

# SUMMARY REPORT ON THE WORKSHOP “OCCUPATIONAL HEALTH FROM THE PERSPECTIVE OF FUTURE ACCESSION OF POLAND TO THE EUROPEAN UNION” Łódź, Poland, 30 June – 1 July, 2000

ANDRÉ N.H. WEEL

Netherlands School of Occupational Health  
Amsterdam, the Netherlands

## INTRODUCTION

The workshop was aimed at identifying the different approaches to occupational health services delivery in different European countries. The current diversity between European Union member states clearly illustrates that common EU directives may guide many aspects of occupational health care, but do not automatically realize a uniform system. Economical, cultural and historical differences between the countries are of great influence and can be held responsible for the observed diversity. The question has to be formulated on whether a uniform system and identical structures for all member states are a necessary condition for good quality of occupational health care throughout the EU. The answer is important for the countries that will access to the EU in the next five years. Poland is expected to be one of them.

The workshop was organized by the Nofer Institute of Occupational Medicine (Łódź, Poland) and sponsored by the University of Iowa (USA) and the European Institute in Łódź.

## OBJECTIVES

The following objectives for this workshop have been formulated:

1. Identification of the scope of similarities and diversities of the Polish occupational health services (OHS) delivery system compared with other systems.
2. Evaluation of the Polish organizational and structural solutions as compared to other models.
3. Discussion on the effective training of OHS professionals in terms of the future services they will be delivering to a working population.
4. Formulation of a summary report including remarks on the perspectives of the OHS system in Poland with regard to its future accession to the EU.

The summary report should give some indications for a national Polish policy regarding the OHS system, taking into account not only EU directives but also the experience and results gathered so far in EU member states.

## STRUCTURE

This summary report starts with an account of a two-day workshop. From each contribution those remarks, observations and discussion points are mentioned that give some insights according to the four objectives formulated above. At the end, a series of final conclusions and recommendations is presented.

### THE FIRST DAY: 30 JUNE 2000

On the first day the program consisted of a number of presentations with some time devoted to discussion.

In her opening address, **Maria Karasińska-Fendler**, Director of the European Institute in Łódź, told the story of the mammoth's disappearance. It is a story about continuously changing conditions, so that one is never able to comply. There is a strong similarity with the course of affairs in the accession of countries up to now. Finland was able to keep an isle outside the EU, the UK was allowed to pay a lower fee, and Luxemburg to maintain a situation of discrimination. So the conditions for the membership are not clear and they are not being applied in a consequent way. These circumstances do not contribute to a well-directed pre-accession policy for candidate member states.

**Jacques A. van der Vliet**, President, European Network of Societies of Occupational Physicians, the Netherlands, described the way in which the EU Framework Directive of 1989 was implemented in the Dutch legislation and OHS practice. All employees got access to OHS delivery, and four elements in the delivery system became legally binding: the risk inventory, the risk-based periodic health examination, the sickness absence management, and the consulting hour by the occupational physician. These legal requirements are not a guarantee for good quality of services. The concept of organizational health stresses the importance of the management responsibility and involvement. Its goal is to support the development of a healthy workforce in safe and sound working conditions. Co-maker-ship of organization and occupational health services is

an important element. The occupational physician plays an important role in organizational health, but cannot do the job alone: a multidisciplinary team is needed to cover all aspects of healthy and safe working conditions. New legislation can promote the origin of new concepts like organizational health, and these new concepts can reinforce the effects of the new legislation.

**Tar-Ching Aw**, Institute of Occupational Health, University of Birmingham, UK, described the new targets the British Government has set for the year 2010. These are: major reductions in injury accidents by 10%, work-related ill-health by 20%, and working days lost due to health and safety failure by 30%. The results of some Delphi studies show current trends in work and health. Large differences between the UK and Malaysia are observed. For the UK the top-five problems are: 1) musculo-skeletal problems; 2) stress; 3) asthma; 4) suicide and depression; and 5) vibration and noise. For the practical approaches, he stressed some important principles: to create multidisciplinary services; to look at client needs; and to promote self-regulation.

**Jerzy A. Kopias**, Nofer Institute of Occupational Medicine, Poland, elucidated the multidisciplinary model of OHS, based on ILO Convention No. 161/1985 and the 1996 WHO Global Strategy. In most EU member states the use of multidisciplinary services is compulsory. Does this model really operate in Europe? At present this question cannot be answered. The EU would have abandoned its ambition to harmonize OHS in Europe. He quoted Professor Gevers: "The generalization of occupational health care, its gradual extension to all enterprises and its multidisciplinary character, make it more and more difficult to define and impose a single common model, apart from the different conditions prevailing in each of the member states".

In the **discussion** it was stressed that there is no scientific evidence to prove the effectiveness or the "additional value" of the multidisciplinary model. All of us support it but why? We do not know if it works, or how it works. What is the basis for our belief?

In the USA four disciplines have been trained by NIOSH since the early 1970s. This was especially needed for the OHS serving small industries; the larger industries have their own multidisciplinary teams.

In the Netherlands, four disciplines have been assigned by law to be represented within OHS. These are: occupational physicians, safety engineers, occupational hygienists and organizational experts.

**James A. Merchant**, Dean, College of Public Health, University of Iowa, USA, presented “Worksafe Iowa”, a unique Network linking community-based occupational medicine clinics across the state of Iowa to provide comprehensive health and safety services to employers in their communities. The Network offers good training sites for physicians, nurses industrial hygienists and physical therapists. The services offered are integrated, comprehensive and statewide. The clinics pay an annual membership fee of \$6,500 for which they get a lot of advantages from cooperation, referral, exchange of information etc.

**Marcin Ajewski**, Head of Consulting Team, “Medicover” Development, Poland, presented “Medicover” as an example of a Health Maintenance Organization in occupational health. “Medicover” is a private company providing health care in Eastern Europe. There are no legal obstacles for such initiatives in Poland. At present, there are 20 “Medicover” centers in Poland. Primary care, specialist care and occupational medicine are among the services offered. In most cases the customer who pays is the employer. So occupational medicine is an important part of the services. There is a hard struggle against sickness absence. If doctors certifying sickness absence for an affiliated company are not willing to cooperate with “Medicover”, they lose their license.

Still in the concept stage is GP HESME, an abbreviation for Good Practice in Health, Environment and Safety Management in Enterprises, presented by **Jacek Michalak**, Nofer Institute of Occupational Medicine, Poland. It is a process model based on the conclusions drawn during the meeting of EU Ministers of Health and

Ministers of Environment in London in 1999. WHO played an important role in the elaboration of this concept. The core of the model is the involvement of all stakeholders: employers, employees, government, professionals, etc. Fulfilling legal obligations is necessary, but not enough for good results. Benefits of application are to be expected in the fields of health (occupational and public), environment, well-being, economy and politics. The enterprise can improve its image from the viewpoint of employees by applying GP HESME.

**Lech T. Dawydzik**, First Deputy Director, Nofer Institute of Occupational Medicine, Poland, presented an overview of the legal regulations on occupational health care in Poland. He described the transition from the post-war “industrial health care system” to a modern market-based quality-controlled occupational medicine system, with its basis in the new Act of 27th June 1997.

After a lunch break, **Jan Nosko** and **Marek Mikulski**, School of Public Health, Nofer Institute of Occupational Medicine, Poland, presented the new training program for occupational physicians in Poland and discussed the role of Schools of Public Health in the training process. In Poland, new regulations concerning the specialization training system for physicians have been introduced in 1996 to harmonize the Polish system of specialization training with the EU system. Occupational medicine has been assigned as one of the main medical specialities with a five-year duration of training. At the beginning of the year 2000 a new training program in occupational medicine was accepted by the Ministry of Health. Specialists in occupational medicine should be competent to perform a number of tasks. These include not only classic responsibilities, like early diagnosis and treatment of occupational diseases, but also more modern tasks, e.g. development and implementation of health promotion programs at workplaces and advising the employers in decision-making processes relating to the workplace health and safety issues. The curriculum consists of theoretical courses, and practical instruction. The latter is implemented in obligatory rotations in inpatient and outpatient departments. Finally, there is a supervised practice

in occupational health services with a minimum duration of 24 months. Tests or oral examinations are taken at the end of each theoretical course and rotation. After some of the rotations there is a practical skills examination.

**André N.H. Weel**, Netherlands School of Occupational Health, the Netherlands, gave a description of the new Dutch curriculum for occupational medicine started in 1998. He referred to some EU regulations about the mutual recognition of the national qualifications. Learning contents and objectives have not been defined by these regulations. So official rules permit space for own insights. The principles for shaping the curriculum are as follows: needs of occupational health services; professional standards; and state-of-the-art. The new curriculum is characterized by the interaction between theory and practice; self-management; co-makship with occupational health services; and multidisciplinary. The curriculum consists of a course/theory and a practical part. Most of the theoretical part is presented to a so called core group of 12 students, which is to be maintained during the full course period of 4 years. The adage for the practical part organized in the certified OHS is: “the best teaching OHS are learning OHS”. Learning is a lifelong task. Re-certification of occupational physicians – with a validity of five years – was introduced in 1999.

**Andrzej Boczkowski**, Nofer Institute of Occupational Medicine, Poland, referred to the common core competencies for occupational physicians as defined in Glasgow in 1997 by three professional societies: European Association of Schools of Occupational Medicine (EASOM), Union of European Medical Specialities (UEMS) and European Network of Societies of Occupational Physicians (ENSOP). He reported a questionnaire survey into the requirements for occupational medicine training in Europe as seen by Polish professionals. There was a higher approval of the set of requirements/competences in experienced professionals. Because of the future accession of Poland to the EU, a re-evaluation of the importance of the different competences within the Polish training programs should be considered.

**Ewan Macdonald**, Department of Public Health, University of Glasgow, UK, introduced the training of occupational physicians in the UK. There are five distinct levels of training programs. The Assistant of the Faculty of Occupational Medicine (AFOM) syllabus is a guide for the AFOM examination. This examination is part of the specialist training. The highest level is a Member of the Faculty of Occupational Medicine (MFOM): one can be admitted as MFOM after four years of supervised full-time work in a post approved by the Faculty and published work relevant to occupational medicine. For the future, the following requirements are foreseen:

- a competent doctor who performs acceptably,
- cradle to grave learning,
- able in quality management of OHS,
- periodic re-certification,
- increasing harmonization of training internationally.

#### THE SECOND DAY: 1 JULY 2000

The second day was devoted to group discussions. There were two topics on the agenda:

- a. Trends in occupational health and safety services development in the countries of the EU.
- b. Training of occupational physicians as leaders in OHS multidisciplinary teams.

Because of a rather small number of participants, both topics were discussed by the whole group of attendants in one session. The discussion was chaired by Jacques A. van der Vliet.

**Jacques A. van der Vliet**, member of the Dutch delegation to the Permanent Committee of UEMS (that has a direct access to the European Commission), referred to a Position Paper on Occupational Health prepared by a working group of this Committee, and a positive reply from the European Commission to this paper. The paper and the reply circulated among the attendants.

At first, the issue of **multidisciplinary teams** was discussed. In this discussion, some aspects of the other topic were also introduced. Later, the discussion moved

towards the competences needed, and the following issues were raised:

**Why** do we work in multidisciplinary teams, **what** are we doing there, and **how** do we do it?

**Why** working multidisciplinary: it is not common in many countries; regulations and traditions play a role!

Other reasons for multidisciplinary working have been summed up by the group:

- in risk assessment, you need experts of exposure;
- exposure and health are two different areas of expertise;
- in the effect management, not only health effects, but also psychological effects are important;
- skills and expertise to manage problems in occupational health care are so broad that it is not easy to combine all of them in one expert;
- there is a need for more flexible services depending on the needs of clients/different companies; two types of employers can be distinguished: the survivors, interested in lowering sickness absence, and the developers, interested in risk management.

**What** can be carried out by multidisciplinary teams?

Other activities have been summed up:

- Risk assessment; for this activity (and other ones) you may need a safety engineer, an occupational hygienist, an organizational expert and an occupational health nurse. What are the “core disciplines” you always need? To answer this question you should look at “availability” and “national needs”. In Poland, the risk assessment is done by the safety engineer.
- Risk effect management.
- Risk reduction.
- Risk communication.
- Employee health improvement.

You can also sum up the four general objectives of occupational health care, put in the following order of importance:

1. Health promotion.
2. Reduction of occupational injury and disease.
3. Minimizing effects of exposure.
4. Facilitating return to work.

Who clarifies these concepts for companies and employees?

What should be the case in Poland?

Who is the client in a particular situation?

**How** to work in a multidisciplinary team? For Poland: how to combine all activities in one body? What model of working you are going to use?

In Poland, the occupational physician is a decision maker, not an adviser. But to some extent, multidisciplinary work is possible.

Regulations and traditions play a role. So one way to reach the goal could be changing the regulations.

The answer also depends on the number of experts available for the teams! In Poland there are 8000 occupational physicians. The number of occupational nurses is practically zero. The number of safety engineers is unknown. There are no trained and registered specialists in this field.

What key relationships do occupational physicians have in Poland? To what extent do they interact with safety engineers or line managers? How are they able to co-operate if there are no mates for them?

As a policy for implementing multidisciplinary work, you could:

- train occupational physicians in a broader field of occupational health care, or
- organize, train and certify other occupational health care disciplines.

There are different modalities for teamwork. The physician can be a leader of this team. In some countries, he or she is often a regular member of the team, without decisive or leading authority. This modality might not be feasible in each country.

#### **WHAT COMPETENCES ARE NEEDED FOR AN OCCUPATIONAL PHYSICIAN WORKING IN A TEAM?**

“Management skills” appear to be low-rated on an importance scale by doctors.

In Poland, occupational physicians are valued very highly in the society! But in UK, the situation is quite different. There, OHS has been called “the uneconomic tail”, or “non-productive”, or “overhead”. How do others see us? In UK, some ideas about an occupational physician exist,

like: “he takes them away from their proper job”, “doctors cannot manage”, “I don’t know what they do”, or “they are a tool of management”. So the occupational physician is undervalued as are his/her managerial skills.

For the future occupational physician, three skills are considered to be of decisive importance:

- professional/technical ability;
- humanistic ability (people and issue management);
- conceptual ability (needs of business; where is business going; the paradigm shift).

## CONCLUSIONS

In recent years, the Polish occupational health care system has become more client- and market-based. This development should be considered to be mainly a consequence of the political and societal reorientation since the early 1990s. Legal regulations do not hinder private health care initiatives like “Medicover”. The whole legislation regarding occupational health care has been renewed in a “western” way in 1997. The European orientation of Poland in general has resulted in the nomination for the European Union, and accession to the EU is to be expected in the next three to five years.

During this workshop, a lot of useful knowledge, ideas, research results, and experiences from care and training practice, shared by Polish and foreign participants, have been brought together. It is evident that EU membership has not lead to a uniform occupational health care system in the member states. We now see the first indications of a decreasing diversity within the EU! The laborious process of mutual recognition of qualifications, exchange of experiences and adaptation of regulations and systems has just started within the EU. So this is a favorable period for accession of new members who support the general principles of the 1989 Framework Directive.

In the curricula presented at the workshop we see a wave of renewal. Independent from each other, many training and education institutes have restructured their programs in the recent five years, adopting newly formulated principles of good occupational health care and looking to

competences needed to be a good occupational health professional.

Multidisciplinary teams in occupational health care have not yet been established in Poland. The whole “team-concept” is rather new. There is a lot of interest in this approach, but the structure still hinders its implementation. One important obstacle is the separation between health care and sanitary/hygiene care for companies. Another problem is the lack of well-educated and registered professionals in disciplines like safety engineering and occupational hygiene. Polish occupational physicians also lack experience of professional co-operation because of the absence of occupational health nurses. They are much more ‘soloist’ professionals than in the western European countries.

## RECOMMENDATIONS

In spite of changing conditions and the EU regulations, it is important to keep motivation for the accession at a high level and to avoid any delay. In spite of all justified criticism about the EU, do not hesitate to prepare the accession. The EU offers a good platform for stronger international co-operation in the field of occupational health care. Polish experiments with new forms and structures of occupational health care are important. The mistakes and failures made in other countries provide useful indications for the organization of such experiments. Such experiments could be carried out on the basis of bilateral agreements with other countries which can support them.

Reconsideration and re-evaluation of the position of an occupational physician in Poland is strongly recommended. He or she should become able to be a good member and even manager of the multidisciplinary occupational health care team, operating the occupational health service for a particular company, and integrating medical, technical, hygiene and psychosocial approaches to one advisory strategy. We have some good examples taken from practice that the team concept has been effective, especially for employers who can be considered “developers”! It is a pity, that the scientific evidence to prove the effectiveness of the team approach is still lacking.

Education, training and registration of other occupational health care professionals like safety engineers, occupational hygienists and occupational psychologists, should be organized as soon as possible. These professionals are already present in Poland, but professional associations, well-defined education programs, certification and recognition are still missing.

For occupational physicians as well as for other disciplines, competences should be agreed and formulated clearly to provide a good starting point for the national

training programs. For doctors, a set of core competences has been defined in Glasgow in 1997. Within them, national priorities should be indicated.

To become and to be a good professional, one should have knowledge and experience. However, the real test of capability for a given profession is in the availability of competences. How does he or she perform? Continuing education and training is needed for professionals in occupational health care.