

Unemployed People's Experiences and Feedback of Preventive Health Care Services in Finland

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Abstract

The aim of our study is to describe unemployed people's experiences of preventive health care services, and to investigate how the health care system responds to their individual needs. We conducted the study under the name Occupational Health Counseling project, in Kuopio, Finland, between 2008 and 2010. We examined the transition from one service to another from the unemployed person's perspective whilst also canvassing their views on health and work ability. According to general consensus the link between health services and employment activities should be flexible between authorities. However, currently a health check is still quite separate from employment activities. Participants' satisfaction with the service was high. When targeted at the unemployed, this special type of health service meets clients' needs very well. Nonetheless, more attention should be paid to individuals who report reduced subjective health. Young unemployed people especially benefit from objective health evaluations, and it imbues them with self-confidence. Preventive health care services for the unemployed are important and services should be offered actively to them. Finnish law requires municipalities to arrange these services but still they are not active in every region. Also the process and contents of the services vary considerable. The situation has improved during the last few years, but work is still needed to ensure the continuation and development of the services. Also, this study shows that preventive health care services for the unemployed are important from the international point of view. The unemployed have many health care needs in common.

Keywords: Unemployed, health services, network, client satisfaction

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1 Introduction

The unemployed are a heterogeneous group and have different service needs [1]. All the problems of the unemployed cannot be solved by health care because the service structure is very complex and this group faces social problems [2]. Brussigemail et al (2014) showed that health promotion with labor market programmes is possible but requires agreements and coordination between the different social security branches. In labor market policy, stronger emphasis on voluntary programme participation is also needed. Health promotion requires skills and competencies; the staff in employment offices as well as in work organizations should adapt the needs of the unemployed [3]. Romppainen et al (2012) stated the production of health services for the unemployed to be a complex diversity of contemporary labor market trajectories. For example, non-standard employment, temporary work and unemployment are high, and some of the traditional professions have disappeared. In their study occupational health nurses felt, that health care services are insufficient for unemployed clients of health services approaches. The study argues that although the structural and economic conditions can change relatively quickly, change in social habits is slow [4].

Attitudes in health care also have an impact. Welfare services do not always respond adequately to the needs of the unemployed [4]. Virtanen et al (2006) stated that the use of physician services varies according to labour market status, being relatively low among the non-permanently employed and the unemployed [5]. Dropping out of health services correlates strongly with unemployment according to Teff et al (2014) [6]. Policy makers should be aware of cyclical changes in preventive care use. As physician recommendations can have a strong impact on patients' use of health care, providers could increase efforts to persuade patients to seek screening examinations and necessary vaccinations during periods of high unemployment [6].

Reducing inequality in health services in Finland is one of the focus areas in development. Working-aged people's health care is divided into municipal health, occupational health and private health sector. Preventive services are used the more the higher the income group the person belongs to. However, persons in lower income groups and unemployed persons have more health problems. This relationship has been observed consistently across 23 European countries [7-8]. Many studies have demonstrated that differences between social classes in well-being and health have even grown [9-13]. Preventive health care services should be arranged according to Finnish Health Care Act [14] to unemployed in every region in Finland. Although about 89% of municipal health care centers carry out these services, the volume and quality of the practices are not known [15]. The coverage of occupational health care for salary and wage-earners in Finland in 2010 was 92% [16].

There is a lot of research related to the health of the unemployed and health services for them but the studies on client's point of view are just a few [1, 3]. Aim of our study is to describe the unemployed persons' experiences of preventive health care services, and to investigate how the health care system responds to their individual needs. Case is the Occupational Health Counseling project Kuopio, Finland in 2008-2010. The article is mainly descriptive. It examines the transition from one service to another from the unemployed person's perspective whilst also canvassing their views on health and work ability.

2 Materials and Methods

2.1 The Context of Occupational Health Counseling Project

During 2007 – 2010, the unemployed health services for the unemployed were developed in 18 different sub-projects of the Finnish National Institute of Health and Welfare. One part of the project was coordinated by Finnish Institute of Occupational Health called the Occupational Health Counseling [17]. This project took place in the years 2008 – 2010, and the preventive health services for the unemployed were organized in connection with the primary health care. Occupational Health Nurse (OHN) checked clients' health.

The role of the OHN is prominent and independent in Finland. They have the statutory education and qualification for required for this job. They coordinate the services and cooperate with organizations and enterprises. OHNs are specialized in health promotion. [19]. They also deal with health examinations (over 600,000 every year) [20]. This means direct contact between the nurse and the employee. This usually involves a discussion of the employee's life situation and the balance between private life and work life, workplace atmosphere, workload (e.g. time pressure, information load) and how the employee is coping with his/her work. The nurse also encourages the employee to adopt on safe work approaches and life habits and talks about nutrition, alcohol, tobacco and physical exercise. Working with unemployed needs know-how about unemployment and labor market specific issues [2, 17].

The OHN in health center made appointments with participants from various sectors, for example employment and economic development office, social welfare office, educational institutions and in the intermediate labor market (Figure 1). The participants were young unemployed people aged 15-25, and the middle-aged adults undergoing labor market training [2, 17, 18]. The intermediate labor market is an interphase between free labor market and unemployment. Unemployed persons aim to move to the free labor market. During the health examination the OHN surveyed clients' health and work ability by using different tests. After the meeting, the nurse and client planned in cooperation any further treatment or follow-up meetings, either in health care or other organizations (Figure 1) [2,18].

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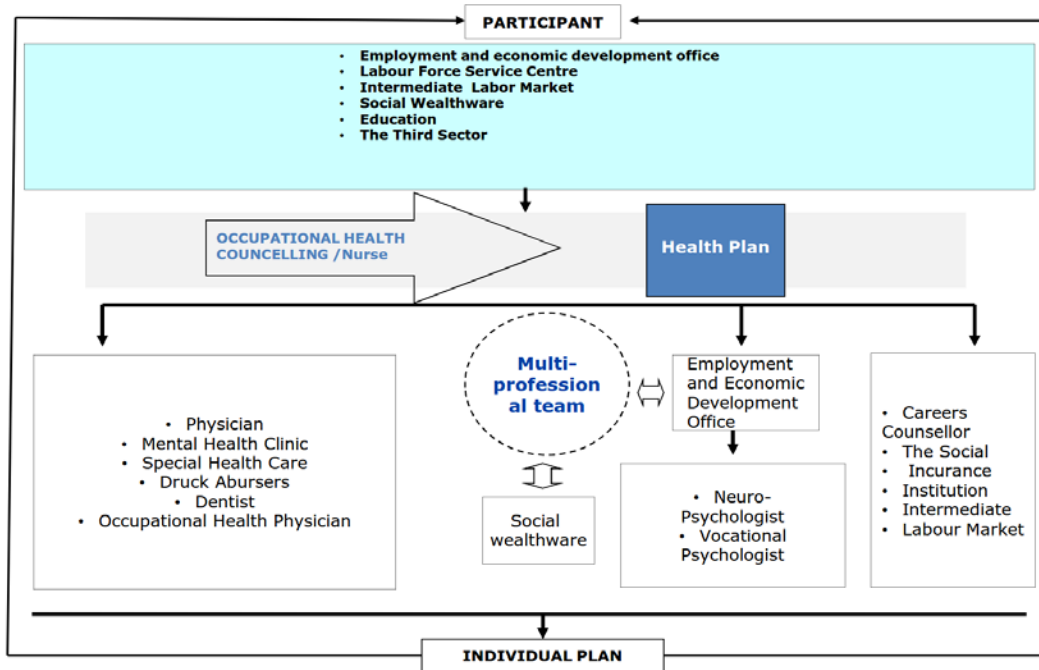


Figure 1: Occupational Health Counseling Model

2.2 The Data Collection

Data was collected through interviews ($n=9$) with young participants, aged 20-25 and through questionnaire feedback; $n=130$ from all clients aged 15-54. We reminded once and also contacted telephonically but still only 42 responded (response rate 32%). The majority were females ($n=37$). The maximum responses was in 25-54 age groups. In the oldest age group were middle-aged adults undergoing labour market training in cleaning and assistant nursing. Those trades are dominated by women. The survey was conducted out in February-April 2010 (Annex 1).

The feedback questionnaire was developed by Finnish National Institute of Health and Welfare in Development Partnership Project 2007-2010 [1]. It was used in 18 different sub-projects. It was based on professionals, researchers and previous projects knowledge. The response rate in other sub-projects was 15-39%. The questionnaire included questions about background information, statements and meaning of the health check and follow-up care (Annex 1).

A semi-structured interview was based on themes selected beforehand while there was no clear structure or order in the questions during the interview [21, 22]. This method of collecting material enables interaction between the interviewer and the interviewee, making it possible to use questions to extend understanding [23].

The interviews took 6-15 minutes. Three interviews were carried out early 2010 and four late 2010, and the remaining two in June 2011. Seven of the interviews were conducted out face to face and the remaining two by telephone (Annex 2).

We present our findings by combining the statistical analysis and content analysis. This triangulation method gives a wider understanding of the aim of the study. Also, the small number of responses of questionnaire does not allow more complex statistical

analysis.

2.2.1 Content analysis

The interviews underwent content analysis using Atlas/ti program (Atlas/ti 5.1). Content analysis considers similarities and differences. [24, 25]. The units of analysis was chosen as the material purpose. In qualitative research data collection, processing and analysis is difficult to separate [26, 27]. The process begins with the analysis of the analysis unit, which may be a word, a word combination or a phrase. The second step in the data is coding and the classification. In data classification simplified expressions are grouped, and the categories are classified as lower and higher. Consolidation will continue as long as it is meaningful. In the last phase of the material results are interpreted and conclusions are drawn. [26, 27, 28, 29].

The content analysis of the first phase of transcribed texts were fed into the Atlas/ti-program, after which the data were coded. The first phase of coding examined the content of the text and the meanings in the interviews. These parts were conceptualized with different codes, a total of 57. In the second part, the researcher examined whether codes have the correct code name. Some of the lower categories had the same contents, and the codes were combined. This was done manually by printing all of the coded expressions and by sorting, thus nine categories were established. As the data was small a two-level classification of the material was adequate.

2.2.2 Statistical analysis

SAS for Windows 9.2 was used for the statistical analysis. Data underwent descriptive analysis, direct distributions and the Pearson Exact Chi-Square test.

Statements based on a 5 step Likert scale (totally agree, tend to agree, neither agree nor disagree, tend to disagree, and strongly disagree). In the analysis we combined the first two classes. A comparison based through age distribution. The Pearson Exact Chi-Square test, value was used for statistical analysis because of the limited data.

3 Results

3.1 Experiences of Service Utility

The interviewed participants (n = 9) ranged from 20 to 25 years. Six of the participants were men. Their life situations ranged from unemployment (n=3), job training or education (n=4) to employment with the support of rehabilitative and work place units (n=2). Two of them had mental health problems or substance abuse problems. Some of the participants had moved to a new city, and they did not yet have a social network there. One client had no income at all at the moment, but he lived on his spouse's income. The common factor for all of them was rather low physical activity or lack of hobbies. Clients were directed to a health meeting from different sectors. The employment and Economic Development office sent three clients. Three other participants came from Intermediate Labor Market, and two participants had noticed a brochure of the project and had made an appointment by themselves. One participant came suggested by his girlfriend.

Table 1: Background information of the participants who answered the feedback questionnaire

	n=42
Sex	
Female	37
Male	5
Age	
under 25	8
25-34	4
35-44	11
45-54	19
Life-situation	
unemployed	5
employment with support	3
employed	6
education to employment	28

By the time the participants were prompted their health checks, most of them had forgotten it. What they remembered, was fill in forms, measuring height, weight and blood pressure and vaccination. Accessing to this service was easy and they all received basic information of their health status.

"It was at least quickly and the situation was uncomplicated and very clear. Easy to go there [laughs] "[sic] (Male 20).

Of the clients 88%, opined that the health check gave a true picture of their health status. This was especially true for older clients (Table 2).

All of the young participants interviewed felt that the service was useful and necessary. Most of these had rather limited suggestions for improving the service. Their opinions of health check meeting were mostly positive. They felt it important that they received an assurance that they had not more severe health problems. One participant had concrete help in accessing treatment for back problems.

"Really useful, you do not... Had there not been this opportunity for an appointment yet, just that. And that it was free, that.... at their, there'd probably have to send us. It was fine to get that opportunity to go "[sic] (Male 21).

Participants were asked about the instructions during the health check. They considered instructions; lifestyle issues (smoking, alcohol, physical activity, and diet and weight management issues). Below are two comments about the instructions.

"Stop drinking. [laughing] I thought it was" [sic] (Male 23).

"Well, in this example from the physical activity of any kind that , you have a hobby

activities , example from exercise according to all that the world of ball games and a lot of hobbies recommended that , in this age people can be recommended " [sic](Male 20).

Some of the interviewees felt that the health check also affected their health habits, although they were unable to specify this effects. One interviewee felt that the meeting import confidence and courage to apply for studies or work. Participants liked the easy way to get the service and the possibility to get their process forward. One participant felt that health check was not relevant at all.

The feedback during the health check was considered sufficient by 73% of the respondents, most among the youngest age group, and least among the group 35-44 group (Table 2). Of the respondents, 40% considered that the health check had made them to pay more attention to health status and health habits. This was generally more common in the younger age groups (Table 2).

Table 2: Participant`s feedback of unemployed health check by age-group (n=42).

Opinion	Totally/ tend to agree				Total n (%)**	p-value*
	Age					
	Under 25 n (%)	25-34 n (%)	35-44 n (%)	45-54 n (%)		
Health check gave a true picture of own health status	6 (75)	3 (75)	10 (90)	18 (95)	37 (88)	0,43
Feedback from the health check was sufficient	7 (88)	3 (75)	6 (55)	15 (79)	31 (73)	0,67
Health check made me to pay attention to the health status and health habits	4 (50)	2 (50)	4 (36)	7 (37)	14 (40)	0,93
Health check was necessary	7 (88)	3 (75)	6 (54)	17 (90)	33 (79)	0,24
Follow- up care had been achieved	4 (50)	2 (50)	6 (54)	9 (47)	21 (50)	1,00
Health examination attention was paid to the wishes	7 (88)	3 (75)	7 (64)	13 (68)	30 (71)	0,53
Health check should be regular	8 (100)	3 (75)	11 (100)	19 (100)	40 (98)	0,10
Unemployed need health checks	8 (100)	3 (75)	10 (91)	19 (100)	40 (95)	0,10
The results of health check were taken into account in the employment services	3 (38)	1 (25)	4 (36)	4 (21)	12 (29)	0,25

* Pearson Exact Chi-Square test

** All the respondents did not answer to all questions

The Beck Depression Inventory [30] showed over 10 points for six persons who responded to participants feedback. Four of them totally agreed or tended to agree that the health check had prompted them to pay more focus to their health status and health habits. The health check included regarding ability to work where compared to the life-time the best [30]. The scale was from 0 to 10. The estimation was under 8 (reasonable or poor) for four responses.

Three of these agreed or tended to agree that the one outcome of the health check had made them to pay more attention to their health status and health habits.

Table 3: Participants' opinion about the health check utility by age-group (n=42). Answer "Yes".

Health check was relevant	Yes					Total n(%)**	p-value*
	Age Under 25 n (%)	25–34 n (%)	35–44 n (%)	45–54 n (%)			
To my health	4 (50)	2 (50)	5 (45)	9 (47)	20 (48)	0,92	
To my wellbeing	4 (50)	3 (75)	5 (50)	12 (67)	24 (60)	0,69	
To my employment	2 (25)	1 (25)	3 (27)	4 (24)	10 (25)	0,98	
To my finance	0 (0)	0 (0)	2 (18)	2 (12)	4 (10)	0,88	

* Pearson Exact Chi-Square test

** All the respondents did not answer to all questions

Health check was considered necessary by 79% of the respondents. This was slightly more common among the youngest and the oldest age groups, but there was no statistical difference between the groups (Table 2).

We asked whether the health check was meaningful (yes, no, cannot say) to their health, wellbeing, employment and finance. Naturally responses rated effects on wellbeing highest; 60%, followed by health (48%), employment (25%) and finance (10%) (Table 3).

3.2 Follow up Care and Authority Network

The respondents were asked about follow-up care, and there were no differences between the age groups (Table 2). Four of the six who had over 10 points in BDI considered the follow up care successful (agreed or tended to agree). Two out of four respondents had the score below 8 when estimating their ability to work (score 0-10). They tended to agree or totally agreed with follow-up care provision.

According to participants' opinion, only 29% of them felt that the employment services took into account the results of the health check. This opinion tend to be more common among the youngest and the oldest age group. The interviewed young participants were not involved in multiactor meetings during the project. Follow-up care included an appointment with the doctor or laboratory guidance.

The interviewed participants were asked about the network of authorities around them and other organizations in which their health or work ability issues had been discussed. Some of the young people did not have the need for network support, but listed a number of the authorities involved, such as the Social Insurance Institution (SII), the Employment and economic development office, the intermediate labor market, the social welfare services, the mental health services and doctors' appointments. Also, family members and participants' relatives were mentioned in connection with this theme.

"Okay, welfare, SII... Employment office, then." [sic] (Female, 22).

"SII and Social welfare they probably are, and, I'm not sure about vocational school network, it is anyway related" [sic] (Male 20).

3.3 The Participants Role and Wishes

Of the respondents, 71% considered their preferences were accommodated during the health examination. This was more common among the youngest age group (Table 2). In the older age group there were more expressions (32 %) of neither agree or disagree.

In the interviews, the participant's own role rated as equal to the OHN. All of the interviewees were of the opinion that they gained relevant understanding of their life situation. One of them expressed a certain wonder regarding her situation in life. The OHN was described as a knowledgeable and attentive person.

Almost all of the participants considered that a health check should be at regular intervals (98 %) and that unemployed persons need health checks (95%). Also, 86% considered that

health checks were relevant to their own health; among the youngest age group, this percentage was smallest, 75 (Table 2).

However, participants' opinion was that it is important this kind of service is also available for the unemployed and persons who are out of the coverage of occupational health services. The service was welcomed as it was. The only practical development proposal was that the number of questionnaires should be reduced.

"It's a good thing that there is a service, like this [sic] (Male 21).

In the free comments section of the feedback survey almost all participants hoped for regular health checks. One recommended that regular health checks should be mandatory. Participants hoped for more information about the services and health opportunities that unemployed could access to. One main positive point was that the service was free. Participants also hoped free exercise facilities and physiotherapist services to maintain their ability to work. Long appointment periods were criticized. One participant felt that this kind of health check is representative of one's situation of life.

In the feedback survey, 79% of the respondents thought that the health check was needed, 73% got sufficient feedback, and 88% considered that it gave a true picture of their health status; while 72% considered that their own needs and views were taken into account. Almost all considered that unemployed persons as a whole (95%) needed health checks. Almost all the respondents hoped regular health checks (Table 2).

4 Discussion

The aim of the study was to describe unemployed persons' experiences of the health care service and their opinions of maintaining work ability.

The unemployed need health checks, and they consider them important. 40% of the respondents thought that health check made them pay attention to their own health status and health habits. Of those six, whose BDI was over 10 points, four agreed or tend to agree that the health check had made them pay more attention to their own health status and health habits. Also, of the four whose estimation of work ability was under 8, three shared this opinion. Meeting with a health professional is even more important and appropriate for those in a vulnerable life situation. Those persons need to get support and are willing to change their health habits. The young among unemployed specially benefit an objective health evaluation, and imports them self-confidence.

Axelsson et al, indicated that the quality of life (QOL) is good among a majority of unemployed young adults. Positive QOL also seems to be related to high self-esteem, satisfaction with spare time and a great extent of decision-making. In order to achieve more equity in health they suggest that special attention should be paid to individuals who report reduced subjective health, especially anxiety. Therefore, efforts should aim at empowering unemployed young adults by identifying their concerns and resources. Individual programs should include personal development beside work and education [31]. This has an important message also for health care sector; personnel need to direct clients to right service.

According to participant perceptions the results of the health check were taken into account by the employment services in only 29% of cases. Is an action still quite separate on the employment sector? The transition from the health check to the employment services is not necessary seamless even though the project tried to develop this co-operation. This link needs more attention in the future. Unemployed persons' health monitoring for maintaining work ability needs a complex networking of different actors from health care, social and employment sectors and voluntary participation. The health service should be close to the employment service, so that organizational limits disappear. The needs of the unemployed should be truly shared in different organizations. In this study we had a network of actors from various sectors. Referring organizations included, for example, the employment and economic development office, the social welfare office, educational institutions and the intermediate labor market. Based on the individual plan, the unemployed were referred to different actors in the health care sector, career counsellors, vocational psychologists, the SII, the intermediate labor market among others.

The majority of the respondents thought that during the health examination attention was paid to their wishes. In the older age group, there were more expressions (32%) of neither agree nor disagree. Why is the older group more crucial than the younger group? This is perhaps because they have more life experience and they want more from the service. Young people find it difficult to compare services due to their lack of experience. Memory of the health checks was minimal. The health check should be more relevant and focused on clients' needs. A small group (4 persons) felt that the follow up care was not as successful as planned during the health check. New methods like mobile applications could prove useful even though they do not compensate for human contact. Even though some of health care personnel think that the health care of unemployed is mentally laborious these services should be available. It is also important to take care of the

personnel's own coping, for example, by supervision of their work. Health care services should be offered actively to unemployed persons.

The report of Finnish National Institute of Health and Welfare report from regarding the health of those unemployed for a long time (Development Partnership Project 2007-2010) [1] showed the participants' feedback was very positive as regards their health in the review. 61% (in this study 40%) of participants told in the review they paid more attention to the health status and health habits after the health check. Some participants were moved to rehabilitation and some others started receiving disability pension. In the partnership project, the participants were mainly long-term unemployed and belonged to the older age group [1]. Overall the results in this report and the current study are quite consistent.

The evidence from health checks has been recently discussed very much in the OHS field in Finland. There is scientific evidence about the effectiveness of health checks in OHS according to Taimela et al (2008, 2008, and 2010). They divided high risk patients into an intervention and control group. After a one year follow-up, in the intervention group there were less sick leaves, and less costs than in the control group [32, 33, and 34].

The benefits of health services for the unemployed has also been studied. For example, Kreuzfeld et al. (2012) [35] mentioned degrees in the blood pressure, CVD risk, back pain and depressive symptoms among long-term unemployed as a result physical activity program. Horns et al. (2012) [36] showed similar results, the healthy lifestyle after intervention. Rothländer et al, (2012) [37] used an experimental design, in which the intervention included cognitive-behavioral methods for health promotion. Researchers found a significant difference in the health status: the intervention group's self-rated health was better. Evidence can be found of the benefits of support methods for the employment in Dalen et al. (2008) [38]. The similar evidence of workplace skill improvement in the unemployed in Finland has also been shown (Vuori et al., 2002) [39]. Based on these studies, participatory interventions seem to bring health and wellbeing benefits. Our study shows also welfare and health benefits for such clients.

Verbeek et al (2001) [40] reviewed the literature on the concept of consumer satisfaction with health care and on surveys of satisfaction with occupational health care. Consumer satisfaction is an important indicator of quality in OHS. Researchers claim that high average ratings of satisfaction is the most important methodological problem to avoid. It is important to measure specific aspects of occupational healthcare experiences among patients and clients because satisfaction is a multidimensional concept. Client feedback helps to better understand client preferences and to improve the quality of the services. It would be important to inform these unemployed persons themselves of the study results.

Hall and Doman (1988) [41] have analyzed over 200 studies concerning patient/client satisfaction. The average "satisfaction" count was 76%. Several researchers have showed that even though the satisfaction is 90%, the responses to certain specific questions can be very critical and negative [42, 43]. In this study we found also criticism, for example, in follow-up care.

4.1 Study Limitations and Ethics

However, there are some limitations of this study. The results are context-related to the Finnish health care system and therefore the results have to be interpreted and transferred with care. Also, limitations of this study relate to the results of generalization, research methods and the low response rate. The data would have been limited by itself, and we

ended up to use mixed methods. The results cannot be generalized to complete. [44]. The response rate for the feedback questionnaire was quite low (32%).

The older age group answered more often than the younger group. It was hard to get responses even by phone. The young clients did not necessarily answer to a phone call or back after call request. The majority of respondents were women. The clients who were undergoing employment offices labour market training were assistant nurses or of those training to be cleaners. These lines of work are dominated by women. Because of the limited data, we could do only a simple statistical analysis. We could not compare, eg. differences between the genders in their opinion of the services. These results are approximate.

It was a challenge to get the participants for the interview. Although the interview time was agreed upon, the interviewee did not necessarily arrive at the venue. It was hard to get responses even by phone. The result of interviews were also rather limited and the interviewees responded to most items pretty briefly. The young participants did not have very many opinions about the service, and they were satisfied. This clientele is passive and do not necessarily count on authorities, not to mention researchers. In the content analysis data classification and naming was checked several times. Material classification, however, always represents researcher choices and interpretation [25]. When the interview data is relatively small, a two-level classification is sufficient. Also, direct quotes illustrate the material.

The study underwent the Ethics Committee statements in the Finnish Institute of Occupational Health. Interviewees were informed before an interview about its content and the voluntary nature of their participation. Informal consent was obtained from all interviewees beforehand. Anonymity was assured and the individual interviewees cannot be identified. The role of researcher was neutral during the interview and the themes used were congruent in both groups. The participants also made a written assent. The phases of the study are also repeatable as it comes with the territory. [45.]

5 Conclusion

Participant satisfaction in health service for the unemployed was high. Targeted at the unemployed, this service meets clients' needs very well. Preventive health care services for the unemployed are important, and services should be offered actively. Individuals who report reduced subjective health should be given more attention. Young unemployed people especially benefit from objective health evaluations, and it imbues them self-confidence. The link between health care services and employment activities should be flexible between authorities.

Monitoring the health of unemployed persons in order to maintain their ability to work needs complex networking of different actors from health care, social and employment sectors and voluntary participation. It seems that currently health check is an action still quite separate from employment activities; the transition from health check is not necessary the seamless service with the employment service. This link needs more attention in the future. Voluntary program participation is also needed. This service construction is complex and needs new models in different organizations.

The findings give important information about preventive health care for the unemployed. In Finland, the law that stipulates municipalities arrange services, but certain regions still lack these. Also the process and contents of the services vary a lot. The situation has come

better during the last few years, but work is still needed. From the international point of view this study shows that preventive health care services to unemployed should be arranged. The unemployed have many health care needs in common.

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Appendix

A1. The themes of feedback questionnaire

Background information (sex, age, working situation)

Statements of the health check (Scale 1-5)

Health check gave a true picture of own health status

The practice worked well

Feedback from the health check was sufficient

Health check made me to pay attention to the health status and health habits

Health check was necessary

Follow- up care had been achieved

Health examination attention was paid to the wishes

Health check should be regular

Unemployed need health checks

The results of health check were taken into account in the employment services

Meaning of the health check (1= yes 2= no 3= I don` t know)

To my health

To my wellbeing

To my employment

To my finance

Follow-up care after the health check (different follow-up services)

Physician

Health/sick care services

Dentist

Physiotherapist

Physical exercise services

Mental health clinic

Druck Abusers services

Labour Force services

Social wealth ware services

ISS services

Employment and Economic Development Office

Something else

Any other free comments

A2. Theme interview questions to Occupational Health Counselling participants

- 1) Can you tell briefly about your life situation?
- 2) How did you come to Occupational Health Counselling project?
- 3) Can you tell in your own words what happened in the health meeting?
- 4) What good sides were there in the health meeting? What improvements would you suggest?
- 5) What kind of further treatment options were discussed?
- 6) How useful did you find the counselling?
- 7) What specific steps did you get from health appointment?
- 8) What kind of role/position did you have in health meeting? How was the understanding of your matters?
- 9) What other organizations have dealt with your health / your work ability related things?
- What kind of network operators are there around you?
- 10) How the health meeting has influenced with your health / your ability to work?
- 11) What new opportunities the health meeting highlighted to your health and work ability in the future?
- 12) What other feedback / wishes or development ideas you have about this service?