Blind Spot for work in general/ public health: a danger for the third pillar

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Each society needs a healthy workforce

- Prevention
- Early detection
- Adequate treatment
- Rehabilitation

- The five pillars are directed at prevention. However, even in the most perfect situation workers still will develop health problems. Then early detection/treatment/rehabilitation is at stake, often meaning: good coordination with OSH: the Third Pillar!

- But: often separate worlds: OSH, Health Care, Social Security!

What if OHS is not available?

Despite Alma Ata (1978), Beijing (1994), 'Workers Health' (2007) and BOHS however, only about 10-15% of the global workforce has access to a kind of OHS (WHO, 2009)

So who cares for the 85-90%?

Do we need a sixth pillar: health care?

Structure of my presentation

- **Who do workers with health problems visit for medical help?**
- **Does ‘help’ include attention to ‘work’?**
- **If not so – the Blind Spot - , does it matter?**
- **Conclusion regarding the Third Pillar**

Workers visit General Health Care

- A minority of the global workforce has access to OHC, others visit general health care – if available… PHC manage 95% of all problems;
- PHC often the first to be consulted for work related diseases, being a substantial part of the diseases presented in PHC (Weevers ao, 2005);
- Europe: ‘Brussels 1989 Directive’ aimed at OHC for all workers in the member states. Yet 20 years later only Slovenia, France, Belgium, Finland and Holland have a 80-100% coverage;
- In most countries with a quite developed social security system workers finding themselves unable to work because of medical reasons, must visit (mostly) their GP, in order to get a sick note.

The ‘Dutch Case’ (1)

Even in The Netherlands (90% OHS coverage; no sick note needed) most workers with health problems do visit their GP:

- Andrea (Occ Med, 2003) followed 12.000 employees *not on sick leave* for 6 months. Because of health problems 35% visited their GP, 3% their OP (when thinking at only psychological causes);
- 43% from 555 employees with fatigue visited their GP during 2 months *before* sick leave (OPs 11%). *After 4 weeks sick leave* 74% did visit their GP (OPs 69%) (Anema a.o. JOR 2006)

The ‘Dutch Case’ (2)

Amstel&Buijs (OEM, 1999): from a sample of 232 Dutch OPs

- 57% thinks treating physicians have too little OHS knowledge;
- 52% thinks they don’t take into account their patient’s job;
- 49% thinks they do’nt realize sick leave can harm patients.

In 269 of 501 videotaped GP consultations with workers ‘work’ was mentioned, mostly by patients, without further exploration. Only in 25% of the cases GPs asked about work (NIVEL 2003);

vDijk a.o. (EJGP, 2006): from 13.000 workers visiting the GP within a year, GPs detected only 3844 as ‘having work’, of whom 61% were not asked about sick leave, working conditions etc.

The ‘Dutch Case’ (3)

NEA (TNO, 2004): 10.000 employees; response 56%;

- within 1 year 47,3% visited a treating physician during sick leave; 64,5% of them said they were not asked about possible relations between health complaints and work(ing conditions);

Anema a.o. (JOR, 2006): from 555 employees with fatigue 43% did visit their GP during 2 months *before* sick leave; 26% of the GPs asked about working conditions or conflicts at work (OPs: 78%), and after 4 weeks sick leave, 35% did (OPs: 55%….)

So most GPs seem to pay no attention to work relatedness

Does generalprimary health care elsewhere pay attention to work relatedness? (1)

- Stein found 60 patients reporting hazardous exposures at work, while 5 were recorded in PHC medical files (J Fam Prac,1985);
- In a PHC survey 64% of 1000 textile workers reported symptoms indicative of an occupational disease; 4% said physicians told them they had such a disease (Herbert a.o. Am J Ind Med 1997);
- De Bono a.o. (Occ Med 1999) studied asthma patients; the job of 1/3 could have caused or contributed to it, but in only 18% there was any record of a GP reference to occupational asthma.

Does general/primary health care elsewhere pay attention to work relatedness? (2)

- Clayton ao found that only 32% of GPs (clinicians 0%; OPs 74%) knew the EB guideline on RTW-advice to patients after operation. Advices about sick leave duration varied from 2 - >12 weeks;

- (Politi a.o. (JOEM, 2004) analysed 2050 hospital medical charts: only 27,8% had an occupational history completed (GPs 24%) against 99% on age or gender;)

- ‘Frequently, GPs do not recognize work-relatedness of diseases. That can cause more serious health problems, unnecessary (long) absenteeism and higher costs’ (sytematic review Weevers a.o. Fam Pract 2005)

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- Ops/GPs from 11 countries and 3 continents
- Almost all see sick listed workers for certification
- Almost all feel not well equiped/educated to perform

Conclusions…..

- Landrigan a.o.: ‘Development of heightened sensitivity of PHC providers to occupationally induced disease is of urgent priority’ (Med Clin 1990)
- “'Occupational illness plays a prominent role in the health of society, yet physicians often neglect occupational history-taking'. Politi ea (2004)
- “Current approaches have failed to achieve a desirable level of interest and involvement in OHC by the average primary care practitioner (Goldstein, Editorial, JOEM 2007)

……: a Blind Spot?

Blind Spot: A lack of attention, expertise and collaboration within general/primary health care, regarding the relation work - health.

- *Causal*: work as a cause of complaints/diseases
- *Conditional*: work as an (in)adaptable condition to enable people with a (chronic) condition to start/continue/resume work'.

Problems related to the Blind Spot

1. Not enough expertise about, and/or paying attention to possible work relatedness of complaints or diseases;

2. A lack of collaboration/coordination with OSH (third pillar);

3. Organisation problems: waiting lists; only ‘open’ from 9-17 hrs; often having to return for diagnostic tests etc.;

4. Little attention to the worker perspective/patient empowerment.

PM. In Holland consensus between the main stakeholders (2005);

Lack of cooperation regarding the third pillar
(Buijs a.o. OEM, 1999)

- Little cooperation; 9 out of 10 times OPs take the initiative;
- Yet > 80% of the GPs/OPs wants better cooperation, in order to improve reintegration and to avoid contradictory advises or medicalisation.

Obstacles: GPs fear OP abuse of information provided by them;

- think OPs serve employers more than employees;
- don't know what OPs really can do for their patients.

Prerequisites: OPs need to clarify their independent position;

- to take 'serving the worker's health' as their main principle;
- to promise they won't give GP info to others, without informed consent.

(See also De Bono (1999), Anema (2002), Beaumont a.o. (2003), Nauta (2004), Bakker (2005), BMJ editorial 2005, etc.).

Do these 'third pillar problems' matter? (1)

Worldwide occupational risk factors are responsible for:

- 37% of back pain
- 16% of hearing loss
- 13% of COPD
- 11% of asthma
- 9% of lung cancer
- 8% of injuries (WHO, Global burden of disease, 2002)

"Next to two million work-related death annually, work-related diseases will grow in relatively significance as component of morbidity and mortality of society as a whole, increasingly caused by shiftwork, overwork and work-related stress. Estimated costs: 3% of GNP" (Takala, AJIM 2007)

Do these 'third pillar problems' matter? (2)

Increase of health problems expected among work forces in Europe, N-America, Japan and elsewhere, because of:

- ageing population
- enhancing the retirement age > 65 years old
- Higher barriers to get incapacity and disability benefits
- more chronic and life-style diseases
- improved medical treatment.

So - next to prevention - it becomes more and more important how treating physicians deal with work relatedness of health problems

Do these ‘third pillar problems’ matter? (3)

Potential consequences/risks for workers:

- Incomplete/inadequate medical histories, diagnoses and/or therapy;
- assessments without expertise of working conditions, while patients often take curative advices the most serious;
- not referring when necessary; referrals to health care provisions with long waiting lists and/or without occupational expertise;
- unclearness if work can be continued (adapted), while waiting for further clinical examination;
- No feedback to OSH about possible work relatedness
- *medicalisation* of complaints without medical cause (e.g. due to disturbed relations at work).

Potential consequences (2)

Unnecessary (long) sick leave, which can lead to (permanent) disability - endangering workability and productivity - and to unemployment – a burden for social security and a considerable risk for health/wellbeing:

- GPs selected workers with MSD: after 18 months 44% was supported by unemployment funds or social welfare (RCT, Rothmans a.o. 2005)
- growing body of evidence shows that having/keeping/getting a job is good for health&well being (review 350 studies, Waddel&Burton 2006)
- Case: Jimmy, 42 years old, truck driver (McDonald, 2008)

Conclusions (1): the third pillar is in danger

- Despite the best prevention, workers still will get ill;
- Medical problems among workers are expected to increase;
- In general ‘work’ is good for health&well being, while the opposite - unemployment – is a big threat;
- Most workers with health problems visit PHC/GP;
- In (P)HC there is often a Blind Spot for work, although a vast part of main diseases is work related (causal/conditional);
- There is insufficient coordination between OHS/OPs and the public/general health care;

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Conclusions (2): do we need a sixth pillar: Health Care?

- So the third pillar is in danger and needs to be strengthened;
- Also a sixth pillar is needed: a Health Care, that takes ‘work’ into account!

Final conclusion

Together these six pillars sustain the roof:

a healthy workforce, the backbone of each society!

- Thank you for your attention!