

CURRENT TRENDS, EXAMPLES OF REGULATIONS AND PRACTICAL APPROACHES TO OCCUPATIONAL HEALTH SERVICES IN THE UNITED KINGDOM

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Abstract. Occupational health services in the United Kingdom are evolving from the traditional approach using doctor and nurses to provide clinical care at the worksite for any medical ailment, to multidisciplinary occupational health practitioners focussing on the prevention of ill-health from workplace factors. Nevertheless, there continues to be an artificial divide between safety departments and occupational health departments within the same organisation. Many occupational health services focus on the need to comply with the requirements of health and safety legislation. In the UK, these include the Health and Safety at Work, etc. Act of 1974, the Control of Substances Hazardous to Health, the 1994 regulations, and a newer legislation based on the European Union Directives. A practical approach to providing occupational health cover has been the development of occupational health departments within the public healthcare sector, private occupational health service providers, and independent consultants. These are some similarities between the UK situation and other countries in the models used for providing occupational health care. The appropriate model for any country would depend on their perceived needs, resources, industries and hazards.

Key words:

Perceived needs, Delphi studies, Health and safety, Ethics, Risk-based control strategy

INTRODUCTION

The provision of occupational health services in any country is in part driven by legislation, social needs, and perceived importance of such services by employers, workers, healthcare providers and politicians. What is included in the structure and functions of these services will depend on the occupational exposures, nature of occupational ill-health, as well as availability and competence of occupational health professionals in a particular country.

CURRENT TRENDS

In the United Kingdom, trends in employment show a shift away from manufacturing industry to service industries. There are changes in the way in which work is organised. Increasingly part-time work, flexible working hours,

and working at home become available. There is also less job stability and security, and constant updating of skills and expertise is required to cope with changes in the work environment and job demands.

The changes in the workplace have resulted in changes in the spectrum of occupational diseases. In developing countries, such as Malaysia, the priorities for research and services for occupational ill-health have focused on workplace injuries and chemical poisonings, noise-induced deafness, and occupational lung and skin diseases [1]. Delphi studies in the UK have identified different priorities for occupational diseases [2,3]. These are musculoskeletal problems, stress, asthma, suicide and depression, and effects of vibration and noise.

In the UK, occupational health professionals represent different disciplines. Many occupational health depart-

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ments are staffed by occupational health nurses and physicians. Occupational safety departments are often separate, and staffed by safety practitioners. Very few services have occupational hygienists, toxicologists or epidemiologists. The duration of training and syllabuses for different professional groups vary. There is a trend towards multi-disciplinary training, with provisions for continuing professional development, and a requirement for re-certification or revalidation.

LEGISLATION

In the United Kingdom occupational health laws are general in some areas, and prescriptive in others. The Health and Safety at Work, etc. Act, 1974 was a real milestone in the British occupational health and safety legislation. The Act spells out general duties for employers, employees, and the public. Employers are required to do all that is reasonably practicable to ensure health and safety of their employees and other parties. Employees are required to co-operate with employers to ensure that provisions for workplace health and safety are implemented. The Control of Substances Hazardous to Health, (COSHH) regulations of 1994 were another significant step towards ensuring safety at work. This commits employers to assess the health risks of hazardous workplace substances, and to take appropriate measures to reduce them. In addition, Codes of Practice are approved, and guidance notes produced by the relevant government agency (the Health and Safety Executive in the UK) to assist in the interpretation of and compliance with the health and safety law.

Unlike in France and the Netherlands, there is no specific legal requirement in the UK to provide occupational health service for any industry, regardless of its size. Yet, the UK and its partners in the European Union (EU) have to take steps to ensure compliance with EU legislation on health and safety. This has resulted in a number of EU Directives being translated into UK regulations. As an example may serve the '6-pack' regulations dealing with manual handling, display screen equipment, personal protective equipment, management of health and safety at work, and workplace health, safety and welfare. Other

EU countries will have their own mechanisms for dealing with EU directives.

There is an obvious advantage in harmonising many of the laws on health and safety (and indeed all other laws) throughout the EU. This will lead to consistency in legal requirements throughout Europe, with its inherent advantages in terms of cross-border trade and employment. In this regard there are several initiatives on harmonisation, for example the European Commission Directive under the Chemical Agents Directive to establish an initial list of indicative occupational exposure limit values at the European Community level [4].

PRACTICAL APPROACHES

The Health and Safety Executive (HSE) as the UK government agency for health and safety, initiated a consultative exercise in 1999 to "take forward a strategic appraisal of health and safety ... to re-launch the health and safety agenda ...and to reduce workplace accidents and ill-health still further". As a result of the consultation exercise a strategy statement was released in June 2000. This spelt out 44 action points and set new targets for health and safety which include:

- a) a reduction of 10% in major injury by 2010;
- b) a reduction of 20% in work-related ill-health by 2010;
- c) a decrease of 30% in working days lost due to health and safety failure by the year 2010; and
- d) achieving half of the above improvements by 2004.

It would be of interest to see whether and how these targets are achieved.

A practical approach to providing occupational health services is to identify clients' needs and to set up systems to address these needs. However, it has been shown that when employers, workers and occupational health providers are asked to rank a range of services that they perceive to be important, there is divergence in views between these three groups [5]. There is also great variability in access to occupational health services. As these services are not compulsory in the UK, less than 5% of industries have an occupational health service. These tend to be larger industries with appropriate resources, rather

than numerous small industries (employing less than 100 workers) where there is likely to be a greater need for such services.

Occupational health services in industry have seen a decline in numbers and availability. There is a trend towards contracting out such services to independent occupational health providers. The number of independent groups or single-handed service providers has increased. A considerable expansion of occupational health services within the health service has also been observed. There is an increasing number of specialised occupational physicians and occupational health nurses employed in hospital departments of occupational health. It may be assumed that this is due to an increased concern about the health and safety of health care workers as they form the largest occupational group in the UK. However, it is possible that this increase reflects the possibility that such services may be a good financial venture in that services can be sold to factories and workplaces in the surrounding area. There are divergent opinions about selling occupational health services. Most practitioners agree that where such activities lead to more resources that can be used for improving health and safety of their own workers, then the issue should be considered.

Practical dilemmas and ethical issues are often encountered in the provision of occupational health services to external clients. Where there is a conflict between clients' needs and professional goals, a practical approach may involve several pathways. These include access to guidelines on ethics, obtaining advice from ethical committees of professional organisations [6], discussion with colleagues, and consideration of a business decision versus professional views. The knowledge and attitudes to ethical issues vary between different groups of occupational health practitioners, and also between similar practitioners with different social and cultural backgrounds [7,8].

Much is made of the need for self-regulation for occupational health and safety. This is opposed to central control where legislation is enacted to ensure the provision of services, or monitoring and surveillance procedures, or control measures. Self-regulation for control of workplace hazards will work if there is a genuine interest in reduc-

tion of risks at the workplace. This may happen because it is an approach expected from a benevolent employer, or if a pragmatic employer recognises the consequences of injury or ill-health from uncontrolled hazards and decides in favour of risk reduction rather than saving on costs for health and safety measures, and thereby taking a chance on the consequences.

Where laws and codes of practice are promulgated for control of workplace exposure, there are different approaches that can be taken. A risk-based control strategy has some advantages over a hazard-based approach. The hazard-based approach involves the identification of a workplace agent; the analysis of its toxicology and health effects; and the decision regarding the level of control for that agent, regardless of where or how it is used. The risk-based approach identifies a workplace agent and its toxicology and health effects, but reviews the circumstances of workplace exposure and decides on control based on a risk assessment and the likelihood of exposure [9]. It allows for safe use of a toxic substance in defined circumstances. This strategy is used in the UK COSHH regulations in the section on medical surveillance, where surveillance is required for specified substances if they are encountered in specified processes, rather than for all processes in which the agent is used.

CONCLUSIONS

The UK experience in regard to current trends, legal framework and practical approaches to occupational health services may be used as an indication of what might or might not be relevant to other countries. Current trends in occupational health may be similar for many developed countries, whilst developing countries may be going through phases experienced at an earlier stage by developed countries. Laws and regulations should take into account local requirements, but in order to have uniformity in regional entities such as the European Union, there must be mechanisms for harmonisation of legislation. There are already attempts made in this area within the EU. Amongst the many models for provision of occupational health services, the choice for any country would

depend on the perceived needs, available resources, and range of industries and workplace hazards.

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