Integration of workers’ health in strategies for primary health care

Government of Chile, Ministry of Health, Ministry of Labour and Social Security, and
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Meeting report

Introduction

About half of the world’s population is economically active. The health of workers is determined by a number of occupational hazards, individual risk factors and access to health services, which in turn are influenced by social factors, such as employment status and power relations.

When carried out under favourable conditions, work provides income to support human needs and has a positive impact on the health and well-being of individuals and on social and economic development.

However, most of the world’s workers still labour under unhealthy and unsafe working conditions, resulting in about 2 million deaths annually from diseases and injuries. Occupational risks account for a substantial portion of the burden of chronic diseases. Between 3 and 4% of global GDP is being lost to costs associated with sickness absenteeism, diseases and injuries resulting from work.

Unemployment also has a negative impact on workers’ health and well-being. In 2008, 190 million persons were unemployed, and in 2009 the unfolding financial crisis will probably add another 50 million to this number. Of the 175 million migrants worldwide, 120 million are migrant workers and their families.

Though highly effective occupational health interventions exist, less than 15% of the global workforce has some access to occupational health services, primarily in big enterprises in industrialized countries. Workers with precarious jobs, the unemployed, migrants and those in the informal economy and agriculture often have no access to preventive or curative health care at the workplace. Where primary care units provide services to working populations
such services often lack sufficient expertise in tackling work-related health risks and outcomes.

The changing world of work is characterized by increasing mobility of the workforce, growing numbers of small- and medium-sized enterprises (SMEs), an informal economy, subcontracting, precarious forms of employment, the rapid spread of new technologies, and transfer of occupational health hazards between and within countries. Unfortunately, health services for workers do not adapt sufficiently quickly to new conditions and in many cases are incapable of responding adequately to the changing health needs.

In many countries, occupational health services, if they exist at all, tend to focus on medical check-ups, registration, treatment and compensation of occupational diseases and injuries. At the same time, general health services fail to detect and address health problems related to employment and working conditions. The linkages between occupational and general health care services are often very poor, and in some countries the two are structurally separated.

Such fragmentation of the health system results in insufficient primary and secondary prevention of work-related health problems, rising rates of sickness absenteeism, an inability to reintegrate sick and injured workers back into the workplace, a lack of continuity in care, and inefficient use of human and financial resources.

Besides being primarily an arena for prevention of occupational health hazards, and for protection and promotion of workers’ health, the workplace also provides ample opportunity to implement certain public health interventions such as treatment of tuberculosis, immunizations against certain infectious diseases, tobacco control, as well as to promote healthy diet, physical activity, well-being and mental health. However, many public health programmes, e.g. prevention of cardiovascular diseases, cannot reach working populations because they are insufficiently integrated with primary care.

The Alma-Ata Declaration on Primary Health Care of 1978 emphasized the importance of bringing health care as close as possible to “where people live and work”. However, when primary health care was put into practice, the focus was mostly on health services where people live. With only few exceptions over the last 30 years, the provision of health care where people work was absent from the debate, the programmes and the strategies on primary health care. A number of countries that are reforming their health systems based on the primary health care approach have asked WHO to provide policy options for the provision of health care to working populations.

Concerned about the low level of access of workers to health services, the World Health Assembly (WHA) urged Member States in 2007 “to work towards full coverage of all workers, including those in the informal economy, small- and medium-sized enterprises, agriculture, and migrant and contractual workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries” (Resolution 60.26, “Workers’ Health: Global Plan of Action”)

In 2008, the World Health Organization (WHO) launched a set of reforms to provide PHC to all citizens. The 62nd World Health Assembly in 2009 emphasized the need to strengthen health systems based on PHC in keeping with the values and principles enshrined in the Alma-Ata Declaration. Action must be taken to provide universal access to PHC by developing comprehensive health services and by introducing national equitable and sustainable financing mechanisms. PHC puts people at the centre of health care by adopting, as appropriate, comprehensive delivery models focused on the local and district levels.

This renewed attention to developing PHC provides plentiful opportunities to scale up occupational health services based on the values of equity, solidarity and social justice and the principles of multisectoral action and community participation. Such a process could
enable health systems to adequately respond to the specific health needs of a large group of workers who are currently left out, particularly by providing channels to participation and intersectoral action, covering working populations in a given territory, and integrating approaches to health at work and in family life.

Accordingly, the government of Chile in collaboration with WHO convened this consultation with the aim of identifying directions for integrating workers’ health into the strategies of PHC. The experience of the participating countries showed that this is feasible. The exchange identified ways taking a PHC approach to addressing the health needs of working populations in different socioeconomic contexts.

The lessons learned from countries about integrating occupational health and PHC policy will be useful for other countries that are currently reforming their health systems and facing the challenge of ensuring access to occupational health for all workers. The experience shows that existing services and capacity can be used more strategically to support and complement PHC policies, through providing a referral system and workplace risk-reduction guidance to a wider constituency.

Background

There have been many calls to renew PHC at international, regional and national conferences organized by or in collaboration with WHO, many coinciding with the 30th anniversary of the Alma-Ata Declaration. The basic idea behind health for all through PHC is that taking into account both priority health needs and fundamental determinants of health enables people to lead socially and economically productive lives, which in turn helps to drive overall development. Member States have reaffirmed their commitment to the values of equity, solidarity and social justice, and the principles of multisectoral action and community participation that are part and parcel of PHC. The calls represent the goal of dealing effectively with current and future challenges to health, mobilizing health professionals and laypeople, government institutions and civil society in support of an agenda whose key elements include transforming health-system inequalities, organizing service delivery, setting public policy and furthering development.

Following the World Health Report 2008 (WHR 2008) Primary Health Care: Now More Than Ever, the 62nd World Health Assembly (WHA) urged Member States to take a number of actions to strengthen health systems based on PHC (resolution WHA 62.12 "Primary health care, including health systems strengthening"). This includes the following goals:

i) ensuring political commitment to the values and principles of PHC enshrined in the Alma-Ata Declaration of 1978;

ii) accelerating action towards universal access to PHC by developing comprehensive health services and by developing national equitable and sustainable financing mechanisms;

iii) putting people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive primary healthcare services; and

iv) ensuring that vertical programmes, including disease-specific programmes, are developed and implemented in the context of integrated PHC.

The 62nd WHA also discussed the reducing health inequities through action on social determinants of health. The WHA resolution emphasizes the need to take health equity into account in national policies that address such determinants, including employment, to strengthen intersectoral collaboration, to involve all partners, and to empower individuals and groups to improve societal conditions that affect their health. Universal PHC would help to achieve these goals.

The 60th WHA in 2007 endorsed the WHO Global Plan of Action (GPA) on Workers’ Health 2008–2017 (resolution WHA 60.26 "Workers’ Health: Global Plan of Action"). This plan deals
with all aspects of workers’ health and is underpinned by certain common principles. All workers should be able to enjoy the highest attainable standard of physical and mental health and favourable working conditions. The workplace should not be detrimental to health and well-being. Primary prevention of occupational health hazards should be given priority. All components of health systems should be involved in an integrated response to the specific health needs of working populations. The workplace can also serve as a setting for delivery of other essential public health interventions, and for health promotion. Activities related to workers’ health should be planned, implemented and evaluated with a view to reducing inequalities within and between countries. Workers and employers and their representatives should also participate in such activities.

One of the objectives of the GPA is to improve the performance of and access to occupational health services. It states that coverage and quality of these services should be improved by:

- integrating their development into national health strategies, health-sector reforms and plans for improving health systems performance;
- determining standards for their organization and coverage;
- setting targets for increasing the working population covered;
- creating mechanisms for pooling resources and for financing the delivery of services;
- ensuring sufficient and competent human resources, and establishing quality assurance systems;
- providing basic occupational health services for all workers, including those in the informal economy, small enterprises and agriculture.

In 2006, the 95th International Labour Conference adopted the Promotional Framework for Occupational Safety and Health Convention No. 187 and Recommendation No. 197, which both require the development of national occupational safety and health systems. Convention No. 161 on Occupational Health Services of the International Labour Organization (ILO) sets specific requirements for the establishment and the functioning of occupational health services.

Implementation these policies requires full integration of occupational health services into strategies for reforming health care. Provision of such services must also be reconsidered in the light of the new employment patterns and with a view to reducing inequities in workers’ health. PHC development strategies should consider the need to provide health services appropriate to preventing occupational diseases and injuries.

The 13th Session of the Joint ILO/WHO Committee on Occupational Health in 2003 recommended a “basic services approach” approach to providing occupational health services to significantly increase workers’ access to basic occupational health services. With Resolution WHA 60.26 “Workers’ Health: Global Plan of Action” from 2007 the World Health Assembly urged Member States to work towards coverage of all workers, particularly for agriculture, small-scale enterprises, informal sector and migrant workers with essential interventions and basic health services for prevention of occupational diseases and injuries.

The principal objective of this meeting was to review countries’ experiences in integrating occupational health services and PHC to expand coverage among underserved sectors and workers.

Opening and keynote speeches

On the kind invitation of the Ministry of Health and Ministry of Labour, Chile, a total of 24 participants from 12 different countries attended the Intercountry Consultation on Integration of Workers’ Health in the Strategies for Primary Health Care, organized on 4–7 May 2009 in Santiago, Chile. The scope and purpose of the meeting is attached as Annex 1, the
backgrounder document by the WHO Secretariat as Annex 2, the guidance for countries’ presentations as Annex 3, and the list of participants as Annex 4.

Dr Jeanette Vega, vice minister of health, bid all participants a warm welcome and officially opened the meeting. She mentioned that health and conditions of work are extremely important, especially now that there are so many health-related problems on the world’s agenda. Political will is essential for improving the public sector. International organizations need to implement their regulations. In Chile, a year ago, a council of experts was asked to examine inequities in health. The council reported that Chile has advanced but that relations between employers and workers still need to be improved.

Dr Vega stated that the purpose of the meeting was to discuss strategies that contribute to the health of workers. Training of primary care personnel in occupational health is a critical element of such strategies. In addition, workers must have access to occupational health services. These issues need to be discussed so that problems and obstacles can be brought to light, in turn pointing the way to possible interventions. Health policies relevant to workers must take into account both working conditions and economic issues.

Dr Carlos Dora, coordinator for Interventions for Healthy Environments, WHO, Geneva, presented the objectives of the meeting. WHO has launched a campaign to revitalize PHC in connection with health systems reform 30 years after the Alma-Ata Declaration on Primary Health Care. WHO has also discussed the Report of the Commission on Social Determinants of Health, and the discussion will be further continued in the 62nd WHA in May 2009. The WHA has also put :PHC on the agenda. The greatest challenges are inequities in health, isolation of vertical health interventions from the rest of the health system and issues related to social determinants of health.

Discussion of occupational health services in PHC is thus highly topical. This meeting is intended to provide ideas about how to integrate occupational health and PHC especially in practice, and how to respond to the great challenges of health systems with the aim of reducing inequities among working people. Dr Dora emphasized the key role and responsibility of governments in implementing health services reform at the national level.

Dr Hector Jaramillo, Institute of Labour Safety, Ministry of Labour, Chile, briefly described the changes in the insurance systems and their importance to workers' health. The Pension Fund Reforms were mentioned as one of the priority activities of the Government of Chile. Other important issues are workers’ access to occupational health and preventive services in general, as well as at the level of PHC. Dr Jaramillo emphasized the importance of collaboration between ministries of health and ministries of labour in improving these services. Such collaborations have been very active in Chile, although the country still records 500 fatal labour accidents per year. This meeting is expected to help stimulate inter-ministerial collaborations in Chile and elsewhere.

Dr Orielle Solar, Ministry of Health, emphasized the need to integrate occupational and public health services. Strengthening the occupational health component is also central to improving conditions of work in general. Usually occupational health services are not very well linked to PHC. Consequently, we need not just more effective networking of public services but also analysis of available service provision models for better integrating them with PHC. This meeting is expected to provide such an analysis as well as new ideas about how to integrate occupational health services and PHC in practice.

The participants thanked the Government of Chile, and WHO for inviting them. They found the initiative timely and necessary in view of the implementation of the WHO GPA, the current needs of occupational health and the state of these services in most countries.

Dr Orielle Solar, Ministry of Health, Chile, and Mr Hector Jaramillo, Ministry of Labour, were appointed as chairs of the meeting, and Prof. Jorma Rantanen as rapporteur.
Social reforms in Chile

Dr Claudio Reyes, vice-minister of labour and social protection, Chile, described the reform of the pension system in Chile launched by President Michelle Bachelet. The reform made major changes that address some key policy challenges, including worker coverage, gender equity, pension adequacy, and administrative and economic efficiency. The cornerstone of the reform is the basic universal pension as a supplement to the individual pension account system. When the reform was initiated, three areas were investigated:

i) coverage of pension system
ii) level of benefits
iii) financial effects and efficiency.

The studies showed that a large group of low-income workers, particularly older women, are without pension coverage, and that for many others the pension level was inadequate. The objective of the reform was to ensure a minimum level of pension sufficient for decent life for workers whose wages are too low to entitle them to a full pension. The third objective was to improve the economic efficiency of pension funds by lowering overhead costs through competition between pension providers.

In March 2008, a comprehensive pension reform law entered into force that addressed many of these issues. It established a basic universal pension based on government solidarity funding, required the self-employed to join the individual pension account system, encouraged greater competition among pension fund providers, lowered administrative fees, provided financial incentives for women to work longer, allowed widowers to receive a survivor pension, divided individual account assets between spouses in case of divorce or marriage annulment, expanded voluntary pensions, overhauled the administrative structure, and launched a financial education programme.

The new system is financed by a mix of government solidarity contributions and peoples’ own contributions. The system will be expanded gradually, but reaching full coverage takes a long time. The reform includes many workers and depends on their willingness to contribute. Previously, obtaining one’s pension was a lengthy process. The new system employs a much more efficient computerized work history and personal identification data, which speeds decisions on pension allocation. A total of 15 000 teachers have been trained to educate people about the reform and to provide advice about pension benefits, as well as to teach people how to manage their personal finances.

The reform is considered a success. Some 1.5 million workers and many more non-working people than before will benefit from it. The reform has substantially improved equity, and has helped somewhat to ameliorate the position of low-income groups, older women, survivors of breadwinners, the handicapped and working mothers. It is thus an important means of eliminating poverty.

Discussion

The following comments were made:

- In management of change it is important to take into account all the changes that are caused to the citizens. Sometimes, if the changes are not planned well, it is difficult to implement them and the reform may have only a partial impact. It is good that the reform particularly addresses the pension of mothers, women and young and handicapped people.
- It is important that criteria are set for the quality of the care and services provided through the new system
- As everywhere, financial crises may affect seriously the pension funds.
Primary health care

Dr Carlos Dora introduced the WHO strategies for renewing PHC with reference to the WHR 2008. He broadly defined PHC and listed five reasons why renewal is necessary:

i) realignment of values and raising expectations
ii) progress does not happen automatically
iii) difficulties in adapting to new challenges
iv) pervasive inequalities and
v) need for leadership and steering.

Unlike earlier perceptions of PHC as a cheap basic package of health-care delivery services for the poor, PHC is now understood to be a system for providing access to services for all, by comprehensively responding to the expectations and needs of constituents, institutionalizing the participation of civil society, and carefully considering the determinants of health. The system may not necessarily be cheap but should be cost-effective. The WHR 2008 identified four main areas of health systems reform:

i) universal coverage reforms
ii) service delivery reforms
iii) public policy reforms and
iv) leadership reforms.

There is need to mobilize knowledge; learn to do more – i.e. expand the health sector for PHC reform; negotiate a virtuous cycle of need, supply and demand; and capitalize on pressure from civil society. The next steps for PHC and occupational health services will be to converge the basis for policy defined by the WHA resolutions and to seek synergies, as many of the problems and solutions are identical. Integrating PHC and occupational health services is a timely objective.

Integration poses a number of challenges. Only 15% of the world’s workers have access to occupational health services; the informal sector, migrant workers and SMEs are the least covered and most in need. Economic losses stemming from inadequate safety are substantial (4% of GDP), and the vertical programmes that were so popular in the past have been found to be ineffective, particularly with respect to prevention.

WHO Global Plan of Action on Workers’ Health

Dr Ivan D. Ivanov, WHO Global Occupational Health Programme, Geneva, introduced the GPA. He mentioned that the Global Strategy on Occupational Health for All from 1996 had stimulated a great deal of activity. A new international instrument to help countries improve workers’ health was needed. Consequently, in May 2007 the 60th WHA endorsed the Global Plan of Action on Workers’ Health. The plan has been translated into practical activities in several WHO global meetings and in the WHO regions of Africa, Europe, the Americas, South-East Asia and the Western Pacific.

Large gaps in workers’ health between and within countries have been recognized. Consequently, the World Summit on Sustainable Development (WSSD), held in Johannesburg 2002, called for linking occupational health with public health. In addition, the ILO Promotional Framework for Occupational Safety and Health Convention No. 187 from 2006 includes occupational health services as an essential part of the national occupational safety and health system.

The factors determining workers’ health have been expanded from traditional occupational hazards to include also social determinants, individual risk factors and access to health services. Many public health programmes are related to addressing workers’ health, such as communicable diseases, health promotion, mental health, environmental health, health...
systems development etc. Therefore, also considering the changes in employment patterns, a new approach to addressing workers' health was deemed necessary, shifting the focus on labour to one on public health – i.e. from occupational health to workers' health.

The GPA was compiled from the countries' consultations. Through adoption of the action plan by consensus of 193 Member States of WHO, the Health Assembly the objectives for developing workers' health for the 10-year period 2008–2017. The WHA urged the countries to take measures to implement the plan.

The Health Assembly urged Member States to develop national policies, provide universal coverage of occupational health services, strengthen capacities and evidence for action, and develop services for local communities affected by industrial and agricultural activities. It also encourages concerted actions by the relevant national health programmes, including workers' health in non-health policies, intercountry collaboration, and reintegration of sick and injured in the workplace.

The GPA aims at the highest attainable standard of health. No workplace should be detrimental to health, primary prevention should be a priority, and the workplace should be an arena for other health interventions. All components of the health system should respond in an integrative way to the health needs of the workers. Actions related to workers' health should be implemented effectively, and health inequalities eliminated. It is important that employers and workers participate in planning and implementing occupational health activities. The GPA sets five objectives:

Objective 1: To develop and implement policy instruments on workers' health
Objective 2: To protect and promote health in the workplace
Objective 3: To improve performance of and access to occupational health services, as well as coverage and quality
Objective 4: To strengthen systems for surveillance, research, communication and awareness-raising
Objective 5: To incorporate workers' health into other policies; and to foster collaboration between the different sectors of the public domain, i.e. ministries.

WHO is requested to promote the implementation of actions on workers' health at the global and national international levels with a definite timeline and indicators for the establishment of occupational health services. In particular, WHO is expected to provide guidance to the Member States for the development of basic packages, information products, tools and working methods, and models and good practices for occupational health services, and to stimulate international efforts for building the necessary human and institutional capacities. One of the principles of the Global Plan of Action is that all components of the health system should be involved in an integrated response to the specific health needs of working populations. Dr Ivanov emphasized the need for achieving tangible results, as the implementation of the GPA will be reported back to the WHA in 2013 and 2018.

Discussion

During the discussion of Dr Dora's and Dr Ivanov's introductions, the following comments were made:

- Universal coverage is a useful goal, but it may be too ambitious to be feasible. The views of the labour sector and the public health sector need to be merged. The language of these two sectors must be complementary, and they must understand the language that is used in both sectors.
- PHC is person-centred, curative, and leaves out the work environment. It is essential that primary prevention and work-environment-oriented activities continue to be the core of an integrated programme of occupational health services and PHC.
- Rural and informal sector workers are usually ignored by services, labour systems and social security systems. For this reason, occupational health would benefit from a public health approach.
The WHO programme on workers' health is crucial. International professional associations, such as the World Organization of Family Doctors (Wonca) and the International Commission on Occupational Health (ICOH) could contribute a lot to the development of occupational health services at the grassroots level by translating research into practice.

Occupational health services require both a comprehensive approach and the combination of occupational health and PHC to deal with new work-related morbidity among working populations, such as diabetes II related to unconventional working hours. Work-related cardiovascular disorders are also increasing: poor work organization and management raises the risk of heart attack 2.5-fold. Night shifts are associated with an increased risk of breast cancer. Irregular work schedules are becoming more prevalent and are associated with common non-communicable diseases, causing excess morbidity and mortality. These research findings call for comprehensive approaches and new thinking in both occupational and public health.

Challenges of integrating occupational health and PHC

A panel discussion on the challenges of integrating occupational health and PHC was held with the participation of Carlos Dora, Ivan Ivanov, Javier Pargas, Carol Black, Hector Jaramillo and Orielle Solar.

The following questions were posed to the panel:

- How to move from occupational health to workers’ health?
- How to develop a compensation system for occupational injuries and diseases?
- How to integrate occupational health and PHC?

On the basis of the panel discussion, the following conclusions and proposals were made:

- We need to analyse the framework where we want to go. Will general practitioners be transformed into occupational health practitioners?. To map the main problems, we have to agree on ways of evaluating the services. We also need to find a way to define and validate the role of the general practitioners in the occupational health services. The work already done by Wonca should be consulted.
- Detachment of occupational health from the mainstream health systems happened a few decades ago. How can we strengthen the linkages between occupational health and PHC? What can occupational health offer the health system? How can we use the current political momentum to scale up occupational health?
- The labour and health worlds must be integrated. Occupational health issues in the informal sector are important. Government authorities must pressure business to develop occupational health services. Resources are needed for training occupational health experts, and they in turn need resources to provide services.
- How should occupational health contribute to a productive workforce? Actions need to be fitted to each country and society.
- Public policies should be implemented more effectively. We need to demonstrate the cost-effectiveness of these policies. Provision of occupational health services should correspond to what workers need.
- The medicalization of occupational health should be avoided. The greatest challenge for occupational health in developing countries is to prevent hazards at work and in the work environment.
- Strategies and methods for practical, effective primary prevention should be developed.
- PHC should not try to focus on every single aspect of occupational health. Rather, a realistic view of the weakness or lack of competence of PHC in occupational health should provide a starting point for integration.
- Manuals and protocols of the most common occupational diseases could be prepared. Some guidelines for a common general practice-occupational health approach of certain common conditions, e.g. burnout, back pain, and musculoskeletal
disorders have already been developed in some countries.

- Workers’ opinions about developing occupational health should be carefully consulted.
- The competence of health personnel in occupational health should be ensured. Also, sufficient numbers of specialists in several occupational health professions are available, such as physicians, nurses, psychologists, hygienists and ergonomists. Not all the problems can be solved by less-well-trained people. Support and referral services should be available in every country.
- Practical methods of serving SMEs, the self-employed and the informal sector should be developed.

**International labour standards for occupational safety and health**

Dr Javier Parga, ILO, described the principles of ILO Convention Nos. 155 and 161. These conventions define the rights and duties of employers and workers in improving occupational safety and health. What is needed at the national level are the legislative basis, national policy, competent authorities, and mechanisms for coordination and inspection. Information sharing with all national actors is important, as is training. ILO Convention No. 187 on the promotional framework defines the occupational safety and health system at the national level. The concept of this system is central. It is not always necessary to create a new system. It is also beneficial to think through the existing system and to identify any defects. The national system establishes priorities and provides guidance on how to carry out activities. At the political and structural levels, it can be difficult to devise a systematic approach. Leadership may also be lacking, and resources are sometimes defined inadequately.

Risk management in companies is important. Business objectives should not compromise health and safety goals. Profit-seeking can compromise the effect of occupational safety and health. The regulations of each country must be analysed to determine whether improvements are needed.

Mr Pargas mentioned that sometimes we lag seriously behind. For example, in Mexico, the list of occupational diseases had not been updated for 30 years. The national policy calls for drafting a national programme on occupational safety and health. Government, employers and workers need to be involved in designing the policy. Workers need a social insurance system. Finally, a critical mass of expert personnel is needed to supply services.

Implementing a national occupational safety and health programme is impossible if is the country has no inspection system. ILO Convention No. 81 and Recommendation No. 81 (1995) define inspector independence, stipulate sanctions and regulate corruption issues. Convention No. 161 and Recommendation No. 171 define the occupational health services that need to be made available to companies and workers. Chile is planning to ratify the promotional framework convention.

**Discussion**

The following issues were raised in the discussion:

- There are numerous limitations in the coverage of tripartism; e.g. the self-employed, precarious workers, subcontractors and the informal sector are not covered and have no representation through trade unions.
- The nature of the labour contract has an impact on the safety and health of workers. New models and new solutions are needed to protect workers in fragmented and insecure jobs.
- Traditional occupational safety and health strategies seem not to work under new conditions where irregular workers abound. New approaches based on a PHC model are needed.
Mr Pargas responded that the ILO has addressed these problems, but they are challenging. In principle, informal workers are partners in tripartism. The ILO’s policy on precarious labour recognizes the risks related to such a work environment. Mobile workers constitute a problem for OSH programmes and inspection.

Employment and health inequities

Prof. Joan Benach, University Pompeu Fabra, Barcelona, Spain, introduced employment, health and work issues. He discussed the social determinants of employment on the basis of recent research findings. He also discussed the recommendations and conclusions of the WHO Commission on Social Determinants of Health. There are many inequities in the world, including access to basic necessities of life such as energy and food, income and health. Income distribution is extremely skewed, the gap between the poorest quarter vs. the richest reveal great differences between countries. Social determinants of health: political factors, employment issues, early life, health-care services, housing, nutrition, all affect the overall health of people and cause health inequities among workers. Prof. Benach gave several concrete examples of major inequities in health and safety caused by social determinants in different societies, both industrialized and developing. These inequities are often invisible and difficult to recognize with narrow monodisciplinary research. Rather, a realistic perspective, transdisciplinary approach and participatory approach are needed. Also, new theoretical frameworks are needed that consider social determinants of health within the political context. We also need action on employment that combines policies at different entry points, and integration of social and preventive policies. Employment conditions must be improved; the concept of *fair employment* is intended to meet the needs of the current situation.

National and global labour market policies require changing, and here intergovernmental organizations and national governments play an important role. Governments should lead national policies. Voluntary measures by employers do not work sufficiently. Public capacity for regulation should be strengthened, and collective agreements between employers and trade unions are needed. Workers’ participation and the role of unions need to be ascertained. Other forces for improving equity and managing social determinants are, e.g., social movements, cooperative modes of organization, universal health coverage, improved work capacity, and health centre networks. A global occupational health services policy is essential. We must make invisibility visible; many hazards are unknown, and we must consider occupational health as a part of human rights. The coverage of services is just 10–15%, and they are often ineffective. We need to go beyond treatment, adopt a social perspective, respect participatory process and allocate more resources for comprehensive, equitable services. Gaps in knowledge need to be filled, health information systems improved, surveillance and research systems established, theoretical approaches developed and evaluations of employment policies studied for their impact on health inequities.

Recommendations include upstreaming issues of employment and work conditions in regulatory policies, contextualizing working conditions and health with the policies implemented, integrating economic and social policy interventions, involving the health sector to a greater degree in actions to reduce inequities, improving participation, developing information systems, and improving training and education on the relationship between employment and health.

The proposed entry points for improvement cover regulation of power relations in the labour market and social policies, modification of employment conditions to minimize vulnerabilities, minimization of safety and health hazards at work, and alleviating the consequences of ill-health and psychological burdens.

Prof. Carles Muntaner, University of Toronto, Canada, analysed the impact of the political context on sociopolitical models in different countries. He found differences in the characteristics of PHC according to the political model applied. PHC reflects collective responsibility together with social citizenship. Analysing Liberal, Wage Earner, Conservative-
Corporatist, Christian Democratic and Social Democratic societal models shows interesting differences and consequences for health and occupational health as well.

He identified correlations between the political and socio-political contexts and features of the welfare state. The political model has a crucial impact on employment conditions and on the position of workers in the labour market. That impact is visible in both industrialized and developing countries, the most unfavourable conditions being found in the informal sector of medium- and low-income countries.

Employment conditions correlate strongly with health as measured by a broad battery of indicators among which are mortality and healthy life expectancy, and occupational health indicators, including occupational injuries. The choices for health systems also depend on the political context; universalism and solidarity vary widely. The health of the population and particularly OSH are affected by the various political economy models.

New trends in employment have an impact on working conditions and workers’ health. The need to develop occupational health services in this new situation is inevitable. Governments should guarantee health and work as rights, along with access to fair employment and decent working conditions. The state bears a fundamental role in mitigating and reducing negative work-related health effects through social policies and workers' full and meaningful participation. The power balance in negotiations between transnational corporations, businesses, employers’ and workers’ associations is unequal.

Health is a human right and a value in itself. Its pursuit should not be justified on the basis of its contribution to meeting economic goals. Judging the success of an economic model requires measuring its degree of health equity among workers and the level of worker participation in its development. Exploitation of workers and stripping away their social protections should not be prerequisites for economic success. Concerns about sustainable environmental development and about climate change miss the health costs and impacts on workers linked to this model of development. Much of the history of employment relations has been characterized by unequal power and conflict between labour and capital, the former often represented by unions demanding higher wages, shorter hours, and better working conditions through strikes, and the latter resisting those demands through firings, lockouts or court injunctions. The following recommendations were made:

- The health sector should assume a fundamental role in achieving health equity for workers and their families. It can do so ensuring that economic development models take into account the labour market; norms and regulations regarding employment and working conditions; and the substantial impact of these factors on the protection and promotion of the health of workers and their families.
- Health and health equity among workers should be a matter of public health, and thus should be guaranteed to working people independent of their conditions of employment. Here, the strategy and model of PHC has a capacity and a responsibility to reach all sectors with preventive and curative interventions and with support for reintegration into work.
- The principal guarantors of health and health equity for workers are the workers themselves. Health cannot be delegated. For this reason, society as a whole must guarantee to workers the right to know about work-related health risks and must provide them tools they need to participate in and meaningfully influence the negotiation and modification of employment and working conditions.
- Information systems must be developed that include health and health equity among workers, as well as follow-up on the impact of associated policies and programmes.
- Health professionals and workers need education and training in social epidemiology, with an emphasis on workers’ health and employment conditions.
We need to consider the viewpoint of a worker who is getting sick: Where does he go? What does PHC know about work-related exposure and health outcomes? We should start with prevention. And we should have the means to influence work conditions.

Discussion
The following considerations emerged from the discussion on the presentations of Profs. Benach and Muntaner:

- Workers play a smaller role in their companies now than in the past. The impact of the economic crisis is seen at many levels, but it is simultaneously a crisis and an opportunity.
- Governments cannot defend equity in the same way that they have done for many years. On the other hand, the neoliberal, unregulated market is not conducive to helping solve social problems. More regulation is needed.
- Fair employment includes the freedom to unionize.
- To change the current state of affairs, we need evidence. In matters of political change the question arises, What is appropriate evidence? In many cases, we lack hard data from epidemiology, but there are many other sources of evidence. The role of safety representatives for workers in companies is important. Evidence is scarce, but the experience of such representatives shows that they may play an important role in improving health and safety.
- The benefits of welfare states should be taken into account in integrating occupational health and PHC. The coverage of occupational health services in most countries is low and should be expanded.
- Although welfare policies are important, they are not enough to eliminate health inequities. Both globalization and the current economic crisis have increased the need for services. Providing services for migrant workers is difficult if the country does not have a health system and basic public health services.

**PHC and workers’ health**

Dr Ivanov of WHO explored the relation between PHC and workers’ health. Currently, a number of different models exist for providing health services at the workplace, such as group and in-plant services, public health centres, external consultancies and teleservices. Their scope varies significantly along with the trade-offs of prevention vs. cure, protection vs. promotion, and generalist vs. specialist service provision. Services may cover only workers, or also extend to their families and further to the community. In some countries and sectors the provision of such services is compulsory, while in others it is voluntary. There are also variations in terms of geographical location – urban (industry and service sectors) vs. rural (agriculture). The providers may be health experts with or without special training in occupational health or volunteers, such as community volunteers and trained workers. The financing of workers’ health services may be public or private, or mixed, with variations in the share of out-of-pocket payments and in the level of pooling of resources.

Recent decades have seen significant progress in developing occupational health services in a number of industrialized countries and economies in transition and rapid economic growth. Compulsory provision of services along with national funds for their financing led to almost universal coverage in some countries and a significant increase of coverage and quality in others. However, there are concerns about the predominant arrangements for provision of health services for workers, which have led to very low and inequitable coverage, services inadequate to the level of risk, provider-driven menus of interventions, a lack of continuity of care and narrowing down content to just a few interventions. In addition there are language, employment status and structural barriers to accessing services which themselves are becoming more and more profit-oriented. In many countries occupational health is not well linked to the remaining parts of the health system, and this leads to fragmentation of care.

The Alma-Ata Declaration called for bringing health care to where people live and work. Thirty years later there are even more compelling arguments for using the workplace as a
point of entry to the health system. At least one-third of world’s population spends one-third of its time at the workplace. Work and employment shape a number of health determinants. The workplace can be a setting for delivery of essential health interventions and for reaching out to workers’ families and communities. In some cases, the workplace is the only way of providing health care, e.g. for mining communities and migrant workers. Improving workers’ health can help reduce poverty, and is an essential prerequisite for productivity and economic development.

PHC-based services for workers would have the following common traits: (1) first contact of workers with health systems; (2) workplace- and community-based; (3) emphasis on primary prevention and promotion, (4) active mechanisms for workers’ participation; (5) sound policy, legal and institutional framework; (6) optimal organization, management and adequate human and financial resources.

Moving towards universal coverage reforms in the world of work requires measures along several dimensions: (1) reducing the proportion of costs to the individual undertaking and/or workers; (2) adding interventions to the package of service provision; (3) increasing the number of workers covered; (4) reducing the barriers for undertakings and individuals to access health services.

New leadership in PHC for workers implies regulation of occupational health services, strengthening the role of ministries of health and ministries of labour in their provision, participation of workers, employers and other workplace actors in health-care reforms and planning and implementing national, provincial and sectoral programmes for occupational health services.

Reforming the delivery of occupational health services requires strengthening their linkages with the primary care centres and providing support (secondary) services, such as occupational health institutes, laboratories, clinics and information centres. The content of occupational health services needs to be reoriented towards the needs of the workers and not geared towards the supply of providers. It also needs practical tools and working methods for essential health interventions at the workplace along with measures to improve the cost-effectiveness of services.

Moving towards PHC-based services for workers requires certain public policy reforms, such as developing national policy frameworks for workers’ health along the recommendations of the 60th WHA (Resolution 60.26). Public policy needs to stimulate intersectoral collaboration and coordination involving health, labour, environment, agriculture, industry, energy, transport, construction, finance, trade and education. Social security institutions, employers, trade unions, the private sector and civil society organizations have a particular role to play in shaping public policies for workers’ health.

Experience from countries in integrating occupational health and PHC

On the request of and according to an outline provided by the WHO, the participating countries were invited to draw up country reports on their current situation in developing occupational health services and on integrating them with PHC. Ten country reports from different WHO regions were presented and extensively discussed by the meeting to share experiences and discuss lessons learned.

Brazil (Dr Clunara Shilling Mendoça)

The Brazilian health system was reformed 8 years ago. It is based on a family health team, or FHT: general practitioner (GP), public health nurse, dentist, health agent and assisting person. Networking with the key institutions and stakeholders in the community environment of the family health team is effective. The team’s responsibility consists of delivering PHC services for 800–1000 families in a defined geographical area. The teams cover populations
of 3500 people/team, including people shuttling from other communities to the workplace. The tasks of the family health team in occupational health are the following:

- registering occupational accidents and occupational diseases
- following up the health of workers
- visiting workplaces
- making preventive interventions.

The entire family health team undergoes training in occupational health by occupational health physicians. The coverage of services has grown rapidly since the reform was launched. The coverage objective by family health teams is 70% of the population by the year 2011. Occupational health activities are best integrated with PHC at the municipality level.

Activities in occupational health vary. What family health teams do varies widely according to local conditions. Teams need to be sensitized to the work-relatedness of diseases, e.g. respiratory disorders. Promotion and prevention depend are the responsibility of the health agents. The clients for occupational health services are mainly small enterprises, the self-employed and the informal sector. Organized workplaces (companies) provide their own occupational health. Areas where no services are available pose challenges. Informal sector workers also constitute an important target group. Citizen participation is organized through workers’ health conferences (every 4 years).

**Chile** (Dr Patricia Grau)

Chile has high coverage of PHC services. The service provision for 78% is funded by the government, 13.7% by private insurance, while 5.7% is uncovered. Chile’s health system is strongly territorial and regional. PHC services are provided by dedicated centres in both urban and rural areas. Some areas also offer specialized services, such as mental health. Farmers are served by the rural centres. The first contact point is a health post that refers the clients to the PHC centres. Enterprises in Chile are generally small; 80% employ fewer than 50 workers, and 88% of them are smaller still – fewer than 10 workers.

Occupational health services for organized sectors are provided primarily by mutual insurances which cover some 40% of the workers. The rest, small enterprises and the self-employed, are covered by the PHC centres. Intersectoral collaboration between health, labour and other relevant actors, such as agriculture, is considered important and needs to be further developed.

The health sector has launched several problem-oriented strategic programmes, including projects that focus on:

- integrating occupational health and PHC services
- recognizing and diagnosing occupational diseases
- developing health education programmes
- work environment
- occupational accidents
- health surveys
- workmen’s compensation
- preventing pesticide hazards
- providing personal protective equipment
- vulnerable groups, such as small enterprises, artisans, miners and fishermen.

The Government of Chile has taken an active leadership in developing occupational health services and integrating them into the PHC system. These activities are being carried out in the context of the ongoing health-sector reform and several other social reforms, including e.g. national programmes for children’s health and reform of the pension system. The key objectives in those reforms are equity, coverage of underserved groups, and prevention and promotion programmes for people’s health, basic rights and response to people’s needs.
China (Dr Chen Rui)
China has a total workforce of 730 million. Over the last 20 years, the economy has experienced double-digit growth. Health policy ranks occupational health high as a priority in the national health system reform. The key actors in occupational health are the Ministry of Health, and the National Center for Disease Control, the Ministry of Human Resources and Social Security, the State Administration of Work Safety and the All-China Federation of Trade Unions. Economic and social change have led to rapid urbanization and industrialization, which poses several challenges to social, health, environment and employment policies. Since 2000 the government has renewed all the key legislation concerning occupational health, work safety and social protection, as well as several other aspects of labour law and numerous provisions of the Ministry of Health specifically for occupational health, including the listing, diagnosis and notification of occupational diseases, occupational health surveillance and occupational health services. The Ministry of Health qualifies and approves the occupational health services for various activities, and the provincial health administrations are entitled to do the same.

The challenges of occupational health in China remain high numbers of occupational disease, particularly pneumoconioses and poisonings; large numbers of migrant workers; transfer of occupational health hazards from abroad, and to less developed and rural areas; high numbers of SMEs; weak implementation of regulations at the grassroots level; and low coverage of occupational health services. Occupational diseases are still a problem, as are work-related accidents, which have been found by the government to be at unacceptable levels. Several actions have been initiated to prevent and control them.

In March 2009, the government has launched guidelines for health-care system reform aiming at full coverage of health services for both urban and rural populations by 2020. The reform includes provision of universal health insurance, an essential drugs system, improvement of PHC facilities, equity in public health services and reform of state-owned hospitals. The key provision will be public health service at all levels.

In 2006, the Ministry of Health introduced a programme of providing basic occupational health services for underserved sectors and workers without services. The programme has been implemented in three steps: first, creating an organizational structure and prerequisites for pilots at all levels, including surveys for situation analysis; second, building capacity for pilot projects, and third, implementing the pilots. Pilot projects were implemented in 19 counties located in 10 provinces. The pilot programme included a planning module, with training for responsible officers at all levels and pilot personnel, and preparation of provincial and national occupational health profiles.

The pilots were successfully implemented, reported and evaluated, and currently the extension of project to other provinces is being discussed and prepared. The pilot models were found to be feasible for providing occupational health services to underserved groups in China.

Finland (Prof. Jorma Rantanen)
The Occupational Health Care Act in Finland goes back to 1978. According to the legislation, services must be provided for all workers. The self-employed are also entitled to receive services on a voluntary basis from municipal health centres.

The Finnish occupational health services model is a comprehensive one. The act principally requires preventive activities, but allows curative GP-level services as well. One of the specific substantive features of the Finnish occupational health services model is the maintenance and promotion of work ability, which has been a successful social innovation.

The 2004 national programme endorsed through a government resolution (OHS 2015)
includes 10 key lines for the development of occupational health services. The implementation of the key lines has continued steadily. Some of the prerequisites have, however, changed substantially as a consequence of changes in the structure of the economy and in the health-service systems.

The coverage of services is high: 90% of all employees with contracts, and 85% counting all people at work, including SMEs, the self-employed, farmers and other small units. Entrepreneurs are entitled to get services for their own occupational health from the municipal health centre. The coverage of enterprises is virtually 100% among enterprises down to 10 workers, but drops rapidly to 50% among smaller units and the self-employed.

The financial incentive included in the legislation is reimbursement of 50–60% of the costs of occupational health services back to the employers. The level of reimbursement depends on the content of services in favour of prevention. This policy has effectively increased the coverage of occupational health services.

The structure of the service system in Finland is in dynamic development. The four service provision models – municipal health centre (29% of workers), in-house model (15%), group service (2%) and the private medical units (48%) – are rethinking their contributions to services. The growth of the private occupational health centres’ share has been very rapid in the past few years. At the same time, some municipalities have reorganized their service based on a public corporation model. Recently, discussion has turned to the need to more effectively control the external service providers, particularly in view of ensuring that preventive and work-environment-oriented activities remain a priority.

The information and follow-up systems include several regular national surveys: Occupational health services in Finland (triennial), PMWA barometer (triennial), Health and work in Finland (triennial), Work life barometer (Ministry of Labour, annual), and Working conditions survey (conducted in connection with household surveys by Statistics Finland every 7 years).

*Italy* (Dr Diana Gagliardi)

The Italian occupational health services system underwent a reform of occupational health law in 2008. As a result, the entire area of risk assessment and management was reorganized and enlarged to include emerging risks (such as psychosocial and organizational risks) and all categories of workers (including the self-employed, temporary and/or precarious workers, and those employed in the informal sector), and even introducing new concepts of workplace health promotion within the prevention and protection offered by workers’ health legislation.

Providing occupational health depends on occupational health physicians whose role is to check the health conditions of workers and to prevent any threat to it, either by participating in risk assessment and evaluation activities and delivering periodical medical check-ups to assess workers’ fitness.

The system of control is a public service under the jurisdiction of the Ministry of Health, which now has been joined with the Ministries of Labour and Social Affairs into a single Ministry of Welfare. The practical service includes prevention, surveillance, promotion and other relevant services and is provided by multidisciplinary teams of local health units and OSH departments linked to primary care services.

The National Institute of Occupational Safety and Prevention (ISPESL) plays a key role in prevention and safety in the workplace through its multidisciplinary scientific support. ISPESL services to the frontline organizations are mediated by 36 regional units that cover the whole country.
South Africa (Prof. David Rees)

South Africa has a workforce of 14 million. The unemployment rate of 23.3%, together with the global financial crisis, constitutes a great challenge. The major societal reform is still ongoing and poses several major problems to be solved. The social policy reform is under way. The needs of workers’ health are amplified by the HIV/AIDS epidemic (18% adult prevalence rate and 5.7 million cases), which is associated with a secondary tuberculosis epidemic and the general effects of globalization.

The major industries and the organized sector have traditionally had well-working occupational health services, but the SMEs, the self-employed and the informal sector lack services. An occupational health committee was appointed by the government in 1996 to make a proposal for the renewal of the occupational health system. The committee produced a model that uses existing systems and proposed setting up regional occupational health centres with occupational medicine, a hygiene laboratory and an advisory service for compensation issues to support the PHC system. Work environment services would be organized by the environmental health services. The plan was well received but has only been partially implemented. The need for services is evident, particularly in the SMEs and other underserved sectors. There may be an opportunity to organize pilot experiments to demonstrate the need for and feasibility of the proposed model.

Thailand (Dr Somkiat Siriruttanapruk)

Two-thirds of the 36 million workers of Thailand are employed in the informal sector, often exposed to high risks. The Labour Protection Act and the Labour Welfare Act regulate OSH, including employers’ obligation to provide occupational health services. The governmental health-care system extends from the central national level to provincial, district and sub-district levels, the grassroots service providers being subdistrict health centres or primary care units (PCUs). Financial responsibility to provide services rests on government in the public sector and private employers in the private sector. The informal sector services are financed by the health security funds.

A well-designed four-year pilot project for introducing, implementing and evaluating integration of occupational health into PHC by using existing PHC structures was reported. The project was divided into four phases: planning, model development, implementation and expansion, and quality assurance. The study design included ex ante assessment of both the occupational health services situation (baseline survey) and the competence of PHC workers in occupational health. The implementation of pilots in 17 PCUs of eight provinces was supported by the second-level organization and the expert project group. The project was planned as a pro-active comprehensive service intervention integrated with PHC and including workers’ participation according to the ILO WISE (Work Improvements in Small Enterprise) model. The programme included preparation of practical guidelines and 5-day training courses for pilot personnel.

Evaluation of the project produced the following observations:

- The project included an initial step for making a baseline survey of the occupational health services situation in the whole country.
- A modest level of government funding was allocated to the pilot units.
- Numerous important findings on practical operation, on interacting with enterprises and other workplaces, and various levels of health system were collected.
- Special efforts were made to improve working conditions in the stone-carving industries.
- The training of PHC workers both in the substance and practice of occupational health was successful, and improvement in their competence and skills was demonstrated in both worker- and workplace-oriented activities.
- Some obstacles also become obvious, including limited financial and human resources, no advanced knowledge of occupational health, weak support from the upper levels of
health organizations, insufficient law enforcement, and inadequate use of information for preventive interventions.

- It was feasible to integrate occupational health services into Primary Care Units in Thailand.
- The Ministry of Health has decided to expand this experience to the entire PHC system in Thailand.

A special case report described the prevention of silicosis in small stone-carving industries by using the PHC approach and implementing the ILO WISE participatory method for practical interventions. Seven primary care units in seven provinces participated in the project, which consisted of drawing guidelines, training for local health officers, setting up pilot projects, providing pro-active workplace services at outpatient units for workers exposed to silica, and establishing a network between various levels of the health-care system. The conclusions of the project were that the primary care units are able to provide both workplace-oriented preventive services and worker-oriented individual occupational health interventions for silica-exposed workers. Integration of occupational health with PHC was feasible and successful.

**The Netherlands** (Dr Peter Buijs)

During the 80s and 90s The Netherlands were often called ‘The sick man of Europe’, because of the high percentages of sickness absence and work incapacity (almost 1 million for a workforce of 6 million). Therefore, during the last two decades many legal and organizational reforms were undertaken regarding social security, occupational health and the general health systems. The Working Conditions (ARBO) Act from 1981 focused on prevention.

The 1994 reform introduced the obligation for employers to take care of their employees during sick leave. They were required to contract an occupational health service (OHS). Within some years coverage rose from about 40% to more than 90%. Occupational health services are general, regional, sector or company oriented and provide comprehensive, multidisciplinary occupational health care, including primary prevention (advising employers about working conditions), helping employers manage sickness absence and offering support to employees on sick leave to return to work. 1994 also changed the OHS from exclusively not-for-profit establishments to a mixed system of profit-oriented and not-for-profit services. In 2005 the Arbo Act was liberalized, giving employers more choice and making some services voluntary or subject to agreement between social partners. This slightly diminished OHS coverage.

The social security system for work and health is regulated mainly by the Sickness Absence Act (SAA) and Work Incapacity Act. This system was also reformed substantially during the beginning of the 90s. A crucial feature of this reform was the shifting of costs of workers’ health from collective sickness absence funds to individual employers. Employers are now paying the salaries during sick leave. Starting with six weeks for companies with more than 15 employees, and two weeks for the others (1994), that period has been extended in 1996 to one year and in 2004 to two years for all companies. This has substantially increased the employers’ interest in reduction/prevention of sickness absence and premature work disability through improving working conditions, better sickness absence management, medico-social support to employees on sick leave and stimulating a return to work. Unfortunately, some employers are reluctant to employ people with a possible medical condition, despite a legal ban on medical pre-employment assessment (except for certain high-risk functions/jobs).

When after two years an employee is still not capable of work because of health problems, salary payment by the individual employer is taken over by the collective Work Incapacity Act. This requires an independent assessment of the employee’s health and functional capacity and of the employers’ efforts to facilitate work resumption e.g. by adapting specific working conditions, hours etc. The 2004 Gatekeepers Act introduced duties of employers,
employees and the OHS during the first 4-6 weeks of sick leave. All these reforms led to a dramatic decrease in the rates of sickness absence and work incapacity.

The 1994 reform caused some problems in occupational health care, such as commercialization, high turnover of occupational physicians, lack of clarity about their tasks and position, bias and ethical considerations of being too close to the (paying) employers. There is still a wide gap between primary care/general medical practice and occupational health care. This is on the agenda of the government employees, employers, and healthcare organizations. There is already a consensus about the following major problems to be addressed:

1. Little attention and expertise on work-health problems ('Blind Spot');
2. Poor coordination with occupational health care/physicians;
3. Inefficiency (waiting lists, only ‘open’ Monday till Friday, 8-17 hrs etc.)
4. Little attention for the worker’s perspective and empowerment.

Dutch workers with health problems do not have to visit a general practitioner for certification of sick leave and have mostly free access to an occupational physician, or so called ‘work health expert’. Nevertheless, they usually contact their GP first, often weeks before seeing an occupational physician. Though GPs are in a good position for early detection and intervention at work-related problems, many have that ‘Blind Spot’ for occupational health. The result is incomplete medical history, false diagnosis, inadequate therapy, referrals to health care providers with long waiting lists or without competence in occupational health; unnecessary absence from work for clinical examination, and medicalization of complaints without a medical cause, such as disturbed work relations. Combined with healthcare inefficiency, this can cause unnecessary and long sick leave, work incapacity, unemployment, loss of health and well being, and eventually even premature death.

In 1997 the Dutch Centre for Occupational Health TNO carried out a state-of-the-art study on occupational health care and general practice and presented the results to the ministers of health and labour and to the presidents of the organizations of general practitioners and occupational physicians. The study reconfirmed the existence of Blind Spot, poor cooperation and indicated obstacles and prerequisites. It also found that more than 80% of the occupational physicians and general practitioners want improvement.

Based on TNO’s research, the professional organizations agreed to a common vision, regional meetings and demonstration projects including occupational physicians in some primary health care centres. Other pilot initiatives, funded mostly by the government, included developing general or specific coordination guidelines, e.g. for fatigue and musculoskeletal disorders (including modules for cooperation between occupational physicians and general practitioners in medical curricula), an occupational history questionnaire, and a guide for workers' empowerment. However, preliminary evaluations found too little change in the daily practice of occupational and general health care providers; financial support was discontinued and most instruments were not implemented.

**United Kingdom** (Prof. Dame Carol Black)

The UK health-care system is universal and funded from taxation, free at the point of delivery, and covers the entire population. The National Health Service (NHS) is divided into primary and secondary care. Primary care is controlled by regional health authorities through primary care trusts. Primary care is the first point of contact for the public and includes GP practices, pharmacists, opticians and dentists. Secondary care is hospital care, both acute and planned.

Currently GPs have no access to occupational health services. Sixty years ago, when the NHS was founded, occupational health was not included, as it was seen to be of most value and concern to industries and businesses, and so to be paid for by employers. The current coverage of occupational health is about 30% of workers. The trend since the 1990s has
been to outsource in-house occupational health services to external contracted service units. There are no national standards for occupational health provision in the UK as yet.

The major causes of people leaving the workplace (2006 figures) are mental health problems (40%), musculoskeletal (18%), cardiovascular and respiratory diseases (8%), nervous system diseases (6%), injury and poisoning (6%) and others (22%). The overall cost of working-age ill-health is 100 billion pounds per year, and the cost of sickness absenteeism is 13 billion pounds per year. In addition, there are social problems and consequences beyond the workplace, e.g. for children in workless families.

At a time when rising dependency ratios and the effects of ever-greater global competition place huge pressures on economic and welfare systems all around the world, acting to prevent people from becoming ill at work – and supporting and rehabilitating those who do become ill – is not only crucial to the physical and mental health of the nation’s workforce, but ultimately critical to the nation’s financial health, the success of British business, the economy and the very fabric of society.

Current occupational health structures in the UK may have been right when they were created, but there is a need now to make sure that they are appropriate for the present and the future. It is time to reposition and redefine the role of occupational health as an integral part of the new public health policy for the 21st century, and to reconsider the relationship between occupational health and the NHS, especially primary care, together with the wider contribution of occupational health to the national economy.

GPs are critically important colleagues, and need to be supported to change and enlarge their attitude to work as a desirable outcome of a clinical encounter. There is now clear evidence that work is generally good for health, and therefore the benefits of work must feature more prominently in the advice that GPs give to their patients. But general practitioners cannot be expected to change without being offered significantly more support. Occupational health has a role in providing such support.

The challenge for a new paradigm of occupational Health is to examine the care pathways for working people and find new ways to support them before, during and after illness at work. This will require forging new partnerships and new ways of working across traditional boundaries. There is a need to bring together at local level anyone with interest or expertise in occupational health, to find locally tailored and ever more innovative ways to allow occupational health to make its crucial contribution to the health of the national economy.

Carol Black’s report to Government, Working for a healthier tomorrow, published in March 2008, had three key objectives:

i) preventing illness and promoting health and well-being in the workplace;
ii) early intervention for those who are employed but absent with a “sick note”;
iii) improving the health and well-being of unemployed people within the UK benefit system.

Common mental health problems causing absence from work were highlighted as a particular challenge.

The report included the following recommendations:

- Government should work with employers to develop a robust model for measuring and reporting on the benefits of investment in health and well-being.
- Employers should report at board level on staff health and well-being.
- A health and well-being consultancy service should be set up to provide employers with advice and support.
- The role of safety and health practitioners, and where present trades union safety representatives, in promoting the benefits of investing in health and well-being should be expanded.
• Practical ways should be explored to make it easier for smaller employers to establish health and well-being initiatives.

• An integrated approach to working-age health should be taken, underpinned by:
  - inclusion of occupational health and vocational rehabilitation within mainstream healthcare;
  - clear professional leadership from the occupational health and vocational rehabilitation communities to expand their remits and work with new partners in supporting the health of all working-age people;
  - clear standards of practice and formal accreditation for all providers of OH engaged in supporting working-age people;
  - a revitalized OH workforce with the development of a sound academic base to provide research and support in relation to the health of all working-age people;
  - systematic gathering and analysis of data at the national, regional and local level to inform the development of policy and the commissioning of services relating to the health of working-age people; and
  - awareness and understanding of the latest evidence on the most effective interventions developed by organizations such as the Occupational Health Clinical Effectiveness Unit.

The UK Government’s response to Black’s report, entitled *Improving health and work: changing lives*, was published in November 2008. The government accepted the broad thrust and most of the detail of the recommendations in the report. The response sets out new perspectives on health and work, improvement of workplaces, supporting people to work and measuring outcomes of the process. The new approach includes a new electronic “Fit Note”; piloting of a new “Fit for Work” service; training and education for healthcare professionals especially GPs; national standards for occupational health providers; a strategy for mental health and employment; a national centre for working-age health and well-being; and a council of occupational health. The response says: “By working together, our efforts will help us to combat social exclusion, eradicate child poverty, support our aging population and build a workforce for tomorrow. By improving health and work we will make a real difference to people’s lives.”

**United States of America** (Prof. Peter Orris)

The occupational health services in the United States of America are based on voluntary activity of the employer, but they are indirectly obligated by several OSH regulations. To comply with the OSH regulations and other standards, the employer needs expert services from occupational health services, either their own or from external units. The system has been described as a predominantly market-based fee-for-service commodity system that has little or no communication between health care facilities. There are high numbers of several types of expert services depending on the policy of the company; the most common of them are based on employers’ need to comply with OSH legislation. For example, some part is provided as a service supporting the objectives of the company’s human resource policies and development of company’s health, well-being and social objectives.

A model project to integrate occupational health into primary health services was in place at Cook County Hospital from 1978 to 2008. This model began with a grant from a labour union and continued with federal and local monies. It was based on specialty training in occupational medicine as part of internal medicine specialty training in a department of medicine at the only general public hospital in Chicago. Over the years the hospital became the centre and tertiary care hub of a network of three hospitals (a community). The need of the enterprise to deal with issues of workmen’s compensation are also considered.
These facilities cared for a substantial portion of poor, immigrant and minority inhabitants, providing around 15% of health care to the population of Chicago. The occupational health services provided employer-independent evaluations, workers’ compensation reports and testimony for workers with occupational disabilities and people concerned about exposures at work and home. In addition, a group of patients with chronic occupational diseases were followed over a period of years, including those with chronic obstructive pulmonary disease, asthma, pneumoconiosis and chronic metal intoxications. The group of physicians, nurses and industrial hygienists employed by the county government provided educational seminars as well for the primary care physicians, occupational health nurses and medical practitioners, community and labour union groups, and also consultations to industry, labour unions, local, state and national governments. This successful project was closed a year ago due to selectively applied budget cuts.

Conclusions

The meeting participants discussed and agreed upon the following conclusions and recommendations:

1. The working population, like any other subpopulation, has the right to the highest attainable standard of physical and mental health. This right should not be limited to conditions of formal employment. Almost half of the working population do not have formal employment and are exposed to risks in the course of their work. Occupational health is needed not only to increase their productivity but also to allow them to fully exercise their right to health and to favourable working conditions.

2. The health of workers is an essential prerequisite for societal productivity, and therefore services to protect and promote workers’ health contribute to overall economic and human development.

3. Insufficient connections between the world of health and the world of work may jeopardize the health and well-being of the working population. There is a gap in the public policies for health and labour, and this requires strengthening the collaboration between both sectors. There are some good examples of establishing institutional arrangements for such collaboration.

4. Up to now primary care development has not paid much attention to the specific health needs of workers. The development of health systems does not take sufficient account of the needs of the working populations as opposed to other high-risk populations.

5. The ongoing process of renewing PHC and reforming health systems provides an opportunity to rethink and scale up the provision of health services to the working population. Failure to consider the health needs of workers may have long-term unfavourable consequences for public health.

6. PHC development can improve workers’ health by providing basic occupational health services, referral services and specialized occupational health services to more people than by traditional ways. There are a number of suitable models depending on the characteristics of the working population and the types of health systems in the countries.

7. It is feasible to integrate the provision of occupational health services and primary care. This has already been done widely in a number of countries as demonstrated by the cases presented at the meeting. Policy support, capacity building, worker participation and adequate resources are key factors for the success of such horizontal integration.

8. The renewal of PHC is a process that allows for integration of occupational health at the primary, secondary and tertiary levels of health service delivery. This process is undertaken step by step; it may start with promotional activities and then move on to service provision.
9. Providing comprehensive health care at the primary level requires an occupational health component. This is an important tool also to address the social determinants of health at working age.

10. Good occupational health can stimulate the development of PHC and health systems strengthening. It can reduce the disease burden and provide opportunities to improve public health and to implement essential health interventions, e.g. tobacco control and HIV prevention and treatment.

11. Furthermore, providing occupational health services to all workers contributes to achieving the goals of equity and universal coverage and brings prevention and promotion to primary care.

12. The majority of workers, such as those in the informal economy, are not covered by occupational health services and even not with general health care services. The increasing mobility of workers requires new solutions, such as networking, for providing these services. Workplace-based services do not provide complete solutions. A complementary territorial approach to providing health services to workers could overcome this problem.

13. Strong public policies, infrastructure, competent human resources and adequate financing mechanisms are features common to all countries that have achieved satisfactory coverage of and access to occupational health services.

14. Improving the training of primary care providers in the area of occupational health and employment-related health aspects is an essential first step in integrating occupational health and primary care.

15. Research on organizing occupational health services and their integration with PHC should be strengthened in order to provide sufficient evidence for implementation of the WHO strategies in this field.

**Recommendations**

1. PHC policies should take into account workers’ health needs and are particularly well placed to reach out to workers not covered by the current occupational health services.

2. Models and good practices for provision of PHC-based occupational health services which were described at the meeting should be systematically analysed and disseminated. Specific recommendations will be developed on integrating occupational health and primary care, through regional meetings and reviews of experiences.

3. The broad spectrum of stakeholders should be engaged in the discourse on PHC and occupational health, and governments need to take responsibility and be accountable for addressing workers’ health, including inequalities.

4. Policy development at the national level should be stimulated through particular efforts by ministries of health to improve PHC and develop it further, taking into consideration the health needs of the working populations.

5. At the local level there is a need to improve the performance of primary care services in addressing the health needs of workers, including:
   - developing models and standards for providing occupational health services under the primary care centres and community health services;
   - building human resource and institutional capacities of primary care for addressing the specific health needs of workers;
   - establishing mechanisms for intersectoral collaboration on providing health services to all workers;
   - enhancing the participation of workers and working communities in the planning,
implementation and evaluation of health services.

6. Ministries of health have a very important role to play in protecting and promoting the health of all workers by integrating occupational health services into primary care and placing emphasis on primary prevention, including:
   - developing PHC-based systems and structures that address the specific health needs of working populations with emphasis on prevention and promotion;
   - establishing national centres of excellence and capacities for preventing and mitigating work- and employment-related health problems;
   - developing human resources for occupational health;
   - coordinating with other governmental agencies;
   - providing for participation of workers and social partners in the development of policies regarding workers’ health;
   - stimulation and funding of research needed for implementing the WHO strategies in this field.

7. Other stakeholders, such as labour and social security, as well as the social partners, should be fully engaged in the discourse on providing PHC-based services to all workers, e.g. through a global stakeholder forum to be convened by WHO in October 2009.

8. The lessons learned from developing PHC since 1978 and the reasons for failures with regard to workers’ health should be further examined.

9. Success stories on how workers’ health can be improved using PHC approaches should be identified and disseminated.

10. Mechanisms and procedures should be established to take into account work-related health issues at the first point of contact of individuals and communities to the health system.

11. The experience of the participating countries in integrating occupational health and primary care should be systematically described and made widely available.

12. Mechanisms for intercountry collaboration, exchange of experience and joint research should be established at the regional and global levels.

13. WHO, ILO and other international organizations, including international professional NGOs (nongovernmental organizations), the International Commission on Occupational Health and Wonca (World family doctors Caring for people), are urged to provide coherent support to national policymakers to integrate occupational health in the policies for PHC.

14. WHO is invited to establish an international working group to develop concrete recommendations for integrating occupational health in the policies for PHC based on the available evidence, good practices and lessons learnt.

Annex 1. Scope and purpose
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Annex 1

Scope and purpose

Workers constitute one-third of the world's population, and their health is an essential prerequisite for productivity and economic development. There is growing evidence that the health of workers is determined not only by occupational hazards but also by social and employment conditions, individual behaviours and access to health services. Yet only 15% of the global workforce, primarily in big enterprises in developed countries, has some access to occupational health services. Though highly effective occupational health interventions exist, their power is not matched by the ability of health systems to deliver them to those in greatest need, in a comprehensive way and on an adequate scale. Therefore, coverage and quality of occupational health services should be improved by integrating their development into national health strategies, health-sector reforms and plans for improving health systems performance.

The Alma-Ata Declaration on Primary Health Care of 1978 emphasized the importance of bringing health care as close as possible to "where people live and work". Furthermore, Resolution 60.26, "Workers' Health: Global Plan of Action", adopted by the World Health Assembly in 2007, urged Member States "to work towards full coverage of all workers, including those in the informal economy, micro, small and medium sized enterprises, agriculture and migrant and contractual workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries".

Following the World Health Report 2008, Primary Health Care: Now More than Ever, the 124th Session of the World Health Organization (WHO) Executive Board recommended that the World Health Assembly urge Member States to take a number of actions to strengthen health systems based on primary health care (PHC). This includes inter alia the following: (i) ensuring political commitments to the values and principles of PHC enshrined in the Alma-Ata Declaration; (ii) accelerating action towards universal access to PHC by developing comprehensive health services as well as national equitable and sustainable financing mechanisms; (iii) putting people at the centre of health care by adopting, as appropriate, delivery models focused on the local and district levels that provide comprehensive PHC services; and (iv) ensuring that vertical programmes, including disease-specific programmes, are developed and implemented in the context of integrated PHC.

The 2008 report of the WHO Commission on Social Determinants of Health further emphasized the need to address health inequalities related to employment conditions and social protection. This includes access to general health and occupational health services as well as the related system for social security. An additional critical issue to be considered is how to facilitate participation of workers in developing and implementing policies and programmes for protecting and promoting their health. The 62nd World Health Assembly in May 2009 is expected to adopt a resolution on reducing health inequities through action on social determinants of health. This resolution would emphasize the need to take health equity into account in national policies that address social determinants of health, including employment, to strengthen intersectoral collaboration, to involve all partners and to empower individuals and groups to improve societal conditions that affect their health.

In 2006, the 95th International Labour Conference adopted the Promotional Framework for Occupational health and Safety Convention No. 187. It requires the development of national occupational safety and health (OSH) systems, including basic occupational health services. Convention No. 161 on occupational health services sets specific requirements for the establishment and functioning of such services.
These policy developments require full integration of workers’ health issues and occupational health services into strategies for reforming PHC. There is also a need to reconsider the provision of occupational health services in the light of new employment patterns and with a view to reduce inequities in workers’ health. In order to respond to the needs of the working population, strategies for developing PHC should consider the following:

1) **Universal coverage:** The majority of workers, particularly in the informal sector, are not covered by occupational health services. This requires an integrated response by health and social protection systems that can only be achieved by applying a PHC approach.

2) **Territorial dimensions of service delivery:** Nowadays, work has become temporary and geographically disperse and workers are not anymore attached to a traditional workplace. The place of residence as well-defined location with its primary care centre becomes the hub for provision of occupational health services.

3) **Intersectoral collaboration and participation:** Intersectoral collaboration takes place at the territorial level, and therefore working with other sectors is an essential element of PHC reforms to address workers’ health.

4) **Emphasis of preventive over curative care:** In many countries a curative approach to the worker health is still widespread, and the scope of occupational health programmes is reduced to registration and compensation of occupational diseases and injuries. The strategy of PHC provides an opportunity to reinforce disease prevention and promotion of occupational health.

Some countries have successfully integrated occupational health interventions into the practice of PHC and other measures of social protection. The lessons learned would be useful for other countries that are currently reforming their health systems and are facing the challenge of reducing inequities and ensuring access of all workers to occupational health.

Therefore, the Government of Chile in collaboration with the WHO is convening this consultation with the aim of outlining strategic directions for integrating occupational health and PHC. In particular the consultation will discuss how to apply the values and principles of PHC, including equity, solidarity, social justice, universal access to services, multisectoral action and community participation to strengthening the performance of health systems in responding to the specific health needs of workers.

The deliberations of the consultation will allow countries to develop strategies for PHC at the workplace and to take action to strengthen the performance of health systems for workers.
Annex 2

Primary health care and workers' health

Backgrounder document

Purpose of this document
This document has been prepared as background information on the main concepts to be discussed during the intercountry consultation “Integration of Workers’ Health in the Strategies of Primary Health Care” to be held 4–7 May in Santiago, Chile. It describes the main aspects of primary health care (PHC), occupational health services, health systems and occupational safety and health (OSH) systems set forth in the World Health Organization (WHO) and International Labour Organization (ILO) documents and provides a rationale for using the values and principles of PHC for achieving the goal of health for all workers.

Primary health care
The Alma-Ata Declaration of 1978 defined PHC as follows:

“Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health-care process.”

Put simply, it is aimed at ensuring that everyone, rich and poor, is able to enjoy the services and conditions necessary for realizing the highest level of health. It includes organizing health systems to provide quality and comprehensive health care to all, while ensuring that the poor and other disadvantaged people have fair access to essential health services. PHC mobilizes society and requires community participation in defining and implementing health agendas, and underscores intersectoral approaches to health. Most important, PHC ensures that national health development is an integral part of the overall social and economic development of countries.¹ PHC is not poor care for the poor.

Primary care is a component of PHC and usually refers to the first level of contact people have with health-care teams. In some countries this may be a community health worker or midwife; in others, a family practitioner.

PHC has been implemented and expanded in many countries and has shown good results, especially where commitment is strong and investment sustained. Moreover, everywhere PHC has thrived, the state has played a major role and civil society has been an important driving force. In other countries, where investment is meagre or nonexistent, results have

¹ Equity in health (health status) means the attainment by all citizens of the highest possible level of physical, psychological and social well-being. Equity in health care means that health-care resources are allocated according to need; health care is provided in response to legitimate expectations of the people; health services are received according to need regardless of the prevailing social attributes; and payment for health services is made according to the ability to pay.
been poor. In many parts of the world, structural adjustment programmes, sharp reductions in public spending, political instability, lack of political will, too few health workers, and the late 1970s and 1980s focus on medical training and medical models of care for disease limited PHC expansion.

The Alma-Ata Declaration occurred at a time of global dissatisfaction with health services and also of great health challenges. Soon after, many international agencies sought early, tangible results rather than the fundamental, political changes implied by the original concept of PHC. “Selective” PHC and packages of low-cost interventions or disease-specific initiatives to tackle specific health problems took centre stage. While achieving health for many, these approaches had a detrimental effect on the goal of access to health services for all.

Health status and access to health services varies from country to country, and these disparities are increasing. The differences are not biological but depend largely on the socioeconomic environment. Countries are calling for a radical shift in global health policy based on a PHC approach to meet today’s health problems.

The 2008 report by the Commission on Social Determinants of Health documents these inequities both within and between countries, and clearly explains how urgent addressing them is for the survival and well-being of millions of people everywhere. The cost of seeking health care is no less difficult. Every year, more than 100 million people in both rich and developing countries are driven into poverty due to the direct costs of health care.

Health systems are to blame. They have become fragmented, subject to unregulated commercialization, and focused on tertiary or specialized services. Today, chronic diseases are the biggest killer and pose the greatest challenges. The health gains of recent decades mean that people are living longer, and consequently have more and different health needs. Climate change, disasters, political instability, the threat of pandemics and emerging diseases create new pressures. People increasingly expect more from health services, but health-care costs can be catastrophic. Strengthening health systems based on a revitalized approach to PHC is seen as a critical response to these widespread challenges.

The concepts of PHC as they were expressed 30 years ago are still valid today. The World Health Report (WHR) of 2008 outlined four sets of reforms to make health systems more responsive to social change and to rising expectations. In particular, these reforms will

- ensure that health systems contribute to health equity, social justice and the end of exclusion, primarily by moving towards universal access and social health protection;
- reorganize health services as primary care, i.e. around people’s needs and expectations, so as to make them more socially relevant and more responsive to the changing world while producing better outcomes;
- secure healthier communities, by integrating public health actions with primary care and by pursuing healthy public policies across sectors; and
- replace disproportionate reliance on command and control on the one hand and laissez-faire disengagement of the state on the other through the inclusive, participatory, negotiation-based leadership required by the complexity of contemporary health systems.

More money is being spent on health than ever before. Health expenditure is growing faster than the rest of the economy and faster than population. In many places, these resources need to be better spent. In others, more investment – allocated properly – is essential to see improvements in health and health services. Most countries have the ability themselves to start implementing the reforms required for PHC based on existing capacity. The poorest countries will require additional support and funds to “renew PHC”.

Having stronger health systems based on a PHC approach that provide equitable services to all will maximize the benefits of disease-specific programmes, reach those who have not yet
been reached, and help people meet their various health needs and throughout their life – not just for a single disease or a one-time health problem.

**Occupational health services**

The Joint ILO/WHO Committees on Occupational Health defined the following objectives of occupational health:

- promoting and maintaining workers’ health and work ability;
- improving work and the working environment and work so it is conducive to safety and health;
- steering work organization and culture in a direction that supports health and safety and, in so doing, also promotes productivity of an enterprise.

**Occupational health practice** refers to multidisciplinary and multisectoral activity involving occupational health and safety specialists and other specialists both in the enterprise and outside, as well as competent authorities, employers, workers and their representatives. This involvement requires a well-developed and well-coordinated system at the workplace. The necessary infrastructure should comprise all the administrative, organizational and operative systems that are needed to successfully conduct the occupational health practice and ensure its systematic development and continuous improvement.

**Occupational health services** are those entrusted with essentially preventive functions and responsible for advising employers, workers and their representatives on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work.

ILO Convention No. 161 specifies that occupational health services should include those of the following functions that are adequate and appropriate to the occupational risks at the worksite:

- identifying and assessing the risks from health hazards in the workplace;
- surveillance of the factors in the working environment and working practices which may affect workers’ health, including sanitary installations, canteens and housing where these facilities are provided by the employer;
- advice on planning and organization of work, including the design of workplaces, on the choice, maintenance and condition of machinery and other equipment, and on substances used in work;
- participating in the development of programmes for the improvement of working practices, as well as testing and evaluation of health aspects of new equipment;
- advice on occupational health, safety and hygiene, and on ergonomics and individual and collective protective equipment;
- surveillance of workers’ health in relation to work;
- promoting the adaptation of work to the worker;
- contributing to measures of vocational rehabilitation;
- collaborating in providing information, training and education in the fields of occupational health and hygiene and ergonomics;
- organizing first aid and emergency treatment;
- participating in analysis of occupational accidents and occupational diseases.

The 60th World Health Assembly (WHA), held in 2007, stressed that the health of workers is determined not only by occupational hazards but also by social and individual factors, and access to health services. The concern is that, despite the existence of interventions for primary prevention of occupational hazards and for developing healthy workplaces, there are major gaps between and within countries in the exposure of workers and local communities to occupational hazards and in their access to occupational health services. Therefore the Health Assembly urged WHO Member States “to work towards full coverage of all workers, including those in the informal economy, small- and medium-sized enterprises, agriculture,
and migrant and contractual workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries”.

The 2007 WHA endorsed the WHO Global Plan of Action on Workers’ Health 2008–2017. This plan deals with all aspects of workers’ health, including primary prevention of occupational hazards, protection and promotion of health at work, employment conditions and a better response from health systems to workers’ health. It is underpinned by certain common principles. All workers should be able to enjoy the highest attainable standard of physical and mental health and favourable working conditions. The workplace should not be detrimental to health and well-being. Primary prevention of occupational health hazards should be given priority. All components of health systems should be involved in an integrated response to the specific health needs of working populations. The workplace can also serve as a setting for delivering other essential public-health interventions, and for health promotion. Activities related to workers’ health should be planned, implemented and evaluated with a view to reducing inequalities in workers’ health within and between countries. Workers and employers and their representatives should also participate in such activities.

One of the objectives of this plan of action is to improve the performance of and access to occupational health services. It states that coverage and quality of occupational health services should be improved by:

- integrating their development into national health strategies, health-sector reforms and plans for improving health systems performance;
- determining standards for organization and coverage of occupational health services;
- setting targets for increasing the coverage of the working population with occupational health services;
- creating mechanisms for pooling resources and for financing the delivery of occupational health services;
- ensuring sufficient and competent human resources; and establishing quality assurance systems.

Basic services for occupational health should be provided for all workers, including those in the informal economy, small enterprises and agriculture.

Core institutional capacities should be built at national and local levels to provide technical support for basic occupational health services, in terms of planning, monitoring and quality of service delivery, design of new interventions, dissemination of information and provision of specialized expertise.

Development of human resources for workers’ health should be strengthened by:

- further postgraduate training in relevant disciplines;
- building capacity for basic occupational health services;
- incorporating workers’ health in training PHC practitioners and other relevant professionals;
- creating incentives for attracting and retaining human resources for workers’ health, and encouraging the establishment of networks of services and professional associations.

Attention should be given not only to postgraduate but also to basic training for health professionals in various fields, such as promotion of workers’ health and the prevention and treatment of workers’ health problems. This should be a particular priority in PHC.

The WHA requested WHO to provide guidance to the Member States for developing basic packages, information products, tools and working methods, and models of good practice for occupational health services. WHO is also expected to stimulate international efforts for building the necessary human and institutional capacities.
Health system

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes e.g. a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns; health insurance organizations; and occupational safety and health. It includes intersectoral action by health staff e.g. by encouraging the ministry of education to promote female education, a well-known determinant of better health.

To achieve their goals, all health systems must carry out some basic functions, regardless of how they are organized: they have to provide services; develop health workers and other key resources; mobilize and allocate finances, and ensure health system leadership and governance (also known as stewardship, which is about oversight and guidance of the whole system). For the purpose of clearly articulating what WHO will do to help strengthen health systems, the following six essential “building blocks” have been defined; all are needed to improve outcomes:

- Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with a minimum waste of resources.
- A well-performing health workforce is one that works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (i.e. there are sufficient staff, fairly distributed; they are competent, responsive and productive).
- A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status.
- A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- A good health-financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. It provides incentives for providers and users to be efficient.
- Leadership and governance involves ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system design and accountability.

The best measure of a health system’s performance is its impact on health outcomes. International consensus is growing: without urgent improvements in the performance of health systems, the world will fail to meet its health-related goals. As health systems are highly context-specific, there is no single set of best practices that can be put forward as a model for improved performance. But health systems that function well have certain shared characteristics. They have procurement and distribution systems that actually deliver interventions to those in need. They are staffed with sufficient health workers having the right skills and motivation. And they operate with financing systems that are sustainable, inclusive, and fair. The costs of health care should not force impoverished households even deeper into poverty.

National occupational safety and health system

The ILO Promotional Framework for Occupational Safety and Health Convention No. 187 of 2006 requires establishing a national system for occupational safety and health in consultation with the most representative organizations of employers and workers. Such a
system should be maintained, progressively developed and periodically reviewed. The national system for occupational safety and health (OSH) shall include, among others:
- laws and regulations, collective agreements where appropriate, and any other relevant instruments on OSH;
- an authority or body, or authorities or bodies, responsible for OSH designated in accordance with national law and practice;
- mechanisms for ensuring compliance with national laws and regulations, including systems of inspection; and
- arrangements to promote, at the level of the undertaking, cooperation between management, workers and their representatives as an essential element of workplace-related prevention measures.

The national system for occupational safety and health shall include, where appropriate:
- a national tripartite advisory body, or bodies, addressing OSH issues;
- information and advisory services on OSH;
- the provision of OSH training;
- occupational health services in accordance with national law and practice;
- research on OSH;
- a mechanism for collecting and analysing data on occupational injuries and diseases, taking into account relevant ILO instruments;
- provisions for collaborating with relevant insurance or social security schemes covering occupational injuries and diseases; and
- support mechanisms for progressive improvement of OSH conditions in micro-enterprises, in SMEs and in the informal economy.

Workers’ health and PHC

Workers represent one-third of the world population. A healthy workforce is an essential prerequisite for productivity and economic development. Every year about 160 million new cases of occupational diseases and more than 2 million deaths are caused by work. For many workers and their families, the workplace is the only means of access to health care. Yet only 15% of workers in the world are covered with some occupational health services. The economic losses from the lack of OSH are estimated to be around 4% of GDP.

There have been previous efforts by WHO and by countries to integrate occupational health and primary care. Most of these efforts were targeted to reforming service delivery and incorporating some occupational health interventions into delivery of primary care. The experience demonstrated that it is difficult to change the delivery of services without applying a health systems approach to assess the performance of the different building blocks of the health system with regard to workers’ health – governance and stewardship, information provision, human resource generation, financing and purchasing of services, working methods, and technology and service delivery. There is a growing recognition that programmes specific to one public health area or targeted at a specific sub-population are likely to result in health gains in a short run. However, when detached from PHC, such programmes are likely to become unsustainable in the long run when resources become scarce or when political attention shifts to another issue.

The renewal of the PHC movement provides political momentum to scale up occupational health services using PHC principles and values. These include equity, solidarity, social justice, universal access, multisectoral action and community participation, and they are very close to and overlap with the values and principles for action on workers’ health as outlined in the WHO Global Plan of Action on Workers’ Health 2008–2017.

Applying a PHC framework to workers’ health would require a number of elements that are interconnected as well as concurrent action across all building blocks of the health system.
1. Universal coverage and access

Universal coverage implies that financing and organizational arrangements are sufficient to cover the entire working population. This requires removing the ability of workers or employers to pay as a barrier to access to occupational health services.

Accessibility means the absence of geographic, financial, organizational, sociocultural and gender-based barriers to care. For example, migrant workers or workers in remote areas have no access to occupational health services. In other cases occupational health services are provided in a language that workers can't understand.

Acceptability determines whether people will actually use services, even if they are accessible. Workers may refrain from using occupational health services because they don’t trust the providers paid by the employers and because they may fear that their health status will jeopardize their employment.

2. First contact

This means that primary care should serve as a main entry point to the health system for all new health problems and the place where the majority of them are resolved. In some countries and in some settings occupational health services are fulfilling this role, particularly if workers have no access to other health providers, e.g. mining communities.

3. Comprehensive, integrated and continued care

Comprehensive, integrated and continuing care means that the range of services available must be sufficient to provide for population health needs, including the provision of promotion, prevention, early diagnosis, curative, rehabilitative, palliative care and support from self-management. Integrated care requires coordination between all parts of the health system to ensure that health needs of the workers are met, and that prevention and treatment of occupational and work-related diseases and injuries proceeds across time and across different levels of care without interruption. For example, it is very important to ensure that the assessment of occupational health risks revealing high-risk exposures is followed by measures to reduce exposures, and to provide medical examination and referral to a specialized clinic or a laboratory.

4. Family and community-based PHC

This requires care to rely on families and communities rather than on individual and clinical perspectives. In the occupational health practice, there are programmes, such as healthy workplaces, that place emphasis on the workplace or the enterprise as a setting for delivery of essential health interventions for health protection and promotion. Some occupational health services provide also care to workers’ families and even to the whole community, such as in agricultural or mining communities.

5. Emphasis on promotion and prevention

Occupational health services are supposed to be entrusted primarily with preventative functions. Combining health protection and health promotion at the workplace is a cost-effective and ethical strategy for improving the health of workers. It allows working communities and individuals to gain greater control over their health. Employers, managers and workers have an important role in developing and sustaining a culture of prevention at the workplace.

6. Appropriate care

Occupational health services should be centred on the person and the work community rather than on a particular occupational disease, e.g. silicosis, or a particular risk factor, e.g. safety. The worker has multiple health needs; so does the working community in an enterprise or a farm. Occupational health care should be based on the effectiveness of
interventions, considering efficiency. It should meet the common needs the entire working community, while addressing the specific needs of a particular subset of the working population, e.g. high-risk or vulnerable groups.

7. Active participation mechanisms

Such mechanisms guarantee transparency and accountability at all levels. This might include actions that empower workers to better manage their own health and that stimulate the ability of workers and employers to become active partners in setting health policy, and in management, evaluation and regulation. Traditionally this applies to the area of OSH.

8. Sound policy, legal and institutional framework

Occupational health practice should be based on national legislation and regulations for OSH. Regulations should identify and empower the actions, actors, procedures and legal and financial systems that allow occupational health services to perform their specialized functions.

9. Pro-equity policies and programmes

Such programmes aim to ameliorate negative aspects of social inequalities and to address their underlying causes. To implement pro-equity programmes regarding workers’ health requires measures in several directions: (1) increasing or improving occupational health services to those in greatest need, e.g. workers at high occupational risk of disease or injury, agricultural, construction and mining workers, informal economy and migrant workers; and (2) restructuring financing mechanisms to aid disadvantaged and underserved workers, e.g. by creating financial mechanisms to provide occupational health services in low-income or remote settings, pooling together resources for the provision of occupational health services, e.g. insurance schemes and cooperatives.

10. Appropriate human resources

This includes providers, community workers, managers and support staff with the right knowledge and skills mix, who observe ethical standards and treat people with dignity and respect. Traditional occupational health services are usually staffed by multidisciplinary teams. However, it is impossible to provide services to all workers. It is necessary to plan and build human resource capacities for the provision of basic occupational health services according to the specific needs of the working populations they serve.

11. Adequate and sustainable resources

Resources should be determined by analysing the situation of workers’ health by enterprise, geographic and sectoral level data and include inputs (e.g. facilities, personnel, equipment, supplies, lab tests etc.) as well as operating budgets necessary to provide comprehensive, high-quality preventive and if necessary curative occupational health care.

12. Intersectoral actions

Workers are in all sectors, both economic and service. Therefore, a PHC approach to protecting and promoting their health requires collaboration between all sectors concerned at the national and local levels.

Bibliography

World Health Organization, Primary health care: questions and answers, WHO media center, Geneva, 13 October 2008
Annex 3

Guidance for presenting country experience

Presentations of country experience at the meeting will aim at highlighting the lessons learned from different countries in using the values and principles of primary health care (PHC) for the provision of occupational health services. As such they should tell the story of occupational health services in the country from the perspective of PHC. The questions below are to help countries in preparing the presentation of their experience. Country reports will be prepared after the meeting based on agreed criteria and set of questions.

Terminology

A variety of terms and meanings are used with regard to PHC and occupational health services. In order to achieve a certain degree of common understanding, the following terms will be used for the purpose of this meeting:

**Occupational health services** means services entrusted with essentially preventive functions that are responsible for advising employers, workers and their representatives in the undertaking on the requirements for establishing and maintaining a safe and healthy working environment which will facilitate optimal physical and mental health in relation to work; and the adaptation of work to the capabilities of workers in the light of their state of physical and mental health (International Labor Organization, Convention No. 161). Occupational health services may also provide services for health promotion, general or specialized curative care and rehabilitation.

**Primary health care** was defined by the Alma-Ata Declaration of 1978. Put simply, it is aimed at ensuring that everyone, both rich and poor, is able to access the services and the conditions necessary for realizing the highest level of health. It includes organizing health systems to provide quality and comprehensive health care to all while ensuring that poor and other disadvantaged people have fair access to essential health services. PHC mobilizes society and requires community participation in defining and implementing health agendas, and underscores intersectoral approaches to health. Most important, PHC anchors national health development in the overall context of social and economic development of countries. PHC is not poor care for the poor.

**Primary care** is a component of PHC and usually refers to the first level of contact people have with health-care teams. In some countries this may be a community health worker or midwife; in others, it refers to the family practitioner.

Questions

Country presentations should aim at answering the following general question:

*How are the values and principles of PHC (equity, solidarity, social justice, universal access, multisectoral action and community participation) being used in your country to provide workers with occupational health services?*

Specific questions to highlight experience with occupational health services from a PHC perspective include:

1. What is the policy for workers’ health or occupational health and safety in your country? How is the provision of occupational health services included in this policy?

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2 *Equity in health* (health status) means the attainment by all citizens of the highest possible level of physical, psychological and social well-being. *Equity in health care* means that health-care resources are allocated according to need; health care is provided in response to legitimate expectations of the people; health services are received according to need regardless of the prevailing social attributes; and payment for health services is made according to the ability to pay.
2. What is the regulatory basis providing occupational health services in your country? Who is responsible for planning, service delivery and control.

3. How are occupational health services financed? Where do funds come from? Is there any mechanism for pooling funds together? Is there any mechanism for control of purchasing and delivery of services?

4. How are services provided to high-risk work settings, small and medium size enterprises (SMEs), and agricultural and migrant workers? What are the organizational models, providers and financing?

5. What is the level of coverage of workers with occupational health services in general, both according to the law and factual? Which groups are not covered? Are there any barriers to accessing services?

6. How do workers participate in making decisions about planning, providing and evaluating services at the national, local and enterprise/workplace level?

7. What is the minimum/basic content of occupational health services – health protection, health promotion, curative care, rehabilitation, compensation? How does the content of services relate to the actual health needs of the working population?

8. What is the role of the ministry of health and provincial/local health authorities in providing occupational health services? What is the role of the ministry of labour and what are the other main institutions involved in occupational health services?

9. How do different sectors (health, labour, mining, agriculture, industry etc.) collaborate in providing occupational health services at the national and local level? How do non-health sectors make decisions about occupational health services?

10. How do national strategies for health-sector reform address the provision of services for workers?

11. How do occupational health services link to primary care? What kinds of health services does primary care provide to workers? Who pays for these services? What are the constraints and opportunities for providing occupational health services through primary care?

12. What mechanisms are in place to stimulate linkages between occupational health services and primary care, e.g. financial incentives, common governance, training of primary care workers?

13. What measures are planned to scale up the coverage and quality of occupational health services in your country?

14. Based on the experience of your country, what would you recommend to other countries about providing occupational health services? What would you not recommend?
Annex 4

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