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## National Health: time for Occupational Health

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What is the relationship between occupational health and public health? The answer to this question depends, to some extent, on which country is referred to at the time and the way in which training, certification and practice is organised. In the USA, for example, there is a close relationship between occupational medicine and public health with respect to board certification of physicians. In Europe, there tends to be a clearer distinction between the training and practice of occupational medicine, compared to that of public health medicine. In the United Kingdom, the training and accreditation of occupational physicians is overseen by the Faculty of Occupational Medicine, which is part of the Royal College of Physicians of London. There is a separate Faculty of Public Health Medicine. However, the training of occupational health nurses has been focussed on community nursing, which has its roots in primary health care. The culmination of specialist occupational health training is a BSc community (occupational health) and the curriculum is designed such that specific occupational health knowledge and skills are acquired in a module that supplements generic community nursing themes. The role of the occupational health nurse varies from country to country, but in the UK such nurses may be the mainstay of occupational health services.

Historically occupational medicine has been practised by physicians who have been interested in the role of the workplace as a cause of morbidity and mortality of their patients. We are all familiar with the work of Bernardino Ramazzini, the father of occupational medicine, and of his treatise *De Morbis Artificum Diatriba*. The names of Agricola, Paracelsus and, in the UK, Thackrah are also so renowned that they require no introduction. Whilst physicians, such as Thackrah, made "suggestions for the removal of many of the agents which produce disease and shorten the duration of life"<sup>1</sup> societal changes required the assistance of others. Hunter (1) has suggested that Thackrah's interest in industrial diseases resulted from a personal relationship with Robert Owen, a cotton manufacturer who built model mills in Manchester and in New Lanark, Scotland. It is likely that such social reformers

were able to utilise occupational medical texts to strengthen the argument for the introduction of health and safety legislation.

The latter half of the nineteenth century saw the rise of the Public Health movement in the UK. The unsanitary conditions that resulted from rapid urbanisation stimulated by the industrial revolution were highlighted in a report by Edwin Chadwick<sup>2</sup>. Extracts of the report are quoted by Hunter (1) and the inextricable links between working life and home life are clear. Frequent outbreaks of cholera and typhus occurred and epidemic typhus in Manchester factories brought to the fore public champions such as Sir Robert Peel, later known as the *Father of Industrial Legislation* and Thomas Percival, a medical practitioner who was convinced that the transmission of infection was facilitated by the overcrowded conditions in factories. The Manchester Board of Health, that resulted from a report by Percival and others, was an early example of a factory inspectorate.

Despite the common interests of occupational medicine and public health medicine, the development of these specialties in the UK occurred in parallel, rather than in a convergent fashion. Industrial health was seen as the responsibility of the Board of Trade or, later, the Ministry of Labour. Public Health, on the other hand, was the responsibility of the Ministry of Health. Much of the work of the work of physicians in industry was as *Certifying Factory Surgeons, Examining Surgeons or Appointed Surgeons*. Duties included the examination of young workers, periodic examinations of workers exposed to dangerous materials and certification of prescribed diseases for the purposes of compensation. Such duties were of a statutory nature. Nonstatutory medical services were uncommon, apart from in a limited number of large companies. The twentieth century saw the emergence of the industrial nurse. The name of Philippa Flowerday is well known amongst UK occupational health nurses as the first industrial nurse, working for Colmans of Norwich in 1878. An industrial nursing certificate was established, partly by the Royal College of Nursing, in 1932. Such nurses were able to work in the absence of a medical officer, undertaking pre-

<sup>1</sup> The Effects of the Principal Arts, Trades and Professions, and of Civic States and Habits of living, on Health and Longevity, with Suggestions for the Removal of many of the Agents which produce Disease and shorten the Duration of Life. (1831).

<sup>2</sup> Report on the Sanitary Conditions of the Labouring Population of Great Britain. (1842).

employment assessments, health surveillance, accident investigation and welfare activities.

The formation of the National Health Service (NHS) in 1948 was a significant milestone in the development of UK occupational health mainly because occupational medicine and occupational health nursing were excluded from it. For doctors, this meant that there was little or no training in occupational medicine at an undergraduate level and post-graduate training was restricted to those doctors who were employed by large companies, or who worked as *Appointed Factory Doctors* or *Medical Inspectors of Factories*. However, reorganisation of the NHS, in 1991, saw the introduction of NHS Trusts and General Practitioner fundholders, as part of a new initiative to create an internal market for healthcare. The more entrepreneurial Trusts and GPs saw an opportunity to diversify into occupational health provision. In particular there was an opportunity to provide services to small companies that did not have their own in-house occupational health service. In the UK provision of occupational health to workers is not a statutory obligation, although the need to comply with health and safety legislation remains. Thus, it was market forces that initiated a new involvement of the NHS in occupational health provision, something that would develop into a radical new government policy a decade later.

The "privatisation" of the delivery of healthcare coincided with the enactment of new health and safety legislation, in response to European directives. Potentially this enhanced the demand for occupational health services because of the need to comply with regulations concerned with manual handling (2), display screen equipment (3), as well as general duties (4). *The Management of Health and Safety at Work Regulations* (1992-1999) are the UK Government's implementation of the Directive 391 (5). The duties laid down in the "Framework Directive" are similar to those contained in the UK Government's *Health and Safety at Work Act 1974*. This Act is an example of primary legislation that lays down general responsibilities on both employers and employees. It also enables more specific legislation to be enacted, in the form of Regulations. The *Management of Health and Safety at Work Regulations* (1992-1999) contain, in addition, other Directives, such as the Pregnant Workers Directive (6). Another important set of regulations in the UK is the Control of Substances Hazardous to Health Regulations (1992-1999) (7) that incorporate the Carcinogens Directive (8) and the Biological Agents Directive (9).

Existing legislation requires the performance of workplace risk assessments and the maintenance of written records. There is a requirement for the identification and implementation of safe systems of work and for suitable and sufficient health surveillance and the training of workers. However, the definition of the competencies required of the people carrying out the risk assessments is vague. Coupled with infrequent inspections of workplaces because of a depleted Factory Inspectorate, this means that the quality of risk assessments and the occupational health advice may be variable. Specialist occupational physicians are relatively few in number: approximately 800 for a working population of greater than 20 million workers.

Most of them work in large private sector companies that provide occupational health services for their own employees only. 8% of private companies employ health professionals and 1% of such companies have greater than 200 workers (10). This means that less than 1% of private companies are likely to employ full-time specialist occupational physicians. Only a quarter to a third of NHS occupational health services have access to a specialist occupational physician (11), but this will still improve the access to occupational health for small companies. In addition, some NHS occupational health services without a specialist occupational physician will have a specialist occupational health nurse.

In 1997 a new Government was elected which resulted in further changes in the NHS. A consequence was the further elevation of the importance of occupational health, both for the workers in the NHS and for the community at large. The framework for the changes was contained in a "White Paper" (12), the prelude to new legislation. Key features were the abolition of the internal market, a primary health care-led health service, the establishment of Health Action Zones and new health targets for the UK. Of particular note was the inclusion of workplaces as a key area in which to achieve these targets. Health Action Zones are a manifestation of a desire to create partnerships in the delivery of health improvements to local communities. In addition, they represent new models for working across traditional professional and geographical boundaries. An example is the *Health@Work* initiative in the Tyne and Wear Health Action Zone. This has included initiatives focussing on the management of sickness absence, the prevention of low back pain and risk assessment in the workplace. Occupational health doctors and nurses have worked alongside health promotion professionals, physiotherapists, ergonomists, personnel officers and managers to produce information and training packages for small businesses. More recently, the NHS Plan was launched (13) which contained an announcement of NHSplus. This will extend the provision of occupational health services to the UK working population from within the NHS, whilst ensuring an occupational health service to NHS workers. The plan acknowledges that ill health has a big effect on the economy, in terms of lost productivity, unemployment and poverty. This new service will be launched in the autumn of 2001.

There can be no doubt that within the UK occupational health has ascended the political priority list and is now considered to be an important component of the nation's public health strategy. Occupational health has crossed the ministerial divide such that, in addition to being part of the Department of Health plans, it is also a key aspect of a new ten year health and safety strategy launched by the Department of the Environment, Transport and the Regions (14) and of a report and recommendations on improving access to occupational health support by the Health and Safety Commission (15). The latter report draws together much of the recent developments in occupational health and produces overarching conclusions.

Implementation of the national occupational health strategy will be coordinated by a partnership board, in ac-

cordance with the document *Securing Health Together* (16). Key targets are a 20% reduction in the incidence of work-related ill health, a 20% reduction in ill health caused to the public by work activity and a 30% reduction in the number of days lost due to work-related ill health. The new strategy is consistent with the WHO initiative *Good Practice in Health, Environment and Safety Management in Enterprises* (GP HESME). This defines comprehensive occupational health as the long-term maintenance of health and working capacity of employees, taking into account occupational, environmental, social and lifestyle determinants of health. There is now a strong case, both nationally and internationally, for placing good occupational health practice at the centre of a public health strategy.

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