SUPPLEMENT

TALKING POINT

Four pillars of occupational health*

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Most occupational health services in this country and in the Western world are in private industry. They vary in quality and offer little cover for workers in companies with fewer than 300 or 400 employees. The main reason for their development was enlightened self interest; "enlightened" in that most employers had genuine concern for the wellbeing of their workers, and "self interest" in that they hoped to reduce absenteeism, lost time, and compensation claims, and to attract the best labour. These are valid reasons but may or may not result in the best services. Moreover, normal economic competition between companies may inhibit the level of frank collaboration necessary for epidemiological surveillance and research. As for the rest of those who work for a living—self-employed or in smaller companies—they have virtually no cover, apart from the limited advisory and enforcement services of the Health and Safety Executive (HSE). These men and women, comprising half the working population, probably experience far more than their share of accidents and occupational disease; this is not surprising, since conditions and health supervision in small work places are sometimes bad. Various approaches have been tried to cope with this problem. There are a few co-operative group schemes in the United Kingdom but they have proved difficult to finance and have had little impact. France, Finland, Norway, and Sweden all have programmes for small enterprises but progress has been slow, mainly through lack of professional staff. Not only are those at greatest risk insufficiently protected at work but they tend also to be omitted from systematic epidemiological surveillance. Responsibility for this task is seldom explicit and only the resources of HSE are available for the purpose.

Generally speaking, private occupational health services are hierarchical structures with doctors at the top. Some are excellent, but the arrangement has its disadvantages. It is expensive and tends to inhibit the development of any service if no doctor can be found, and it encourages clinical and therapeutic procedures at the expense of primary prevention. It tends to separate health from safety and is not really compatible with the multidisciplinary nature of occupational health. Usually the medical director is employed by the company, with little security of tenure, sometimes subordinate to the personnel manager. Too often he is seen by the work force as the mouth-

piece of management and not wholly trusted on controversial questions.

Industrial health legislation, which originated in the last century, copes poorly with problems of chronic and delayed effects of occupational exposure. Only recently has it sought management-worker participation in self-regulating processes to promote optimal rather than minimal standards. Local departments of environmental health take little or no interest in working conditions despite the lack of any real supervision for over half the adult working population. The National Health Service has yet to make comprehensive provision for its own employees, let alone accept responsibility for any aspect of occupational health.

Since work is done for individual or social profit all costs—including those for health services—are carried by the employer, who feels justified in asking that they do not function against his interests. The employee, unless wholly alienated, shares the same hopes but is naturally concerned for his own health. Some writers see occupational accidents and disease as arguments in their struggle to advance a political cause. Patrick Kinnersley¹ cites injury to a worker as "one example of the conflict of interest between workers and employers when it comes to health and safety. The conflict exists because safety is paid for out of profits." The adversary relationship, so prevalent in North America, is increasingly evident in Europe; this is hard for doctors and scientific workers to accept, but unless changes can be made these are the facts of life.

Formula for collaboration

A new formula is needed to distribute responsibility between employer, employee, and the Government in a fair and acceptable manner. It should contain the following elements.

An absolute requirement that all employers provide a safe work place, including systematic environmental inspection, competent first aid and minor treatment, and simple initial and periodic health screening.

Health and safety committees representative of employers and employees, responsible for agreeing written codes of practice and health and safety measures and for checking that they are carried out.

Health protection bureaus for all main sectors of industry and commerce, responsible for technical and scientific information relating to the health and safety problems of the sector and for the initiation or conduct of research (as partly envisaged by the Health and Safety at Work Act). Each should be directed by a council representative of employers and employees financed on a per caput basis with incentives for good health and accident performance.

Responsibility on the Government to establish basic standards and to co-ordinate and supplement the work of the health protection bureaus (much as HSE already does).

*Taken from a paper presented to the British Association for the Advancement of Science in Salford, September 1980.

Establishment by every regional health authority of specialist units in occupational medicine, with hygiene laboratory facilities as referral centres for clinical, epidemiological, and rehabilitation problems. As an integral part of the Health Service these units should not be financed by industry.

Implicit in these ideas is a shift in responsibility for codes of practice, environmental standards, and related questions to the health and safety committees. Occupational physicians and other technical experts, mostly employed by the sector bureau or in NHS regional units, would acquire a more independent role as professional investigators and advisers. As outlined below, most services in industry should instead be based normally on occupational health nurses or other appropriately trained persons, though the larger companies would if necessary be free to employ occupational physicians or hygienists to manage their health and safety services.

Basic services for all

Any suggestion that the industries and work places in greatest need are those already dealt with can be quickly refuted. Some of the most hazardous occupations—construction work, dock work, fisheries, small-scale chemical and metal works, and repair shops—are those least well covered, while some of the more elaborate services are to be found in large organisations with relatively few physical dangers. The objectives of occupational health services are, firstly, to protect the worker from unnecessary risks; and, secondly, to use opportunities at work to promote health in a wider sense. Achievement of the first objective depends on control of known hazards, early recognition of new or unsuspected dangers, efficient first-aid and ambulance services, and initial and periodic health screening. These are straightforward tasks falling within a fairly circumscribed range. They do not require the continuous presence at the work place of doctors, hygienists, or similar professionals. They do, however, require ready access to these experts for help and advice.

The health promotional potential of occupational health services has been underestimated. Admittedly the main causes of ill health result from many factors of which occupation is only one; primary responsibility for treatment and prevention must therefore remain with the general health services. But all diseases have considerable impact on the individual's capacity for work and much can be done at work to reduce disability, facilitate treatment, and institute preventive measures. Periodic screening tests for presymptomatic detection of diseases in which early treatment is effective can probably be accomplished more easily at work than anywhere else; information and education on health matters can also be given. Again, medical advice is needed in setting up these activities but a doctor is not essential for their operation.

Surveillance and research

Occupational health services must aim to detect hazardous agents before they cause damage or at least with minimal delay. This is a daunting task for modern industry, which introduces new processes and materials every day. Experimental screening tests have advanced rapidly but their specificity is uncertain. For some time to come, therefore, reliance must continue to be placed on epidemiological methods. These also have serious limitations: they are relatively insensitive and can detect only quite large risks—in practice not less than about a 50% excess. They can be applied only after the event and many years may be lost before a long-term hazard is brought to light, and, though effective in testing hypotheses, they have not proved useful at finding them. The insensitivity of epidemiology is largely due to difficulty in making precise comparisons between exposed and comparable but unexposed workers. To compare a specific group of employees with the general population, as is usually done, is so crude that only large differences have any meaning. More reliable comparisons are probably made across a given industry, where some workers are heavily exposed and others less so.

Unnecessary delay in identifying occupational hazards and the lack of hypotheses worthy of epidemiological investigation are related problems. Various proposals have been made, but history suggests that the first suspicions of trouble generally stem from chance findings by astute observers who recognised the unusual: even so, important observations were often made long before any action was taken. Some form of national reporting network is therefore needed to encourage rapid communication so that clinical "hunches" can be screened and tested with minimum delay.

Epidemiological surveillance and research cannot be left wholly to those in the front line, who, nevertheless, have a duty to report suspicions, comply with notification requirements, and above all maintain accurate records for later use. The centres best placed for epidemiological monitoring and research and, indeed, for toxicological work are the health protection bureaux. These would have good access to all member companies in their sector, be familiar with the processes and materials in use, and thus be able to design appropriate procedures for health screening, environmental monitoring, and illness notification.

Rational manpower policy

We must identify the most appropriate type of professional person round whom to build acceptable occupational health services at work. It would be fine if full-time occupational physicians could be found for every 2000 to 3000 workers but I do not see any possibility of this. The United Kingdom would require about 10 000 doctors, who would be overtrained for much of the work and not well suited to the rest. We could create an entirely new type of person—the occupational health officer—and in the long run this might be a good answer; meanwhile, I believe the nurse trained in occupational health is the best solution. He or she has almost all the required qualities: general and professional education, appropriate medical knowledge, acceptance by working people, and experience in technical observations and recording. There are some problems—the "doctor's handmaiden" image and insufficient training in occupational hygiene—but these are not insuperable. More formidable is the fact that we would require at least 50 000 such nurses and facilities for training at least 2000 annually to replace them.

An alternative is to provide technical training specifically for the task. Something on these lines exists in Eastern Europe, and the BSc degrees in occupational hygiene now offered by certain technical colleges in this country contain some of the required elements. What is wanted is a three-year BSc programme that gives roughly equal weight to techniques of environmental measurement, first aid and simple treatment procedures, and basic epidemiological recording methods. It would be an interesting course, particularly appropriate for mature students who had worked in industry.

Since a generalist at the work place—nurse or occupational health officer—is the key to the scheme there remains the need for true specialists, especially in occupational medicine, industrial hygiene, and to a lesser degree in other physical, social, and biological sciences. Doctors who wish to devote themselves to this discipline will increasingly operate as medical or environmental scientists and consultants and less in a purely clinical function. So occupational epidemiology, physiology, and preventive medicine must be emphasised in their training.

Conclusion

Despite the intimate relation between work and health and some notable achievements, social action in this sphere has lagged behind the more determined efforts to provide universal medical care. Four lines of action are called for.

Firstly, new understanding between employers and employees to reduce conflicts of interest in matters of health and safety. We must have effective health and safety committees for each work place, health protection bureaux for each major sector of industry, and regional occupational medicine units in the NHS.

Secondly, basic occupational health services for all employed persons, with reasonable access to laboratories and expert advice. These services should include systematic inspection of the work place for safety and hygiene, initial and periodic health screening, and efficient first-aid and ambulance facilities.

continued on page 88

GMC's Professional Conduct Committee

The GMC's Professional Conduct Committee met in the weeks beginning 24 November and 1 December.

The names of the following doctors were erased from the Register:

Dr Chanabasappa Kurvatteppa Shettar of Grays, Essex, who had been convicted after pleading guilty on 17 charges of obtaining and attempting to obtain money by deception from the Essex AHA and four charges of issuing forged documents. Dr Kallah Harjinder Singh of Ashby de la Zouch, Leicestershire, who had been convicted after pleading guilty on drug charges and sentenced to five years' imprisonment, 19 similar offences being taken into consideration. Dr Louis Aimee Newton of London, who had supplied in return for fees quantities of dexamphetamine repeatedly without adequately examining the patients or

making adequate inquiries about the effects of the treatment. Dr Newton was found guilty of serious professional misconduct.

Dr Aylmer James Crompton was suspended for a further three months. In 1975 he had been convicted of inflicting grievous bodily harm, in 1977 of making menacing telephone calls, and in 1978 of two charges of indecent assault.

Dr Andrew Patrick Brown of Watlington, Oxford, was found guilty of serious professional misconduct for issuing numerous NHS prescriptions for drugs otherwise than in the course of bona fide treatment. His registration was suspended for seven months.

The committee ruled that the names of Dr Mohamed Khondaker Anisuddin and Dr Geoffrey Bowerbank Hayle should be restored to the Register on 30 January and 18 January respectively.

Medical cover for self-employed in EEC

It was announced in the House of Commons on 4 December that the European Community Labour and Social Affairs Council had agreed to extend the cover of the Community regulation on social security, including the provisions on medical care, to the self-employed. The proposals, Mrs Lynda Chalker said, had been largely a United Kingdom initiative. The effect of the new provisions would be to avoid discrimination as regards social security against self-employed people on the grounds of nationality. An important feature of the extended regulations would be that self-employed people who fell ill or had an accident when visiting another member State would be entitled to the medical treatment which was immediately necessary from the sickness insurance scheme of that State on the same terms as its own insured population. It had also been agreed that non-employed people visiting other member States should receive medical treatment on the same basis. The new provisions are likely to come into effect some time in 1981.

BMA's superannuation division moves to London

The superannuation division of the BMA has moved from the BMA Scottish Office in Edinburgh to BMA Headquarters in London. Mr John Mackay has left the staff of the Association and has been succeeded as secretary to the Superannuation Committee by Mr David Mason. Leaflets continue to be available from BMA regional offices. Letters, however, should be addressed to BMA House in London.

"Superannuation clinics" will be arranged on a regular basis for those wishing to discuss problems. Members wishing to avail themselves of the service should contact the secretary.

Future pattern of hospital provision

The chairman of the Central Committee for Hospital Medical Services, Mr David Bolt, has written to the Chief Medical Officer on the Government's report *Hospital Services—The Future Pattern of Hospital Provision*. A questionnaire had been sent to regional committees to ask for views and at its meeting on 4 December the CCHMS was told that Mr Bolt had concluded his letter to the CMO with the following statement: "It is clear that the concept of the district general hospital is still, in the view of the profession, the correct one and that it offers the best ultimate prospect of a first-class hospital service for the people of this country. At the same time, the problems of making any rapid progress towards such an objective in the present economic climate are fully understood. However, when each new development is planned and carried out, it should be possible to see in it a step towards this ultimate objective and not a surrender to expediency which will make the ultimate objective more difficult to achieve. Meanwhile, where good work is being done and any move towards the DGH concept is clearly years away, it is wrong not to preserve buildings and equipment to a standard which will allow standards of work to be maintained in the interim, even if the money can only be found by shutting uneconomic and ineffective establishments in the face of political opposition."

Fund raising by NHS authorities

Section 5 of the Health Services Act 1980 gave health authorities the power to engage in fund-raising activities. Health Circular HC(80)11 describes the new provisions and advises authorities on the use of the new power. The power given to authorities is intended to supplement the work of existing voluntary groups, such as League of Friends, not to replace or duplicate it. Authorities will not only be able to raise funds themselves but also allow them to play a more active part in advising voluntary groups where their efforts can most usefully be directed. The circular states, "It is felt that there is considerable scope for imaginative collaboration between

the NHS and voluntary organisations at local level. More generally, authorities are in the best position to establish priorities for voluntary help which are compatible with their overall plans for providing services."

The circular sets out the activities that would be acceptable on a small scale in the areas of small lotteries, gaming, sponsorship by commercial or other organisations, and the participation of Health Service staff, patients, and relatives. The circular also details unsuitable activities. Authorities are not empowered to hold lotteries other than the small raffles that are allowed at fêtes and bazaars.

Talking Point—continued from page 84

Thirdly, a national framework of epidemiological surveillance and research to ensure the earliest possible detection of occupational hazards. The centres best placed for this type of research, and for toxicological work, are the health protection bureaux suggested for each major sector of industry.

Fourthly, a rational policy to ensure a sufficient number of appropriately trained health and safety personnel for these services. The magnitude of the task calls for a much larger number of occupational health nurses, complemented by an

entirely new type of person specially trained to take responsibility for primary health and environmental services at the work place.

Reference

- 1 Kinnersley P. *The hazards of work: how to fight them*. Redhill, Surrey: Pluto Press, 1973.

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