not completely predictable what its future will be. Since the bedrijfsartsen are
no longer the sole key-persons within BGZ, and especially no longer have a great input in the content of the BGZ, they feel their position isn't guaranteed.

*I believe there is very little time for us 'bedrijfsartsen' to reflect on our job, which is a consequence of the continuous introduction of new elements within 'BGZ'...*I also believe that our voice isn't heared anymore, but they always listen badly in politics. And maybe our voice is too low..........The organisation of the collective 'arbodiensten', the 'BOA', isn't very critical as well.

Others aren't that pessimistic and believe that the actual shortage on the labour-market will turn the tide. Because if you want to attract personnel you have to improve the working conditions.

3.3.2 The perceptions of the employees on the services provided by the arbodiensten

3.3.2.1 The employees and the labour unions want the arbodiensten to hold on to the ideal picture of BGZ: a work situation in which the health and well-being of the individual as well as the collective of employees is guaranteed. As mentioned earlier this ideal tends to be replaced by a transactionalism in which especially the 'real' commercial arbodiensten try to safeguard their sales by offering so called 'tough' products. One of these 'tough' products is the new approach to reduce the ziekteverzuim. Although the labour union said that it is not happy with the extra emphasis on ziekteverzuim-control, the employees in the focus group discussion (FGD) didn't experience it as negative. When they compared their situation with the past, nowadays they receive much more respect from a bedrijfsarts. The employees, who participated in a so called arbo-group, felt the need to have a closer contact with the bedrijfsarts in order to get on equal terms about the working conditions. And even though the labour union expresses a lot of criticism, they admit a basic positive element of the new legislation:

*It is my opinion that since in 1994 all employers were obliged to contract a 'arbodienst', this has been a blessing for millions of employees in the Netherlands, because before this date they had nothing of the kind.*

3.3.2.2 The mini-questionnaire used during the FGD with 6 employees, showed the following results. They considered as the most important quality characteristics of a bedrijfsarts:

1. expertise, on occupational diseases as well as on the internal organisation of a company.
The employees don't complain on a large scale. They see less abuse of power and actually feel that they are more respected by the bedrijfsartsen. They have the expectation that the bedrijfsarts not only will discuss ziekteverzuim and arbo-related matters with the employer, but also with them.

The employers appreciate an active participation on the side of the arbodienst and its functionaries. Secondly, they have become somewhat restrained towards the product-selling-approach of the arbodiensten. What they offer must be kept realistic, technically as well as financially.

3.4 Similarities in job perception and job satisfaction among four groups of bedrijfsartsen

The choice for the division in four groups is based on two ideas: 1. the arrangement in this way gives a clear overview and 2. regularly during the interviews there were signs that there exist similarities within those groups. The 11 interviewed bedrijfsartsen are divided as follows: 5 former verzekeringsgeneeskundigen or controlling physicians; 1(+2) bedrijfsartsen who worked for a former external BGD; 3 bedrijfsartsen, who worked for a former internal BGD and 2 basisartsen, who are in training to become a bedrijfsarts.

3.4.1 The former verzekeringsgeneeskundigen, who now work for a 'real' commercial arbodienst all accept the quantity-first-policy and the emphasis on the ziekteverzuim-control and -attendance in their work. Two of them however clearly expressed preference for the ideal type of BGZ, where the preventive activities for the establishment of good working conditions have priority. So far the influence of the management of the arbodienst has proven to be stronger and their policy is reality. The differences in job perception in this group, depend largely on whether one recently was involved in some training for bedrijfsartsen. This made them aware, more frequently and more intensively, of the ideal picture of BGZ and made them reflect more on their daily activities. Another possible reason for a difference in job perception is the fact that especially those 2 bedrijfsartsen temporary worked for a former external BGD.

Another point of difference worth mentioning is that one of the 5 former verzekeringsgeneeskundigen explicitly chooses the curative method towards the sick employee. He wants to have his own opinion in addition to that of the GP or specialist.
The bedrijfsarts as idealist says:

To me a 'arbodienst' is an organisation, that offers activities that are essential for a 'arbo'-policy. In this context I accept the fact that if one 'arbodienst' qualitatively works better, the companies have the right to change from one to another 'arbodienst'.

The bedrijfsarts in favour of an emphasis on ziekteverzuim-control and -attendance:

With this policy you limit the period of absenteeism and you make somebody fit again faster. This idea suits the employee as well as the employer. The price of our activities that support this policy are marginal in relation to the cost of an absent employee.

3.4.2 Officially I only interviewed one bedrijfsarts from the former external BGD, but in order to have more basis for my statements I added the 2 former verzekeringsgeneeskundigen, who worked temporary in this situation. This turned out to be a rather homogeneous group, because they all prefer to work in a BGZ-setting, where the ideal type is prominent. The 2, who moved to a 'real' commercial arbodienst put forward more advantages of the introduction of the market-mechanism in their work. Especially the fact that the health of employees has become subject of the market-mechanism, is attractive for employees as well as employers. The third, middle aged bedrijfsarts, shows some nostalgia for the past, when he was still completely part of a company and when people still listened to and accepted his advice.

3.4.3 The 3 (ex-combi)bedrijfsartsen, who worked for more than 8 years for a former internal BGD and now involuntarily, for about one year, are part of a 'real' commercial arbodienst, also form a rather homogeneous group. Since long ago they were involved in the ziekteverzuim-control and -attendance, because of the specific measures for big companies or superakers. Under these circumstances they also had quite an intensive relationship with the employer and managers of a company, which didn't change after the introduction of the new legislation. Within this type of BGZ the employer always had and still has his share in the ziekteverzuim-attendance. Under these circumstances the bedrijfsarts more easily takes his role as advisor.

I believe that both can only be successful when you work together. Within this co-operation the management must facilitate and I advise, because I have professional knowledge at my disposal, which forms the basis of my advice. The execution of the advice has to be done by the management of the company.
Preventive action towards the working conditions is considered very important by this group, but very often they are confronted with the complexity of a big company, which hinders the execution of advice.

The one bedrijfsarts, who works for a different organisation than the other two, experiences more pressure from the employer and has heavier job responsibilities. Another difference between the three is the fact that one bedrijfsarts puts more emphasis on the curative method towards the sick employees.

3.4.4 The last group consists of 2 basisartsen working for a ‘real’ commercial arbodienst and are in training for bedrijfsarts. As mentioned before, the training has quite an influence on somebody’s ideas about job perception. The importance of taking an independent and professional attitude, especially towards the employers, is frequently heard in the interview with each of them. Noteworthy here is the fact that one believes that a professional attitude guarantees quality in one’s work, while the other also believes that the added commercial elements in his job represent quality, for example the reception, a quick attendance and the way people are dressed at the arbodienst. The differences here are probably influenced by differences in personal opinion and also by the fact that one worked briefly for a former internal BGD. Also in this group one emphasised the need to pay quite some attention to the curative method of attending sick employees. She expressed the possibility to use this method in a more GP-related context somewhere in the future.

Independently both basisartsen expressed the (negative) experience of working on an island within the arbodienst.

Within the ‘arbodienst’ everybody runs his own island. Although it works out fine, it is obvious that everybody handles the same matters differently. The professional organisation, the ‘NVAB’, does a good job here. After a profound research they have defined some protocols of how to attend clients in our health sector. In their articles you can find what a ‘bedrijfsarts’ is expected to do and how he is expected to handle in specific circumstances.

The bedrijfsartsen in general are rather satisfied with their job. Some said that the variety of tasks adds to their satisfaction. Others believe that by using the curative method towards the sick employee the job becomes more attractive. From a small number of bedrijfsartsen interviewed, I
got the feeling that a type of forced satisfaction existed, as a consequence of different possible factors, like 1. the nostalgia for the past, 2. maybe another specialisation would have been more interesting, 3. being a staff-member. An overall determining factor for the degree of satisfaction is the type of company you are responsible for and the type of contact you have with this company.

In order to find out if other background variables have a determining influence on job perception and job satisfaction, all bedrijfsartsen interviewed were asked for a number of characteristics. Certain characteristics won’t be mentioned, because of confidentiality. The selection of three equals the ones used by Willems in his analyses of the questionnaires filled in by bedrijfsartsen and verzekeringsgeneeskundigen.

3.4.5 Gender effects: there were four women in the group of 11 bedrijfsartsen interviewed, which corresponds to 36% being female. The majority of interviewees came from one 'real' commercial arbodienst and here there are 5 women in a group of 21 bedrijfsartsen, which equals 28.5%. In the past, BGZ was a health sector particularly dominated by male physicians. This has changed, but it still not equals the division within the faculty of medicine, where females with 55% have dominated for about 10 years. Prof. Willems mentions in his article that gender didn’t determine the different experiences with the introduction of the commercialisation of the arbodiensten. If differences were found, women turned out to be less negative than men (Willems 1998:424). In this study three out of four women interviewed were very critical towards the new developments, what probably can be explained by two important factors: being involved in the training to become a professional bedrijfsarts and having a critical personality.

3.4.6 The age effects: the average age of the interviewees was 41, for the women 35.5 and for the men 44.5 years. A division in age groups shows that 9% was older than 50, 54% was between 41 and 51 and 36% was younger than 41 years. Prof. Willems mentions in his article that also age wasn’t an important determining variable, and if there turned out to be a difference, the youngest were less negative than the older ones (Willems 1998:425). In this study the youngest were mainly women (3 out of 4). All the youngest are either still in training or recently finished. Also the youngest group turned out to be very critical towards the new developments, but this is obvious since they are almost the same group as the women under 3.4.5. The youngest group
found it difficult to point out the advantages of commercialisation within \textit{BGZ}, but it wasn't difficult to list some disadvantages.

3.4.7 The effect of political orientation: from the total of 11 interviewees 7 voted VVD at the last national elections and four voted more or less left wing. Noteworthy is the fact that 3 out of 4 women and 1 out of 7 men voted left wing. In Prof. Willems' article there turned out to be an almost linear linkage between the more left wing and the more negative one's experience with the commercialisation (Willems 1998: 425, 426). The author of this study couldn't confirm this effect. There was the impression that one voted left wing in order to allow the representatives of the ordinary people or employees to express their views on the effects of the new legislation. As such they hoped to create a more balanced approach within the actual \textit{BGZ}-policy. Being left wing didn't mean being against the new developments, as one \textit{bedrijfsarts} expressed it: \textit{The commercialised 'BGZ' also has its attractive sides!}

CONCLUSIONS in relation to the fourth research question: Are there differences in job perception and job satisfaction between the different \textit{bedrijfsartsen} working in the same or different \textit{arbodienst(en)}?

Prof. Willems in one of his articles opposes the experiences of \textit{bedrijfsartsen} and \textit{verzekeringsgeneeskundigen} in relation to the commercialisation of the \textit{BGZ}. Both are physicians in the social health sector, but their job description is different in many aspects. The first ones for example are responsible for the control and attendance of the recently absent employees, while the others will get involved only after 10 months of unfitness-for-work. I have to conclude that in three out of four aspects the \textit{'verzekeringsgeneeskundigen'} not only score more negatively in the ratings of '96 and '98, but also their changes in the negative direction were bigger than for the \textit{'bedrijfsartsen'} (Willems 1998: 100).

When the researcher of this study asked Prof. Willems for his reaction to the hypothesis that maybe certain groups of \textit{bedrijfsartsen} have a more independent attitude towards the \textit{arbodienst} as well as towards the employer, he suggested another hypothesis in relation to the independence aspect: the work-environment of a \textit{bedrijfsarts} and the involvement of an employer are more likely to influence the (in)dependency of a \textit{bedrijfsarts}. In this thesis I still used a differentiation in
groups of *bedrijfsartsen*. In the end, the reasons for this differentiation are very much linked to Willems’ hypothesis. The former *verzekeringsgeneeskundigen*, now working in a ‘real’ commercial *arbodienst*, and the former internal and former external *BGD*-physicians were and still are involved in a particular kind of management and a particular type of work-atmosphere. Working either for a ‘real’ commercial *arbodienst* or a former *BGD* also means that you are connected to specific types of companies. Since quite a number of physicians have moved from one type of *arbodienst* to another, they become less rigid in their opinions.

Being (recently) attached to a training institute is a determinant factor for one’s job perception and job satisfaction, beside factors like background, the type of *arbodienst* you work for and the type of company you are responsible for.

Gender and age almost have no influence on job perception and -satisfaction of the *bedrijfsarts*. The fact that young female *bedrijfsartsen* in general have a critical attitude seems to be linked to the fact that they still are in training. Political orientation, in contrast to Prof. Willems results, also doesn’t seem to influence somebody being more or less enthusiastic about the effects of the commercialisation within *BGZ*.

The two *basisartsen*, who at the same time are young and female, turned out not to be very happy with the very individual style of working. It gave them the feeling of working on an island.

### 3.5 Thirteen elements of role-ambiguity and how the *bedrijfsarts* handles them at this time.

#### 3.5.1 The basis for the role-ambiguity is a disparity in the job-description between the training-institute of the *bedrijfsartsen* and the ‘real’ commercial *arbodiensten*. The organisation of professional *bedrijfsartsen*, the NVAB, clearly defines in the *Professioneel Statuut* their ideas about what a *bedrijfsarts* is supposed to do. The co-ordinating organisation of the *arbodiensten*, the BOA, recognise the articles of the *Professioneel Statuut*. This co-operation can’t prevent the individual *arbodiensten* to go their own way. Because role ambiguity, a form of role stress, can lead to a forced or voluntary dismissal of the job (Leigh et.al. 1988: 47), it is important to recognise the most prominent elements of role ambiguity. Next, it is interesting to see which of these elements in fact, are direct or indirect consequences of the commercialisation and the introduction of new laws in the field of *BGZ* since 1994.
In the answers of the first four research questions, the majority of the elements of role ambiguity were already mentioned. A total of thirteen could be selected from all the interviews. Since the bedrijfsartsen recognise them themselves, they started to a certain extent also to handle them, because they believe that they have a negative effect on the quality and the professionality of their job.

3.5.2 The emphasis on quantity caused time-pressure as well as production-pressure. The bedrijfsartsen believe that they can diminish this effect by involving more frequently the other kerndeskundigen. In particular the task of relation-manager can be shared with and sometimes taken over by one of the other kerndeskundigen. One key-informant said about this:

The 'BGDs' in the past were strongly medically dominated. This is changing. There is still a dominance of the medical perspective, but it really is changing. I have always been an advocate for the de-medicalization and that is what is happening now.

One bedrijfsarts from a 'real' commercial arbodienst said in relation to this point:

It is my opinion that when a risk-inventory(RI) is completed, it should be the advisor (other kerndeskundige) to provide follow-up and to discuss the possible use of specific ‘arbo’ products with the employer. This advisor could inform himself about the existence of a plan on how to approach the mentioned advice. Maybe the employer needs some assistance. In this way the contact with the employer is maintained and it keeps the entrance for the advisor open. In the actual situation this is left to the 'bedrijfsarts'.

Beside a good division of labour within the arbodienst, more participation must come from the employer himself. The managers of a company have to take more initiative in relation to arbo and ziekteverzuim matters.

According to the bedrijfsartsen, the pressure on production can only diminish when the employers are convinced of the usefulness of a qualitatively good arbo- and ziekteverzuim-policy in their company. Only then are they willing to pay a good price, releasing the arbodiensten from the idea of only gaining money by quantity.

3.5.3 One of the most criticised elements of the commercialisation is the growing influence of the employers on all kinds of BGZ matters. If the bedrijfsarten aren't cautious they will easily replace
their objective and professional judgement for a more employer driven one. The bedrijfsartsen realise that it is important here to stick to the definition of quality in their work. Although it turned out not to be easy to define quality, certain aspects were unanimously classified as such: 1. always look for the source of the ziekteverzuim-problems; 2. be as professional as possible in your judgement and advice and 3. prevention is the best type of arbo-policy. This professionalism has been supported by keeping in touch with one or another training institute and is also believed to be stimulated by the recently re-started meetings of personal assessment between colleagues (ICT). A bedrijfsarts mentions this aspect of commercialisation:

In fact you can be easily driven in the direction of the one who pays you. It is a matter of professionalism and of a not easy to measure quality-aspect. This is reflected in the capability of keeping your back straight and taking professionally backed-up decisions under all circumstances. The way I fulfil my job is by creating every time made-to-measure products.

3.5.4 Not being able to participate much in primary prevention is another element of ambiguity. The bedrijfsartsen are still looking for a balance between curative and preventive oriented tasks. They also have to come to an agreement with other kerndeskundigen and occupational health nurses about their share in these activities. Regular contact with the employer and company and a critical awareness of everything that passes during the ziekteverzuim- and open consultation hours are considered essential for primary prevention. A regular and serious contact with the labour council or OR is also believed to be very supportive here.

I believe prevention is preparing the employee well during the reintegration-phase. This is in order to prevent repeated health damage from a working situation. When you combine this activity with a visit to the workfloor and a profound analysis of the stories you hear, you can even raise prevention to a higher level. It means that you discuss your observations with the employer and consequently give professional advice.

3.5.5 Bureaucratic registration measures of the bedrijfsvereniging or UVI are considered very inconvenient and not very useful. The bedrijfsartsen want them to be either adapted or abolished. If not abolished they expect the verzekeringartsen to handle the declarations more carefully, in the sense of giving them a faster and more profound feed-back.
We don't want a division within curative health care and I think we have to try to avoid this within 'BGZ' as well.

3.5.9 The uncertainty about the future of BGZ in general and the functioning of the bedrijfsartsen in particular is expressed by different bedrijfsartsen. To become more or less in control of this uncertainty, the bedrijfsartsen feel they have to keep themselves well informed about the introduction of new elements in the BGZ. Consequently the bedrijfsartsen must be willing to formulate their opinion about these renewals and whenever necessary demonstrate their dissatisfaction. So far the collective of bedrijfsartsen hasn't raised its voice very often:

Maybe we don't let our voices be heard very clearly. We probably adapt easily and follow the line set up by the management of the 'arbodienst'. We are too honest and respectable and don't easily say that we don't accept it any longer.

3.5.10 The impoverishment of the mutual contacts between the bedrijfsartsen is kept limited, especially by the regular informal contacts they have. The official bedrijfsartsen-meetings will continue to be a point of discussion, because all kinds of personal motives play a role in one's decision to participate or not.

The meetings at our unit here are not very constructive, because we also have a meeting at the main business unit. We are expected to participate in the latter, but hardly ever do so.

Meanwhile the most important information is exchanged.

Many bedrijfsartsen believe that their contact with the other kerndeskundigen has to be improved. The impression exists that the former BGDs are the most successful in this type of communication. A regular interdisciplinary contact about the different companies exists. They also intend to have the personal assessment of colleagues (ICT) with the different disciplines together.

We have to consider though that in a commercialised BGZ effectiveness and efficiency are first priority and as a consequence of this policy the 'real' commercial arbodiensten tend to emphasis more on the grid than on the group aspect.

3.5.11 The observation of the youngest two bedrijfsartsen about the fact that the more senior colleagues seem to work on an island is a difficult problem, because it is closely linked to the effort of every (occupational health) physician to safeguard one's professional status and authority
of these thirteen aspects were already mentioned as being negative elements of the commercialisation by Willems (1998) and Plomp (1999).

13 aspects of role-ambiguity in the job of the *bedrijfsarts* as a consequence of the commercialisation, and to what extent they have tried to correct them.

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<th>EXTRA EFFORT TO CORRECT</th>
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<th>HARDLY ANY EFFORT TO CORRECT</th>
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* these are the ones already mentioned by Plomp and Willems
4. DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

4.1 Discussion and Conclusions

The basis for this thesis was to find out what happened as a consequence of the introduction of a number of new laws in the field of occupational health (OH) or bedrijfsgenezondheidszorg (BGZ) in the Netherlands. These laws were believed to be necessary, because of a growing problem in the absenteeism of employees. They also were an effect of the political line developed in the Netherlands since 1989, when the presence of the Conservative-Liberal party in the coalition stimulated the privatisation of different sectors. In this thesis special emphasis has been put on the perceptions of the occupational health physicians or bedrijfsartsen in relation to the changes. The most important changes were:

1. the privatisation of the payment for sick-leave. It meant that since 1996 an extra 94% of companies are responsible for the payment up to one year of absenteeism or ziekeverzuim of an employee.
2. the obligation for all the Dutch companies to be attached to an occupational health service or arbodienst. In collaboration they have to guarantee a ziekeverzuim- and OHS or arbo policy.
3. the commercialisation or introduction of a market mechanism within BGZ, which meant that the newly formed ‘real’ commercial arbodiensten immediately, and the ‘non’ commercial arbodiensten only in a later phase, started to work with a competition mechanism, a marketing and sales component and a quantity-first-policy.

Before the introduction of the law TZarlbo in 1994, BGZ already had developed in a certain direction as a consequence of the arbo law from 1983. Working conditions received a lot of attention in the larger and more risk-sensitive companies. The active involvement of the representatives of the employees, the labour council or OR, was part of the arbo law.

The socio-cultural characteristics of BGZ until the late eighties

The bedrijfsarts, besides an occupational health nurse and a social worker, was the only specialist working within the bedrijfsgeneeskundige dienst(BGD), the name of an occupational health service up to 1994. He was the ‘omnipotent medical practitioner’ (Lupton 1994: 2), who with a holistic view took care of all health related aspects of employees. This already underwent some changes as a consequence of the 1983 arbo law, which prescribed the
Involvement of other specialists, like a specialist hygienist and a psychologist with specialisation in mental health, there was a good relationship with the employer, about the improvement of the working conditions and the measures of the *bedrijfsarts*. BGZ was a heal

dangerous and unhealthy working conditions.

claim, the *bedrijfsartsen* still had good access guaranteed an unprejudiced contact with the employer. Within BGZ, the salaries and the second

good. This was possible because of the final agreement. There were differences in the job description caused by the type of *arbodienst* and the role of the homogeneous medical professional group.

Professional organisation (*NVAB*), its refresher courses. At that time it was a different from the colleagues in the company or organisation in the public. In general it meant that the medical profession. Wink in his initial report on the comparison with an 'uninvited guest' passed a rather difficult time in the ideal for well towards the other health sectors.

The most important mechanism

One of the most important changes in the *ziekteverzuim*-control. The BGD already had this duty within the organisation, the *NVAB*, *ziekteverzuim-control* in the Netherlands. The forced reduction of absence became very sensitive is for employees, in the sense of the cost of the payment for
Health professionals seldom consciously view their activities as contributing to social control. In listening to words of distress from their clients, for instance, doctors usually do not see their responsibility as preserving the current organisation of economic production or stability of the family. Nonetheless by focusing on individual troubles rather than on social issues, doctor-patient encounters may reinforce the social order as presently constituted. (Waitzkin 1991:22)

With the extra attention on the reduction of *ziekteverzuim* the involvement of another *kerndeskundigen* in the field of *BGZ* grew rapidly. The psychologist in occupational and organisational matters has become a competitor for the *bedrijfsarts*. More and more absenteeism is considered a behavioural problem and not a mere medical problem. While in the past the *bedrijfsartsen* had to put some effort into comprehending the overall social aspects of the employee in his work situation, he now seems to be drawn back into the limited medical zone of *BGZ*, which comprises the consultation of the sick employees and the related contacts with the curative health sector and the employer. The creation of the 'Gezonde Zaak', an institute specialised in a rapid and effective approach of especially locomotor and psychogenetic problems, also emphasises the curative aspects of the job of the *bedrijfsartsen*. It seems that the overall *BGZ* has become de-medicalized in the sense that many other aspects beside medical ones have been introduced in the approach towards the reduction of *ziekteverzuim* and the development of good working conditions (arbo). The *bedrijfsartsen* however see their task limited to the obvious medical problems of the individual. Although at the moment the physician is still 'the spider in the web' of all *BGZ*- related matters, the fear exists that with 'the increase of the medical management of social problems, the societal roots of the personal problems become less apparent' (Waitzkin 1991: 19).

In fact market-mechanism in its simplest form already existed within *BGZ*, especially in the external *BGDs*. Even on a wider scale we might say that the different forms of health care exist only, because they successfully use the market mechanism: *The concept of the medical market can be used as a heuristic device for mapping the interaction between the supply of and the demand for all kinds of medical services in a particular region at a particular time* (Gijswijt-Hofstra eo 1999:11).

As a consequence of the formalised commercialisation since 1994, *BGZ* openly directed itself to a more profit-oriented market mechanism and this created a lot of changes for the *bedrijfsartsen* involved. Plomp states that as a result of the introduction of a market mechanism, it is no longer the *arbodiensten* themselves who decide on what is a complete and
effective BGZ-package. It is the employer or client, who can choose and will decide on what he wants in the involvement of a arbodienst. The tender or aanbieders market changed into a buyer or aanbidders market (Plomp 1999: ). Consequently the bedrijfsartsen had to work very hard in order to attract enough clients as well as the amount of sales, that guarantees the survival of the arbodienst. The quantity-first-policy was believed to be temporary, but after 5 years no change was notified. It seems that a tight management control and marketing and sales rules continue to define the content of the work of the bedrijfsartsen. This is especially true for the ones working in a ‘real’ commercial arbodienst. Different developments however make believe that also the ‘non’ commercial arbodiensten will slowly change to a more commercially controlled management. Some of these developments are: 1. companies are changing to a ‘real’ commercial arbodienst, 2. former internal BGDs are taken over by ‘real’ commercial arbodiensten and 3. bedrijfsartsen also change from one type of a arbodienst to another.

What does the BGZ-culture look like nowadays?
The bedrijfsarts of today most of the time works in a relatively small peripheral setting, but at the same time is part of a bigger national organisation. The latter controls the management and gives a regular input of new products and approaches. Though still very important and essential, the bedrijfsarts has become only an accessory in a big organisation. The bedrijfsartsen are kept informed on the local level as well as on the national level, but have become more or less passive participants. The same counts for their relationship with the employer, who as a client has a stronger position. The bedrijfsartsen are very much aware of this fact and it is obvious that they try to object to it whenever possible. It isn’t easy though to modify the attitude of an employer, who was forced into the BGZ system and lacks the motivation to give time and money for a good ziekteverzuim- and arbo-policy.
The employee can’t be underestimated in this respect as well, because as a consequence of a democratisation as well as an individualisation process in the Dutch society, they also have a strong position. A lot has been created to safeguard the position of the employees, like there is the possibility for a second opinion in case of a conflict between him and the bedrijfsarts about the judgement of fitness-for-work. It is especially at this point that the bedrijfsarts has introduced a new ‘ritual’. To validate the employee’s fitness or unfitness-for-work today is considered a central task of the bedrijfsarts. To show respect and especially to propose a solution that creates a win-win situation for the bedrijfsarts as well as for the employee, the
researcher considers the new rituals in the job of the *bedrijfsarts*. The term ritual is used here, because the interaction has such a regular and similar character. Ritual is a periodic restatement of the terms in which men of a particular culture must interact if there is to be any kind of coherent social life. In its expressive aspect it portrays in a symbolic form, certain key values and cultural orientations (Helman 1994:225). To show respect and to create a win-win situation are such key values.

In his daily activities the *bedrijfsarts* is confronted with the demands of three parties, the *arbodienst*, the employer and the employee. Besides, there are the demands of the professional organisation, the *NVAB*, who claim a regular personal-assessment or *intercollegiale toetsing* (ICT) and post-doctoral refresher courses. The training institutes give valuable input for the judgement of those demands. They offer the most recent independent information in relation to their functioning in a commercialised setting. They confront the *bedrijfsartsen* with the ideology, a primarily preventive type of *BGZ*, which receives a lot of attention in their approach. In this thesis thirteen elements of ambiguity in the actual functioning of the *bedrijfsarts* were discovered. The *bedrijfsartsen* display a critical attitude and try to develop an acceptable alternative to the majority of these elements. These alternatives need to be more clearly and openly formulated, otherwise it will stay individual options and confirm the idea that *bedrijfsartsen* 'work on an island'.

4.2 Recommendations

From the conclusions it becomes clear that there is a special need for the *bedrijfsartsen* not only to stay critical in times of rapid change, but also to openly state this criticism. They have to look at their preserved ideology as well to the introduced commercial standards. The medical curative input, the social control as well as the primary preventive aspects must be discussed and somehow an unanimous job description of the *bedrijfsarts* must be the result.

I would recommend another study about the position of the other *kerndeskudigen* in the *arbodienst*. During this research there wasn’t enough time to look at this aspect. I also have to admit that only after the collection of the information, did I realise that this very important aspect was hardly given attention during participant-observation as well as during the interviews with the key-informants. During the interviews with the *bedrijfsartsen* it turned out to be of essential importance.
ANNEX I

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ANNEX V

Instrument: question guide for the interview with BA’s

1. What does an ordinary working week look like for you? That means what kind of activities are you busy with and how much time do they take?

probing questions are:
- is part of your job also: routine physical check ups, risk inventory at the company, SMT?
- what kind of administrative tasks do you have?
- how much of your work is so called prevention related work?
- do you experience time-pressure? What causes this the most?
- do you give special attention to certain aspects of your work, this in relation to your fellow colleagues?
- what kind of meetings are there for the BA’s and for BA’s together with other colleagues? Do you participate in them?
- what are quality aspects of your work?

2. How in your opinion, is the assignment of duties between the employer and the arbodienst c.q. bedrijfsarts, where it concerns TZ/arbo?

probing questions are:
- to what extent do you use extra activities to improve the TZ/arbo of a company?
- what does a high ziektleverzuim percentage mean to you? And what do you ultimately do with it?
- to what extent do you have the feeling that employers are guiding you as a BA?

3. Can you give an example of a conflict that you recently experienced either with an employee or an employer, or maybe with both at the same time? This in relation to illness and considering a person fit or unfit for work.

probing questions are:
- how did it start, develop and end?
- is there a possibility to use any official instructions under these circumstances?

4. What, according to you and from the experiences you have had so far, are the advantages of a arbodienst working in a commercialised way? And what are the disadvantages?

Extra questions if time is left over:
- what do you think of the idea that a arbodienst should work as a ‘social accountant’, which means that a company can consult the arbodienst on all kind of matters related to the person and his work.
- To what extent do you feel supported by, or do you look for support from the professional organisation of BA’s (NVAB)?
**ANNEX V**

*Vragenlijst voor werknemers aan de groepsdiscussie*

Hierna volgt een lijstje met kenmerken van een arbodienst. Geef aan wat voor u het belangrijkste is. De nummers kunnen daarbij een andere volgorde krijgen.

<table>
<thead>
<tr>
<th>Nummer</th>
<th>Kenmerk</th>
<th>Beschrijving</th>
<th>Volgorde</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Autonomie</td>
<td>Als de client of zieke werknemer mee kan beslissen in het hervattingstraject.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Kontinuïteit</td>
<td>Dezelfde (bedrijfs)arts zien bij de verschillende contacten met de arbodienst.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Client-arts relatie</td>
<td>Als een (bedrijfs)arts de tijd heeft voor de client of zieke werknemer.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Efficientie</td>
<td>Een (bedrijfs)arts die geen onzinnige middelen inzet bij het herstel van de arbeidsongeschiktheid.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Effectiviteit</td>
<td>Een aanpak die gunstig werkt op het herstel en dus op de terugkeer naar het werk.</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Deskundigheid</td>
<td>Een (bedrijfs)arts die voldoende kennis heeft van (beroeps)ziekten en van de organisatie van het bedrijf.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Informatie/communicatie</td>
<td>Een client of zieke werknemer die goed geïnformeerd wordt over de mate van zijn/haar arbeidsongeschiktheid en over het te volgen hervattingstraject.</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Inlevingsvermogen</td>
<td>Een (bedrijfs)arts die probeert de client of zieke werknemer te begrijpen.</td>
<td></td>
</tr>
</tbody>
</table>

**Uw volgorde:**

Geef als tweede het volgende aan: hoe doet jouw arbodienst of bedrijfsarts het op de boven genoemde punten. Kruis het vakje aan wat naar uw idee het meest van toepassing is.

<table>
<thead>
<tr>
<th>Slecht</th>
<th>Matig</th>
<th>Goed</th>
<th>Prima</th>
</tr>
</thead>
</table>

ANNEX VI

Description of 25 observed consultations with 4 different BA's *

<table>
<thead>
<tr>
<th>diagnosis</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>primary physical</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>primary psychogenetic</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>primary job conflict</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>secondary psychogenetic</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>secondary job conflict</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>14</td>
<td>11</td>
<td>25</td>
</tr>
</tbody>
</table>

F/M ratio : 14 / 11
percentage primary physical : 9 / 25 = 36%
percentage prim. psychogenetic : 4 / 25 = 16%
perc. prim + sec psychogenetic : 11/25 = 44%
percentage prim job conflict : 3 / 25 = 12%
first / repetitive consultations : 8 / 17
no. voluntary or *open* cons : 2
no. of physical examinations : 1

* interpretation in the first place by *bedrijfsarts*, but where not clearly defined at the spot, secondary interpretation by researcher, who is a physician.
PROGRAM COLLOQUIUM

'DILEMMAS IN THE PRACTICE OF ARBO-SERVICES'

'DILEMMA'S IN DE PRAKTIJK VAN DE ARBO-DIENSTVERLENING'

18 JUNE 1999 13.00-17.00

ACADEMISCH ZIEKHUIS VRIJE UNIVERSITEIT

COLLOQUIUMZAAL 1

DE BÖELELAAN 1117, AMSTERDAM

Chair: Prof Dr Gerrit van der Wal, Department Social Medicine Vrije Universiteit

13.00 Opening

13.05-13.30 Why shall we trust the ARBO-services?
Dr Ronald Batenburg, Department Policy and organization sciences, Catholic University Brabant, Tilburg.

13.30-14.15 First set cases: The arbo-professional: sharing management responsibility?

14.15-14.30 Break

14.30-15.10 Second set cases: Should we sell placebo's?

15.10-15.50 Third case: How flexible could Test standards be applied?

15.50-16.05 Break

16.05-16.45 Fourth set cases: The unwilling employer

16.45-17.00 Concluding remarks,
Dr H. Nico Plomp Department Social Medicine, Vrije Universiteit Amsterdam.

17.00-1800 Informal get together

NB Presentations will be in English; discussion in Dutch.

Organized by the department of Social Medicine Vrije Universiteit
Commissie beroepsuitoefening en ethiek van NVAB
ANNEX VIII

Dissemination report

Agenda, as prepared by the researcher:

- Introduction

- Details about methodology: data collection
  data processing

- Adaptations and limitations of the study

- Time for individual remarks on the findings as presented

- What were your answers to the 3 questions I asked in the accompanying letter:

  1) Did you recognise your *arbodienst*, in other words was it a good description?
  2) Are the positive and negative elements of your work well presented?
  3) Did you see any categorical errors in the findings?

- What should your answer be to the unanswered question in the findings, concerning the fact why employers almost never ask for a second opinion at the *bedrijfsvereniging*?

**Present:** 2 BA’s of the 9 interviewed from one particular *arbodienst*. Besides these persons the director was also invited and actually present at the meeting. The other 7 BA’s were either on holidays, had a day off, were busy with other things, simply forgot or maybe were not interested.

**The feedback remarks** concerned:

- small adaptations to the content, where it was believed not to fully explain the truth.

- discontentedness with the way they were quoted.

- not fully understanding what the researcher meant to say on a few aspects.

- one aspect was considered not to guarantee sufficiently the anonymity

- astonishment concerning certain quotes, which was expressed in the following way: *if somebody is expressing him or herself in this way we’d better close the ‘arbodienst’.*

A small discussion started when somebody made a remark about the second opinion. The employers are not interested in the second opinion, because it is difficult to motivate the employee to participate as well. In this way it won’t be easy for the employer to convince the *UVI* of his opinion about the fitness-for-work of a specific employee.

The overall picture was that the 3 persons present were quite happy with the findings as presented.
We agreed on some small adaptations. Also some quotes will be looked over again in their original context in order to guarantee a good reflection of what was said.