Editorials

Primary health care:

what role for occupational health?

Recently, the World Health Organization (WHO) published the outcomes of a Conference *Connecting Health and Labour: what role for occupational health in primary health care?* (The Hague Conference).[1] This editorial considers the context for this conference and whether the outcome has the potential to change our global approach to the health of workers.

Of the global population, 70% have access to some form of primary health care. While this is in itself a concern, it is a much more encouraging picture than access to occupational health care, where globally only 10–15% of workers have such access, and often this does not include those most in need.[2] In order to improve occupational healthcare access it seems reasonable to consider whether primary health care may provide the setting for developing basic occupational healthcare provision. This was the focus of the The Hague Conference, co-organised by TNO Work and Health and the Dutch Ministries of Health and Labour. The meeting in The Hague was an international first of its kind, bringing together experts from governments, health care, finance, and employers, and labour organisations, including the presidents of the two global academic bodies of primary health care and occupational health care, World Organization of National Colleges, Academies, and Academic Associations of General Practitioners/Family Physicians (WONCA) and the International Commission on Occupational Health (ICOH).

HEALTH DETERMINANTS

Social factors such as work, employment, and economic status are important health determinants,[3] and 'having a job' reflects an individual's ability to function as a part of their overall health status.[4] In turn, the ability to continue to function and be productive influences the economic wellbeing of individuals, families, communities, and populations. Work provides income, social contacts, and resources to meet health needs, enhances self-esteem, and is a crucial prerequisite for health and wellbeing.[5] Employment and health are inextricably linked, and giving this appropriate attention is vital for society and for individuals. Health professionals need to give suitable consideration to work outcomes and to managing chronic health conditions to optimise functional capacity.[6]

At the same time, work can be harmful also: annual WHO/International Labour Organization (ILO) global figures[7] on occupational and work-related diseases and injuries highlight the damaging, or even fatal, consequences of unhealthy and unsafe work. A quarter of European Union workers find health and safety a risk, and annually report increasing work intensity levels.[7] These aspects are realities for about half of the global population (including the informal economies worldwide), who spend daily at least 8 hours, and often much more time, working. From a health viewpoint this requires prevention and control of work-related diseases and injuries: the traditional occupational healthcare mission.

INTEGRATING OCCUPATIONAL HEALTH CARE AND PRIMARY HEALTH CARE

These challenges formed the background of the discussions, which focused on four topics: universal coverage; people-centred care; participatory leadership; and health in all policies. Throughout, the experts found common ground between primary health care and occupational health care, and a set of principles were formulated to address the health of workers more effectively (Box 1). The Hague Conference summary outlines the strategy to reach more workers by integrating basic occupational health care within primary health care.[1] Important elements include:

- training primary healthcare professionals to recognise early work-related ill-health, to advise about improving working conditions and health-at-work, to support return-to-work, and preserve and restore working capacity;
- linking primary healthcare centres and occupational healthcare services under local primary care networks and providing joint training, referral systems, and occupational information to foster collaboration and continuity of care;
- financial arrangements for human and technological capacity, including development of work-related guidelines;
- the setting of a research agenda and promotion of good practices; and
- developing national plans for the health of workers, involving professionals of primary health care and occupational health care, and key stakeholders in the society. Governments should guarantee access to care, allowing for a full, productive working life.

The Hague Conference is part of a global process to improve occupational healthcare coverage as requested by the World Health Assembly 2007.[2] The results provide input to national debates about healthcare reforms based on primary healthcare values, that should improve service delivery and ensure equity, through better connection between health and labour sectors, prevention, and care.

The idea to address the impact of work and work environment on health as a shared primary health care–occupational health care responsibility was already included in the WHO 1978 Alma Ata Declaration;[8] to bring primary health care as close as possible to where people live and work. However, the reality has been that primary health care and occupational health care have remained disconnected worldwide.[9] Some countries, for example the Netherlands, have achieved almost full employee occupational healthcare coverage. But the poor integration into mainstream personal health care comes at a high price: an estimated €2 billion annually could be saved when general

Box 1. Principles for integrating occupational health care into primary health care

- The health of workers is part of general health and life
- Health systems should facilitate local strategies to meet health needs of workers
- In moving towards universal occupational healthcare coverage, target first individuals at greatest risk or need
- Involve all relevant stakeholders when developing policies about the health of workers
- Training in health and work should be part of all healthcare professionals training
- Empowering workers and encouraging decision-makers are critical for promotion of the health and safety of workers.

health care takes 'work' into account to prevent or reduce sick leave and working capacity loss.[10]

Integration faces two major problems: often occupational health care is organised as a stand-alone vertical service, resulting in loss of continuity and coordination of care, and in poor effectiveness, like other vertical programmes,[11] while primary healthcare professionals seem to have (developed) a 'blind spot' for work-related aspects of health problems,[12] overlooking 'salutogenic' as well as negative work effects.

By making work-related functioning part of the management and treatment of health problems, integration puts primary health care in an excellent position for early detection of, and intervention in, work-related health problems, preventing long-term sick leave and work incapacity.[13] Integrated primary health care can also reach underserved workers (self-employed, migrants). Moreover, patients tend to trust GPs more than occupational physicians funded by the employer.[14]

THE FUTURE

The next steps following The Hague Conference aim to:

- develop policy options, methodologies, and integrated financing mechanisms;
- extend professional WONCA–ICOH collaboration;
- develop global occupational healthcare training material and information repositories for building capacities for primary care teams; and
- collecting, evaluating, and disseminating case studies and interdisciplinary research agenda setting.

Meanwhile, there are many encouraging developments, in particular in the UK and the Netherlands, where there are joint postgraduate primary healthcare–occupational healthcare training[12] and joint primary healthcare–occupational healthcare guidelines,[15] paying attention to impact of work, working capacity, and employment.

The Dutch College of General Practioners recently revisited its core values, stressing the importance of working conditions as part of the social context of the patient and the need to identify (imminent) work-related health problems in collaboration with occupational therapists. The Dutch College of General Practitioners' revised guidelines on depression includes many work-related aspects.

ADDRESS FOR CORRESPONDENCE

Chris van Weel
Radboud University, Department of Primary and Community Care, Nijmegen Medical Centre, 117 ELG, PO Box 9101, Nijmegen, 6500 HB, the Netherlands.

E-mail: c.vanweel@elg.umcn.nl

The UK seems to have made more progress translating theory into practice, with primary health care in the centre. Providing GPs with robust scientific evidence about links between work and health has provided a foundation to build on their role as patient advocates. GP education on work and health issues and provision of learning resources and web-based information, together with replacement of the 'sick note' with the new 'fit note', have all started to bring about a much needed shift in culture and behaviour. This has been supported by initiatives introduced following the Black Review in 2008, together with work to influence the secondary care community. Much more progress needs to be made, but it provides an example of the role primary health care can play in improving the health and wellbeing of workers.

These developments, combined with the commitments from The Hague Conference, should harness our determination to connect occupational health care and primary health care in daily practice, and to overcome professional parochialism. When the ability to work, or return to work, are addressed routinely in the management of health problems, this can improve health and reduce avoidable ill health, sick leave, work incapacity, and economic loss; equally important in both low- and middle-income and high-income countries. So we should strive together to ensure that occupational health is seen as an integral component of primary care across the world.

Peter Buijs,
Occupational Physician, TNO Work and Health, Rijswijk, the Netherlands.

Bill Gunnyeon,
Chief Medical Adviser, UK Department for Work and Pensions, London.

Chris van Weel,
Professor of General Practice, Department of Primary and Community Care, Radboud University Nijmegen Medical Centre, Nijmegen, the Netherlands

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REFERENCES

1. World Health Organization. *Connecting health and labour. What role for occupational health in primary health care?* Geneva: WHO, 2011. http://www.who.int/occupational_health/publications/hague_executive_summary/en/index.html (accessed 2 Nov 2012).
2. World Health Assembly. *WHA resolution 60.26. 'Workers' health: global plan of action'.* Geneva: WHO, 2007: 94–100. http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf (accessed 2 Nov 2012).
3. World Health Organization. *Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: WHO, 2008. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf (accessed 2 Nov 2012).
4. Huber M, Knottnerus JA, Green L, *et al.* How should we define health? *BMJ* 2011; **343:** d4163.
5. Waddell G, Burton AK. *Is work good for your health and wellbeing?* London: TSO, 2006. http://www.dwp.gov.uk/docs/hwwb-is-work-good-for-you.pdf (accessed 2 Nov 2012).
6. Weel C van, Orbon K, van der Gulden J, *et al.* Occupational health and general practice: from opportunities lost to opportunities capitalized. *Med Lav* 2006; **97(2):** 288–294.
7. Hämäläinen P, Takala J, Saarela KL. Global estimates of fatal work-related diseases. *Am J Ind Med* 2007; **50(1):** 28–41.
8. World Health Organization. *Declaration of Alma Ata.* http://www.searo.who.int/LinkFiles/Health_Systems_declaration_almaata.pdf (accessed 7 Nov 2012).
9. Beach J, Watt D. General practitioners and occupational health professionals. *BMJ* 2003; **327(7410):** 302–303.
10. Steenbeek R, Hooftman W, Geuskens G, Wevers C. *Cost of health related non-participation and the contribution of health care* (In Dutch). TNO report, March 2010. http://arbeidenzorg.com/uploads/rapport%201b%20tno%20april%202010.pdf (accessed 2 Nov 2012).
11. De Maeseneer J, van Weel C, Egilman D, *et al.* Funding for primary health care in developing countries. *BMJ* 2008; **336(7643):** 518–519.
12. Buijs PC, Weel AN, Nauta NP, *et al.* Teaching general practitioners and occupational physicians to cooperate: Joint training to provide better care for European workers. *Eur J Gen Pract* 2009; **15(3):** 125–127.
13. van Dijk PCM, Hogervorst VWG, Buijs PC, van Dijk FJH. The potential role of Dutch GPs in imminent long-lasting sickness absence. *Eur J Gen Pract* 2006; **12:** 74–76.
14. Buijs PC, TudorHart J. Why Dutch GPs do not certify – how murder helped set the course of Dutch general practice. *Br J Gen Pract* 1997; **47(425):** 860–861.
15. Buijs PC, van Dijk FJ, Evers M, *et al.* Managing work-related psychological complaints by general practitioners, in coordination with occupational physicians: a pilot study. *Ind Health* 2007; **45(1):** 37–43.