The main burden of organising the budget and negotiating contracts falls on the shoulders of the practice development manager. The agreed budget was less than the practice had hoped for and this did cause some initial concern, but it has now been accepted as reasonable for the first year. Handling the changes in practice organisation has caused stress among support staff, and the next step is to appoint a clinic administrator and a fundholding clerk, which will lead to greater efficiency in providing services for patients within the health centre. Many of the staff would welcome a reduction in the level of uncertainty but, according to the practice development manager, "I can't let them know when things will actually settle down."

Side by side with the administration of budget holding is the day to day work within the new contract, which has made demands on everyone in the practice.

The extent to which improvements in quality of patient care may have occurred is hard to judge at this stage but the thrust towards defining standards for outpatient and inpatient services is currently the main driving force for change. Overcoming the barriers within the hospital system and the absence of "user friendly" accounting systems are causing difficulties, but everything is new and no one has had any previous experience of negotiating costs of patient care.

It is early days in the process of budget holding with lots of uncertainty still around. The Calverton practice is still committed to what the partners view as an important experiment. The demands on all the staff are considerable, but actually "getting going" has removed some of the original anxieties about how things would work out. A key issue is going to be getting agreements about the specifications for hospital referrals.

The Health of the Nation: responses

Work related disease and injuries

J M Harrington

The consultative document on a strategy for health is described as a new concept for England.¹ It is, and as such should be warmly welcomed. The fact that it is woolly in some places and seriously deficient in others does not detract from its importance as a first step in the right direction. The purpose of the consultation phase is to highlight those deficiencies and sharpen the focus elsewhere. One of the document's deficiencies is the scant attention it gives to occupational health.

Should work related diseases and injuries be a key area?

There are nearly 30 million people of employable age in England and Wales, which, even in these times of high unemployment, means a large number of people at work. Occupational health services of one sort or another are available to about half these people. Most companies employing more than 1000 people have full or part time medical and nursing staff with occupational health qualifications. The under-resourced Health and Safety Executive, through its employment medical advisers, attempts to provide some degree of care for the rest.

This working population faces a variety of workplace hazards. The latest figures (for 1988-9) from the Health and Safety Executive indicate that 514 deaths occurred that year (including 167 in the Piper Alpha disaster), with 150 000 people receiving injuries requiring at least three days off work.² Though these figures show a slight fall year on year, they are actually a considerable underestimate of reality. For what they are worth they suggest one new case of work related disease eligible for compensation per 4500 employees. The equivalent statistics from Finland are 10 times worse while in Sweden the annual reported rate is one case per 100 employees. This reflects, without doubt, more effective recording in Scandinavia, not better British work practices.³

If the diseases and injuries are extended beyond "work caused" to "work related" what meagre evidence is available suggests that for mortality the work relatedness varies from 12% for cancer to 25% for cardiovascular diseases⁴—equivalent to 1800 premature deaths a year among men of employable age.

Diseases and injuries caused by work are all theoretically preventable. Indeed the ability to prevent

Occupational health in the strategy document

The green paper recognises that industry and commerce have responsibilities for improving health and that there is scope for investing in the health of the workforce by:

- Promoting healthy living, ensuring that catering services offer healthy food, and providing exercise facilities
- Offering employees the chance to participate in workplace health initiatives

Nevertheless, no specific role for occupational health professionals is identified either separately or in meeting targets in other key areas

rests largely with the employers and government. As the first medical inspector of factories, Sir Thomas Legge (1863-1932), said: "Unless and until the employer has done everything—and everything means a good deal—the workman can do next to nothing to protect himself, although he is naturally willing to do his share."⁵ Such a division of responsibility for health and safety at work is enshrined in the Health and Safety at Work Act 1974.

Prevention of ill health is a cornerstone of occupational health practice. The Secretary of State for Health considers that specific areas deserving special attention include maintaining good health, preventing ill health, rehabilitating people to good health, and supporting disabled people. These are the *raison d'être* for occupational health services. Such services, staffed by qualified practitioners, thus provide the only logical site for preventing work related disease or injury; they also provide a crucial location for general health education and targeted health promotion. The regular opportunities that occupational health services provide for doctors and nurses to influence workplace exposures and alter lifestyles that are hazardous to health could be argued to be unparalleled elsewhere in the health services. Indeed, given that these services are paid for by employers, the secretary of state is missing an opportunity to use a "free" health service.

The problem of responsibility for leading preventive strategies is bedevilled by the two extreme claims "It's up to individuals" and "It's all up to government." The

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The workplace offers ideal opportunities for health promotion

SALLY AND RICHARD GREENHILL

consultative document fails to provide a viable solution, partly because the paper misguidedly concentrates on the NHS and the Department of Health largely to the exclusion of the rest. Even if one did espouse such a restricted view, it should be remembered that the NHS is now the country's largest employer and has only belatedly woken up to its own health and safety responsibilities for its own enormous workforce.⁶

The case against

The health care of employed people has never been a direct responsibility of the NHS. Since 1947 what government interest has been shown has been considered the responsibility of the Department of Employment and its predecessors. This has, over the years, allowed other government departments—notably health and social security—to abrogate any concern under the guise of not confusing ministerial responsibility.

Such an approach is no longer tenable. Lip service is paid in the consultative document to the need for interdepartmental cooperation and shared responsibilities. However, the issues—and the toll in human suffering from work related disorders—are too important to be left to one department and too central to the strategy for health to be left uncoordinated by central government. The "strong leadership and adequate coordination" advocated for accident prevention in general⁷ applies equally to work related injuries and disease. The case against designating work related diseases and injuries as a key area is not merit. It is negligence in interdepartmental cooperation, poverty of resources, and ignorance by the Department of Health that such vital preventive measures can be tackled now by using free health care resources which already exist in many companies but are historically outwith the NHS. Occupational health practitioners and their services must feel some ownership of the Waldegrave goals or these goals are further off and less attainable than they would be otherwise.

The key areas

The key areas listed in the document are, with few exceptions, key areas for occupational health practice.

Coronary artery disease, though mainly a lifestyle disease, also has work related factors ranging from chemical exposures which cause or exacerbate the disease to stress related influences from the occupations. Olsen and Kristensen recently postulated that 16% of premature deaths from cardiovascular disease in Denmark could be avoided by workplace intervention.⁸ On top of that, the occupational health services can, and do, actively participate in preventive initiatives such as Look After Your Heart. Indeed the workplace has been shown to provide an ideal setting for such health promotion.

Workplace exposures cause 3-6% of all cancers and contribute to the development of cancer in a similar percentage.⁹ This may be a fairly small fraction compared with smoking or diet, for example, but all the workplace agents can be controlled or eliminated much more readily than can lifestyle factors. For some tumours, such as lung and bladder, it is estimated that the workplace factors may cause up to 40% of these tumours in manual workers aged 20 years or over in mining, agriculture, and broadly defined industry.¹⁰ Thus to concentrate on breast and cervical cancer, which the public perceives as important,¹¹ ducks the central issues of how to cope with the other, perhaps commoner, tumours; how to tackle cigarette smoking; and how to aid the control of workplace related cancers.

Accidents at work cause injury and the rates are not improving appreciably.¹² The question of accident prevention in general has been dealt with elsewhere in this series.⁷ The arguments and issues raised there apply equally well to workplace injuries.

Asthma is of growing concern to public health specialists as it seems to be increasing in both children and adults. Workplace aetiological factors are becoming increasingly recognised and, of late, more reliable statistics are becoming available through the new surveillance scheme.¹³ Even so, the Faculty of Occupational Medicine of the Royal College of Physicians of London believes that the estimated 500 cases a year may be an underestimate. Its working party, which is contributing to the Faculty of Public Health Medicine's second report on United Kingdom levels of health (due to be published in mid-1992), suggests a figure nearer 1500 cases would be closer to the truth.

Space does not allow an opportunity to discuss other important disease groupings, such as the 60 000 cases of industrial dermatitis each year. But, for the rest of the key areas such as lifestyle influences, maternal and child health, and rehabilitation occupational health professionals have a part to play in that they care for employed people who will include the pregnant and the disabled. So far as environmental quality is concerned, some of the problem here lies with the industries that pollute. Their occupational health advisers have for some considerable time been an integral part of the environmental control strategies operated by the larger and more enlightened industries. For many of these doctors, environmental health is now of central and increasing importance in their daily work.

Strategies for reaching targets

Others will comment in greater detail, and with greater expertise, on the validity of the government's targets. Some could be stronger. For example, one proposed target from the Faculty of Occupational Medicine working party is for total smoking bans in all enclosed workplaces by the year 2000. For other key areas it should be clear that a vital strategy in setting targets and reaching them is the active participation of workplace based health services and the recognition of the value of such services and their practitioners in the overall scheme of things.

If government departments are going to work

together in a coordinated way to achieve the green paper's objectives then occupational health has an important role. European legislation is likely to press for increased emphasis on occupational health. Active government support of occupational health services in Britain (as proposed by the House of Lords Select Committee on Science and Technology 1983) could ensure these services are developed so that they can make a significant contribution to health promotion. Such action could also influence the European approach to occupational health screening services, which may otherwise focus on procedures of doubtful benefit. It is therefore timely (if somewhat belated) to introduce into the government's strategy on health a scheme for improving occupational health services for all employees. This need not be expensive as the costs are borne by employers. Government initiatives on occupational health are long overdue and this is its opportunity to act.

Problems in achieving targets

The consultative document has been criticised for identifying key areas and setting targets only where data exist on the size of the problem. For occupational health a major difficulty is the paucity of good quality databases on the size of the work related health problem. The Health and Safety Executive has started to tackle the issue but the Reporting of Injuries, Diseases, and Dangerous Occurrence Regulations has been unevenly successful.¹⁴ For diseases the regulations are a failure. The specific new initiatives for respiratory disease surveillance¹³ and now others for urothelial tumours and haematological disorders should gather more accurate information, but as yet we have not shown the same enthusiasm or initiative as the United States Public Health Service in attempting to tackle the serious deficiencies in occupational health and safety surveillance,¹⁵ and in identifying occupational "sentinel health" events.¹⁶ Without this information we do not know the size of the problem, but it seems largely based on known underestimates. Its contribution to the ill health of the nation is considerable on present statistics. Perhaps if and when we have a better estimate, the resources might be made available to tackle a sizable portion of the problem at the

heart of the consultative document: the need to improve the health of the nation.

Conclusions

Improving the health of the nation includes the health of employed people—indeed it could be argued that as they are the money earners, their health has particular importance. The consultative document pays little attention to occupational health practice. Yet it is at the workplace, with thousands of qualified professionals serving millions of employees, that special attention could be paid to health promotion in general as well as attacking the unacceptable level of work related disease and injury which weakens the economic and physical health of the country. The overall goals in the Department of Health's proposals are ideally suited to action from these occupational health practitioners. Their skills and their opportunity for intervention makes them essential, perhaps unique, players in the game plan. The fact that the document largely ignores them and the opportunity they provide to influence the nation's health is a serious omission requiring rectification.

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Exercise

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Exercise can take many forms and, at least until now, has been most commonly associated with the prevention of coronary heart disease. But with the accumulating evidence for preventive and therapeutic benefit in many other conditions, exercise is emerging as a key element in most national health promotion recommendations and strategies.¹⁻⁵ This is hardly surprising as the ability to exercise is intrinsic to most aspects of human life and simple physical training can enable even the most unfit people and those limited by chronic illness to carry out the basic activities of modern sedentary life more efficiently and comfortably.⁶

Exercise as a key area

The importance of coronary artery disease in Western society is not sufficient to justify including exercise as a key area. It must also be possible to conclude that exercise can favourably influence the occurrence or natural course of coronary heart disease⁷ and other conditions.

CORONARY HEART DISEASE

That exercise might be protective in coronary heart disease is biologically plausible even if the scientific evidence is not universally accepted.^{8,9} Exercise could exert benefits by its effects on the main coronary risk factors.^{10,11} Thus aerobic exercise reduces blood pressure,¹² increases high density lipoprotein concentration,¹³ facilitates stopping smoking,¹⁴ and reduces obesity.¹⁵ Recent evidence, however, suggests that it may act on the acute phase of coronary heart disease, possibly on the coagulation mechanism or even arrhythmia.^{16,17}

Many epidemiological studies have investigated the relation between work and leisure time exercise and coronary heart disease¹⁸⁻²¹; the evidence strongly favours the view that regular aerobic exercise of moderate intensity has a protective effect, and the benefit probably increases with the intensity of exercise. Morris, one of the earliest proponents of the protective

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