

Steps towards the integration of occupational and public health: why is it so complicated?

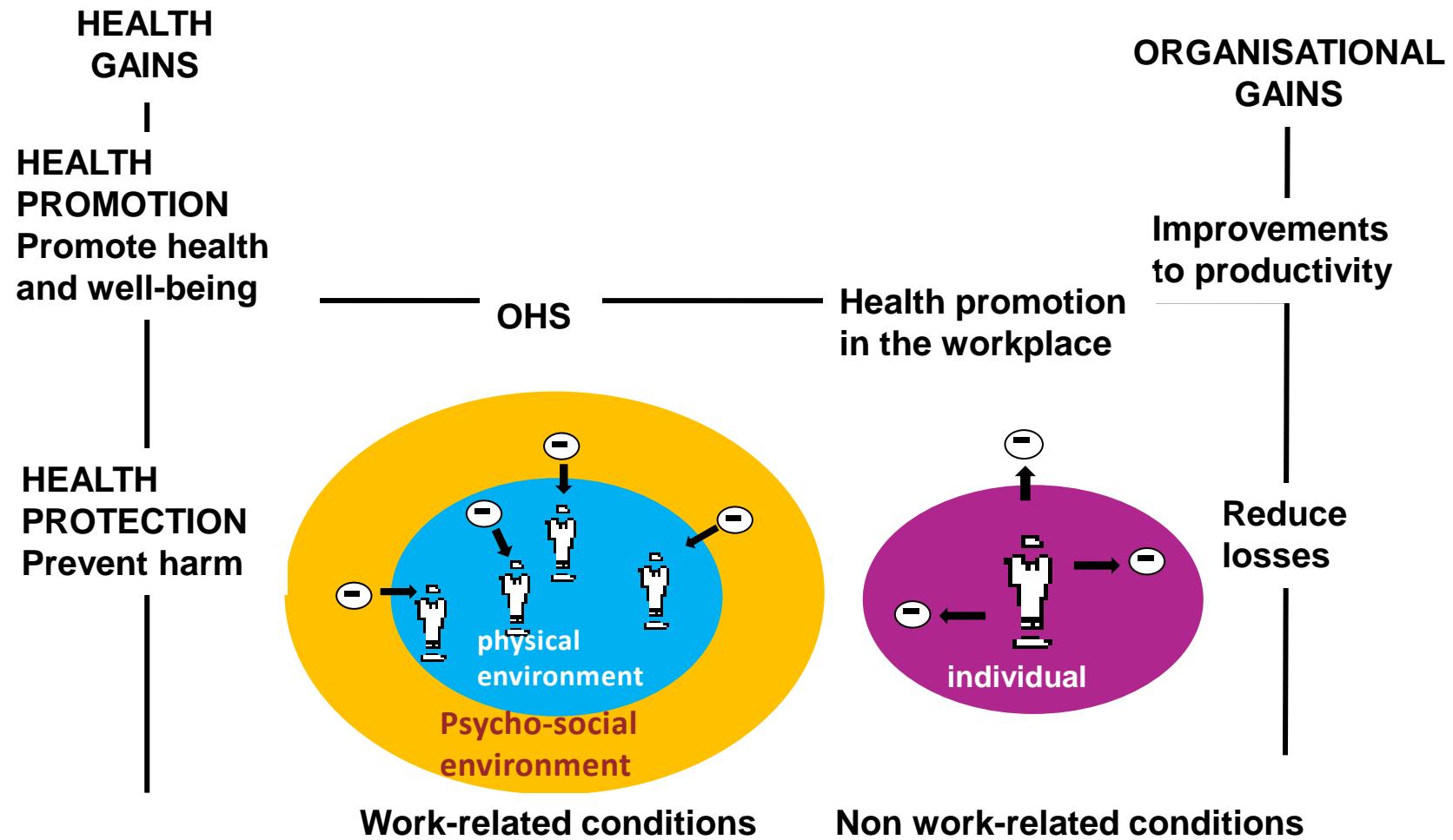
Professor Niki Ellis

WHO, Manila

March 11, 2014

1. What is the traditional OHS approach?
2. What are its limitations?
3. What is the integrated approach?
4. What are its current limitations?
5. Why has it taken so long for these concepts to be taken up?
6. How can we best implement this approach at a system level?

Traditional OHS: Injury prevention



Traditionally OHS and WHP separate

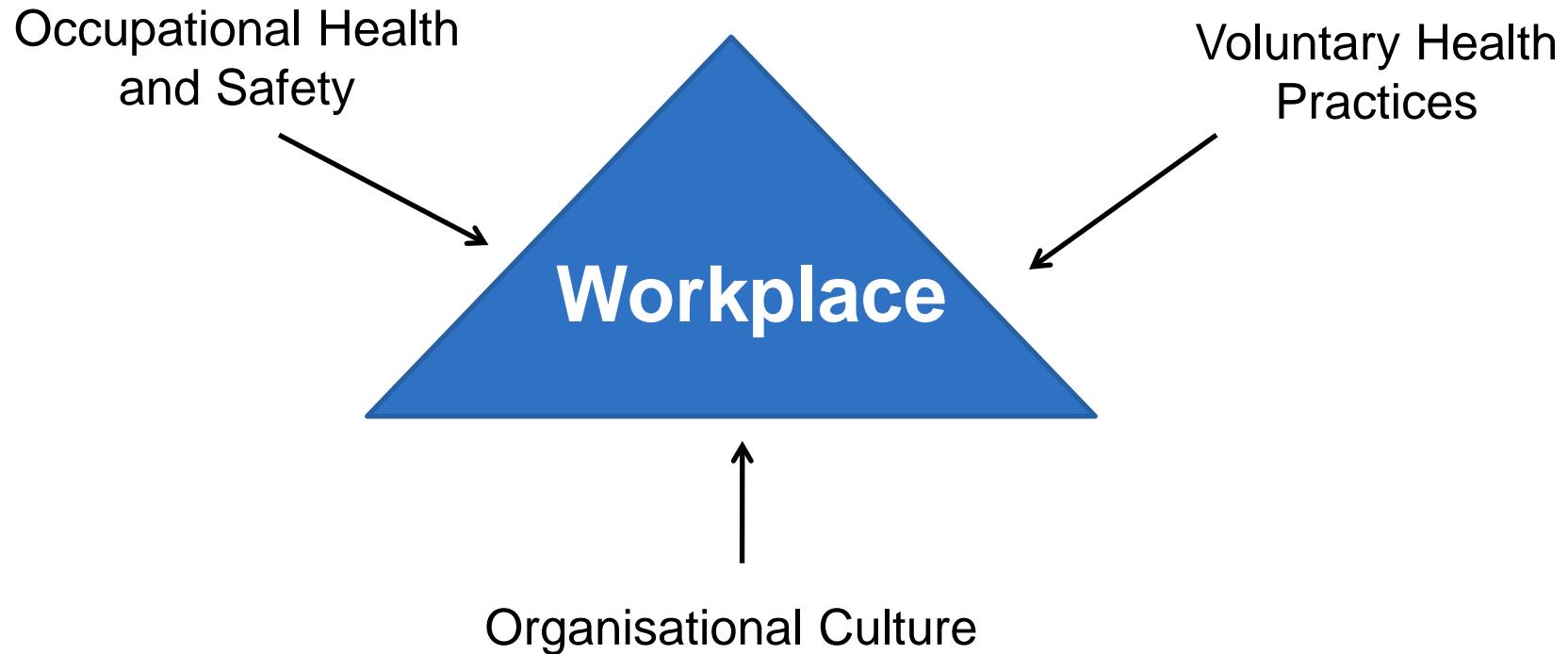
OHS

- Prevention of work-related conditions
- Health protection model (prevent injuries)
- Emphasis on workplace environmental change
- Employer responsibility
- Mandated
- Has focussed on physical risk factors, resistance to psychosocial factors

WHP

- Prevention of non work-related conditions
- Health protection model (prevent disease)
- Emphasis on individual behavioural change
- Worker responsibility, employer support
- Voluntary
- Historically focussed on disease prevention, but responding to mental wellbeing agenda more rapidly than OHS

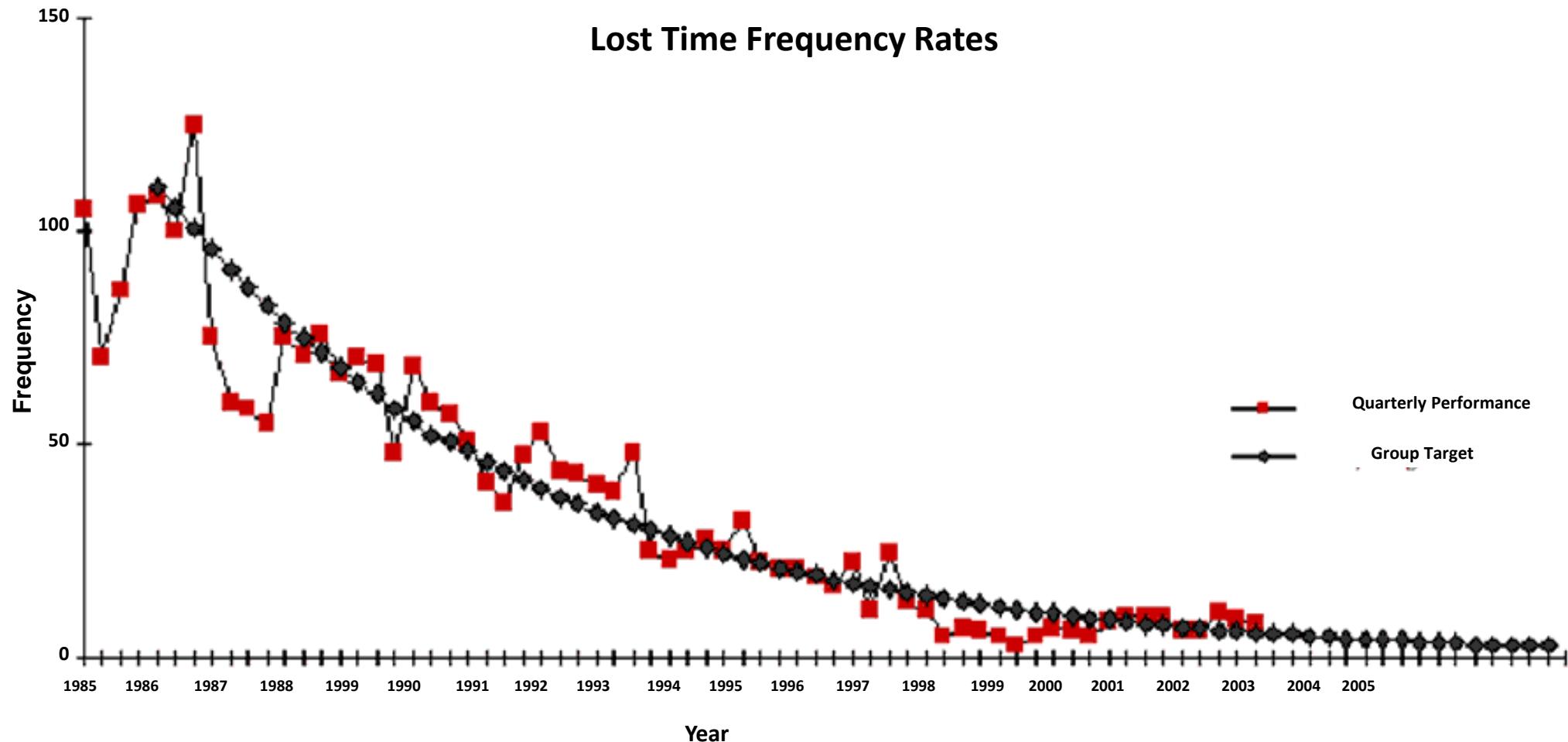
Model for Mental Health Promotion



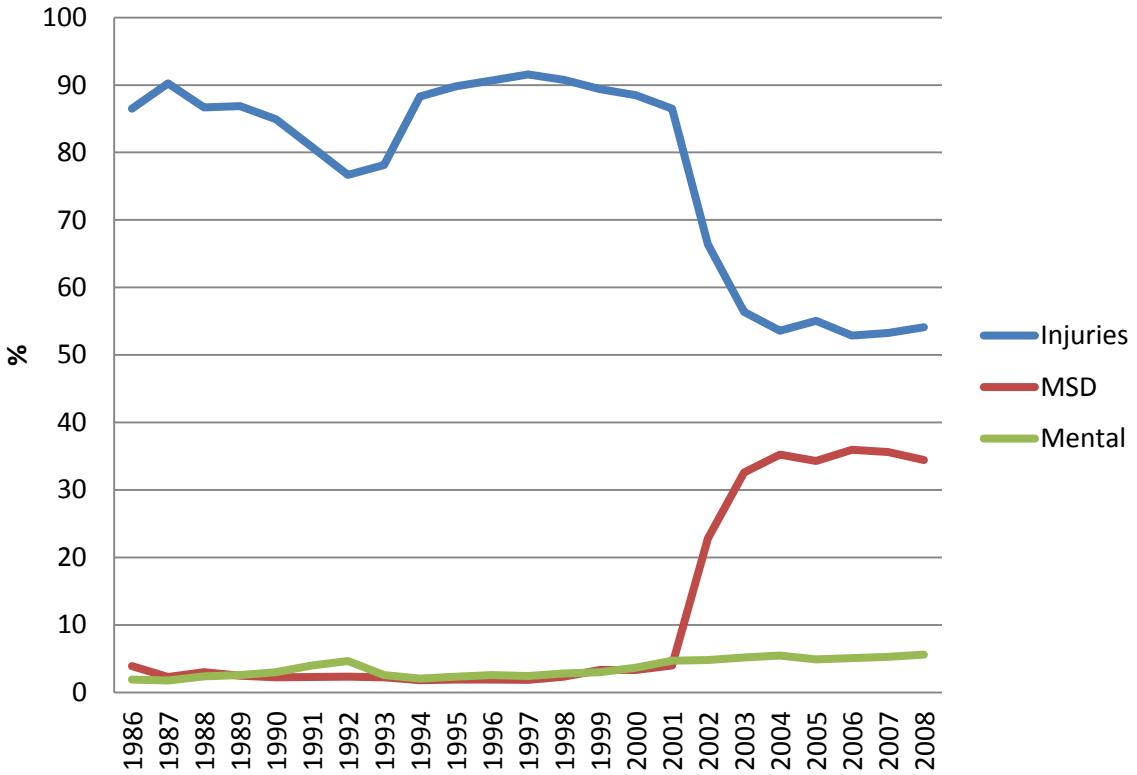
The Canadian Mental Health Association, 2010

Theiss Australia

Lost Time Frequency Rates

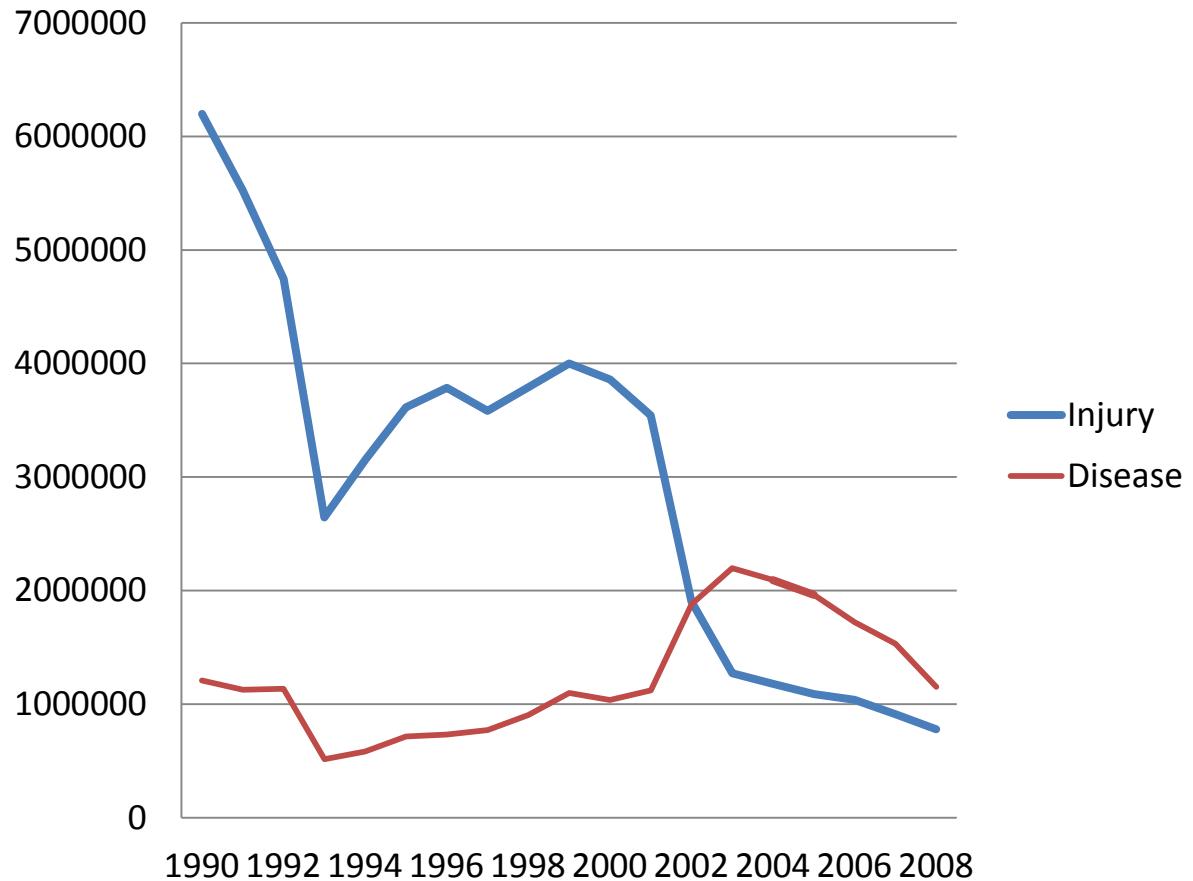


MSD and Mental disease claims vs Injuries



Source: ISCRR,
CRD, 2011

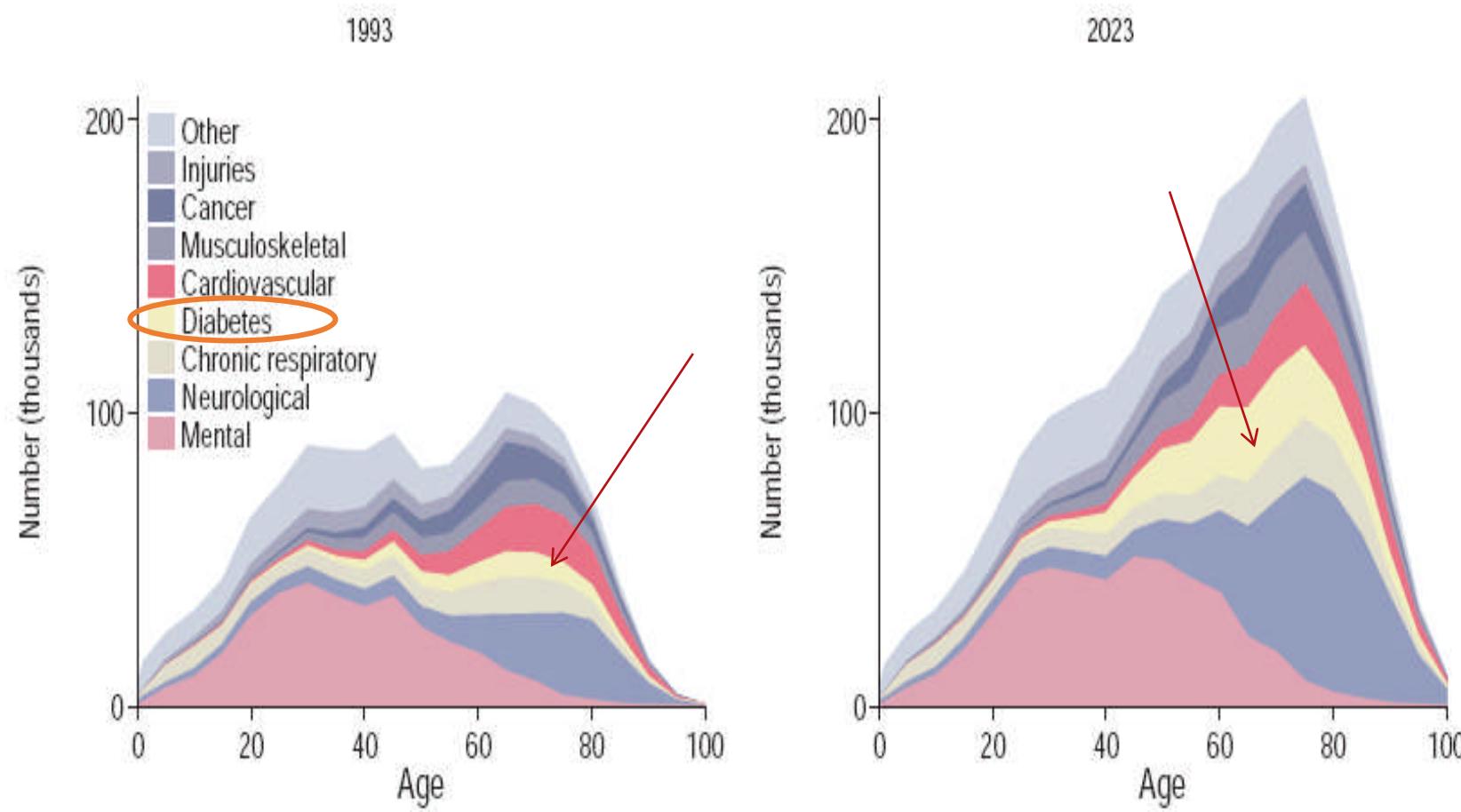
Incapacity days



Source: ISCRR,
CRD, 2011

Age-related trends are changing:

Prevalence of disability (PYLD) due to selected broad cause groups for both sexes combined by age, Australia, 1993 and 2023

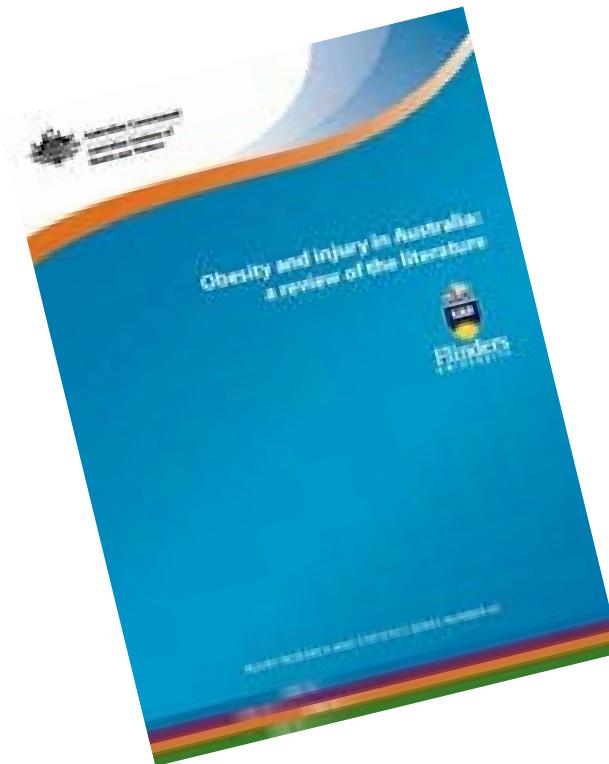


Source: AIHW, *The burden of disease and injury in Australia 2003* AIHW cat. no. PHE 82; 337pp

Slide courtesy of Anne-Marie Feyer 9

Worker obesity shown to increase risk of workplace injuries

- Musculoskeletal disorders
- Heat stress
- Transport accidents
- Vibration-induced injuries



Source: AIHW, 2012

Obesity and workplace injury risk

- AIHW

- Obese injured patients have a significantly longer average length of stay in hospital
- Obese injured patients are more likely to suffer complications of care in hospital following injury
- PPE may be less likely to be worn by/less suitable for obese workers



Source: AIHW, 2012

Health co-morbidities associated with...

Increased risk of injury

Prolonged hospitalisation & rehab

Higher treatment costs

Increased time off work due to treatment & rehab complications

Higher risk of becoming permanently unable to work

Co-morbidities include: asthma, chronic obstructive pulmonary disease, ischaemic heart disease, heart failure, diabetes mellitus, mental health condition (depression, bipolar, anxiety, schizophrenia), cancer diagnosis (lung, breast, colon, cervix, prostate), osteoarthritis

Source: Gribben & Wren, 2012

Presence of 1/ + health co-morbidities showed...

28% more claims

346% higher lump sum payments

59% higher medical treatment costs

39% more weekly compensation costs

Overall 59% more total ACC costs across all cost categories

10.7% of total ACC expenditure per annum directly attributed to the presence of the most common co-morbidities (\$276m NZD 2011)

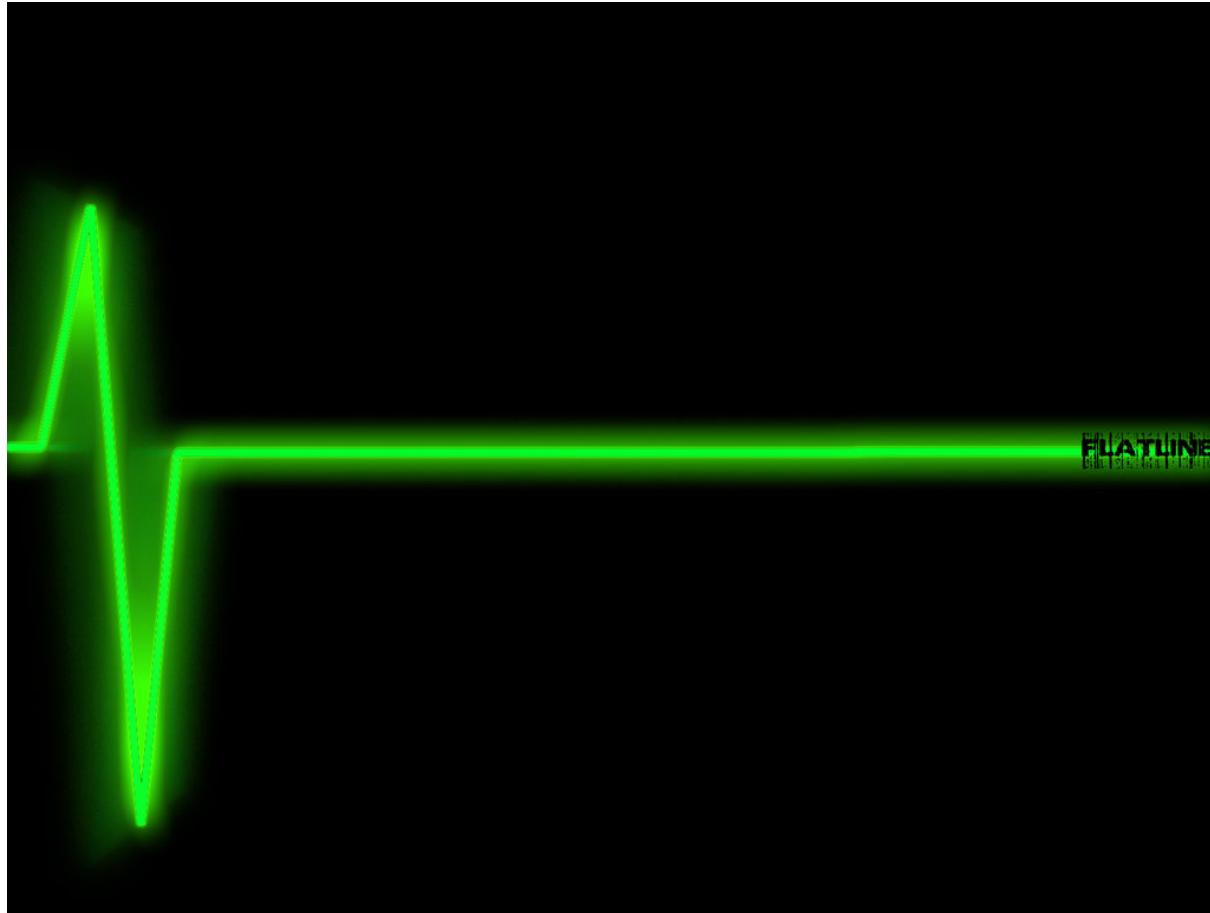
Source: Gribben & Wren, 2012

Impact of injury type, hospitalisations and pre-existing chronic conditions on age differences in absence from work following a work injury in British Columbia

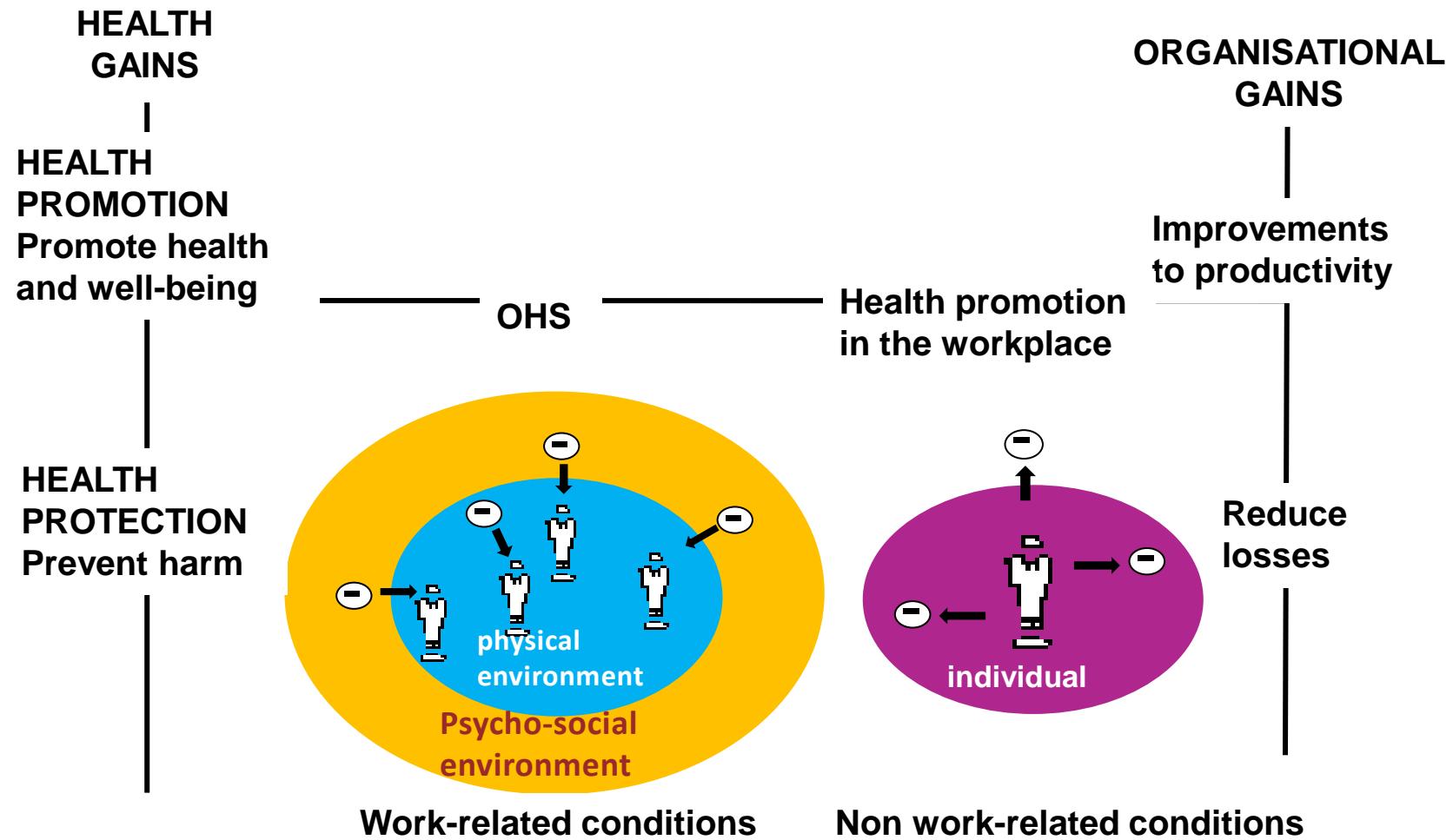
- Chronic conditions, in particular osteoarthritis (OA) and diabetes are associated with an increased risk of work-related injury and greater health care expenditures and days of absence following a work-related injury
- However type of injury and age important relationship
- Mechanism for relationship between chronic conditions and injury not known

Source: Smith et al, 2013

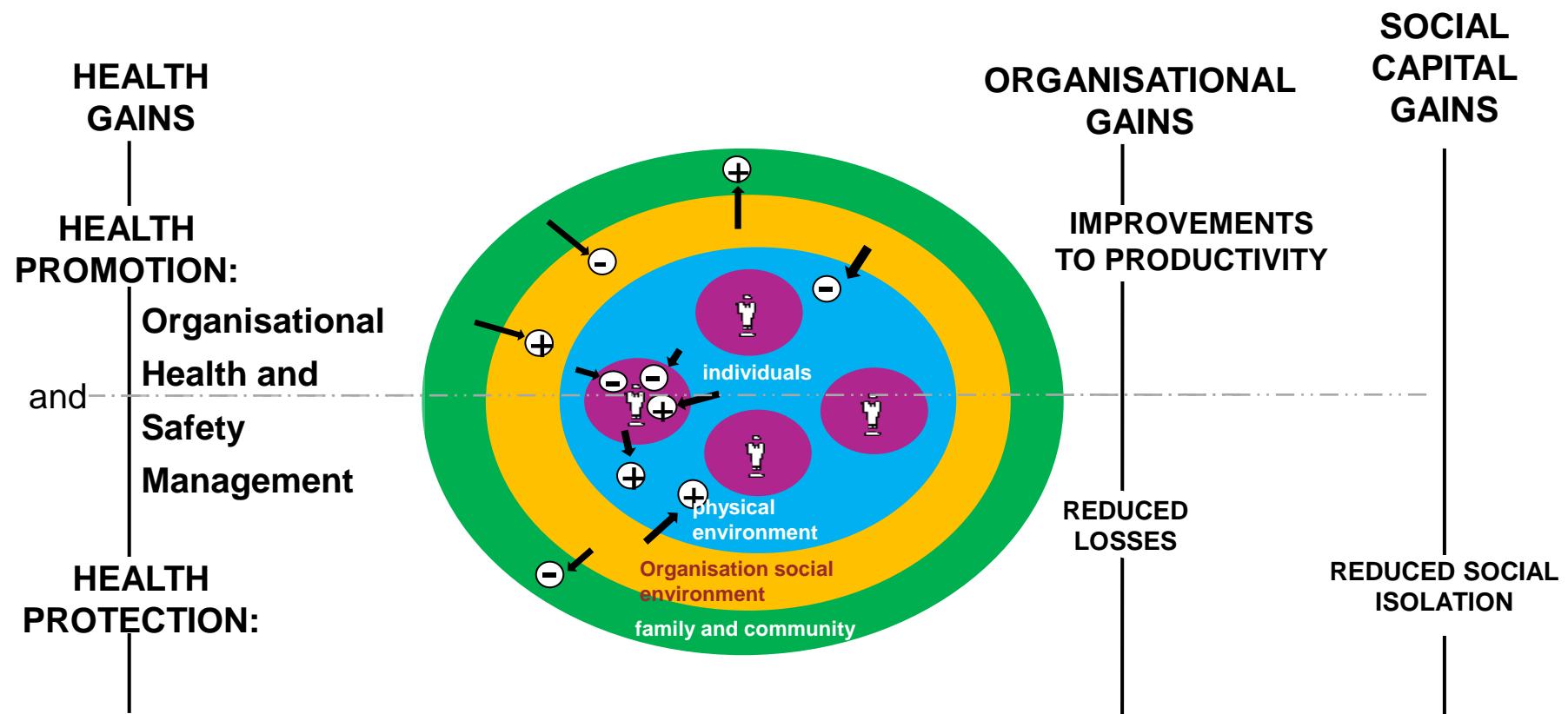
Workers compensation performance
has flat-lined over the past decade



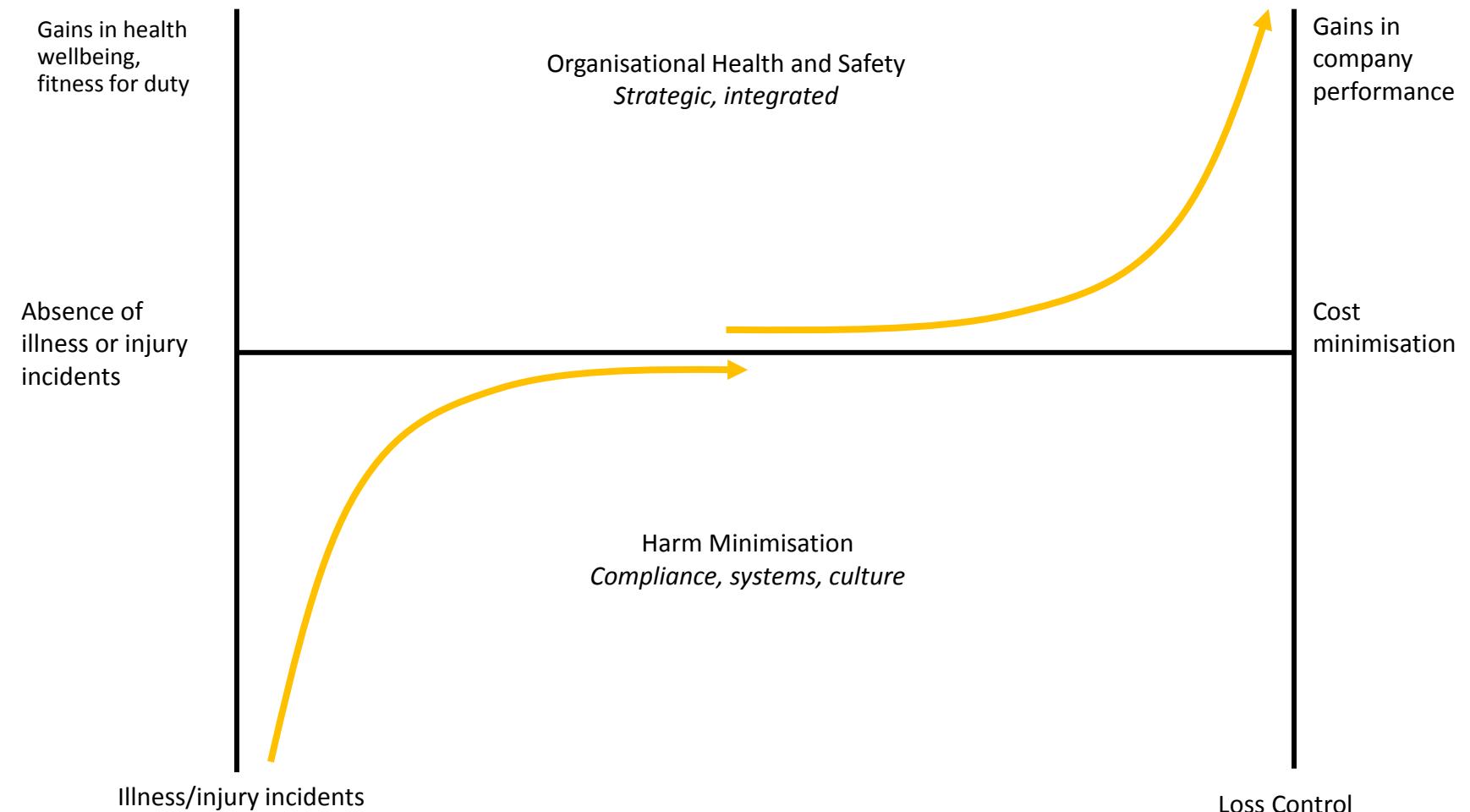
Traditional OHS: Injury prevention



Integrated approach to OHS



Occupational Health in the 21st century.... An expanded value chain goes beyond absence of injury





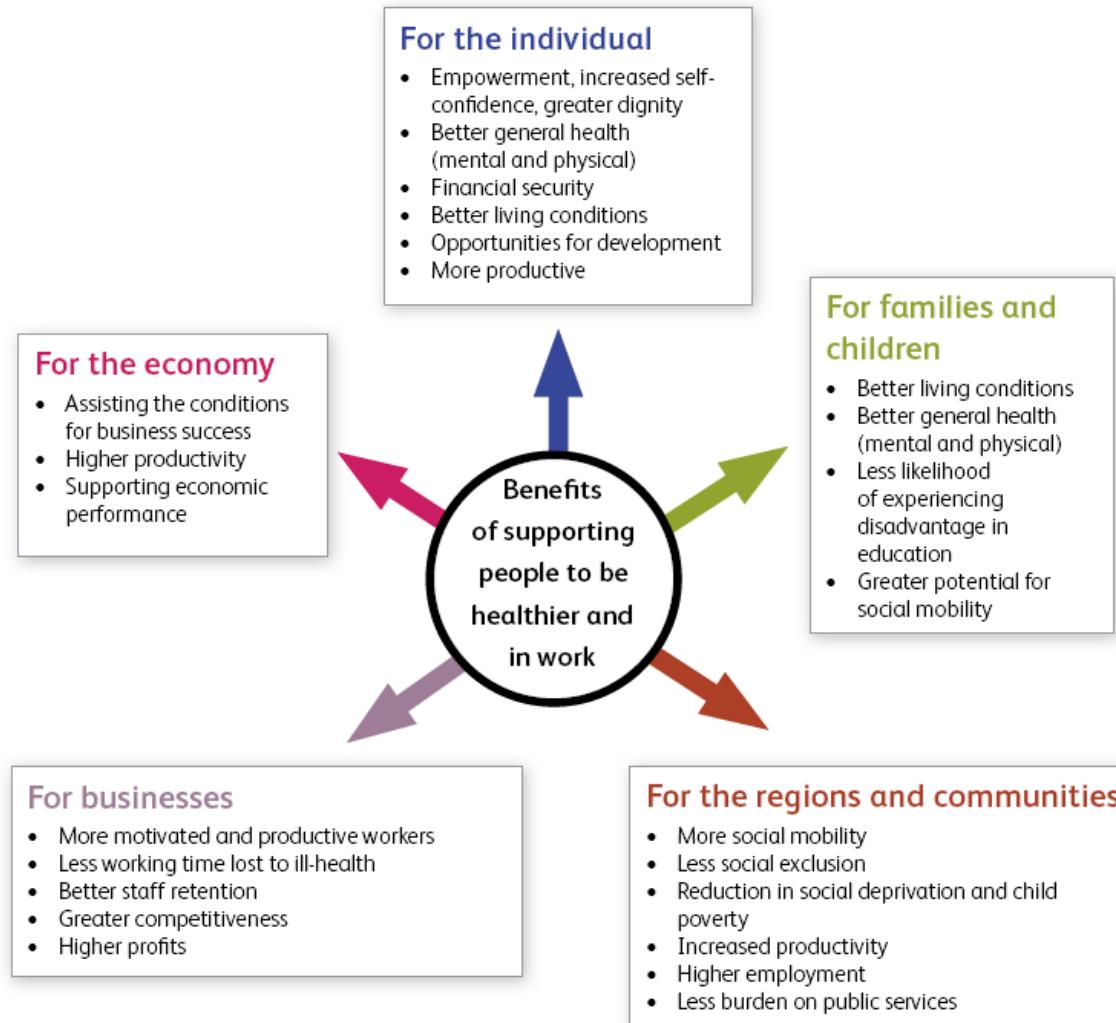
UK Government Response to Black Report 2008

Vision

“We want to create a society where the positive links between work and health are recognised by all, where everyone aspires to a healthy and fulfilling working life, and where health conditions and disabilities are not a bar to enjoying the benefits of work ”

UK Government Response to Black Report 2008

Figure 1.1 – Benefits of supporting people to be healthier and in work



Evidence based model for integrated approach

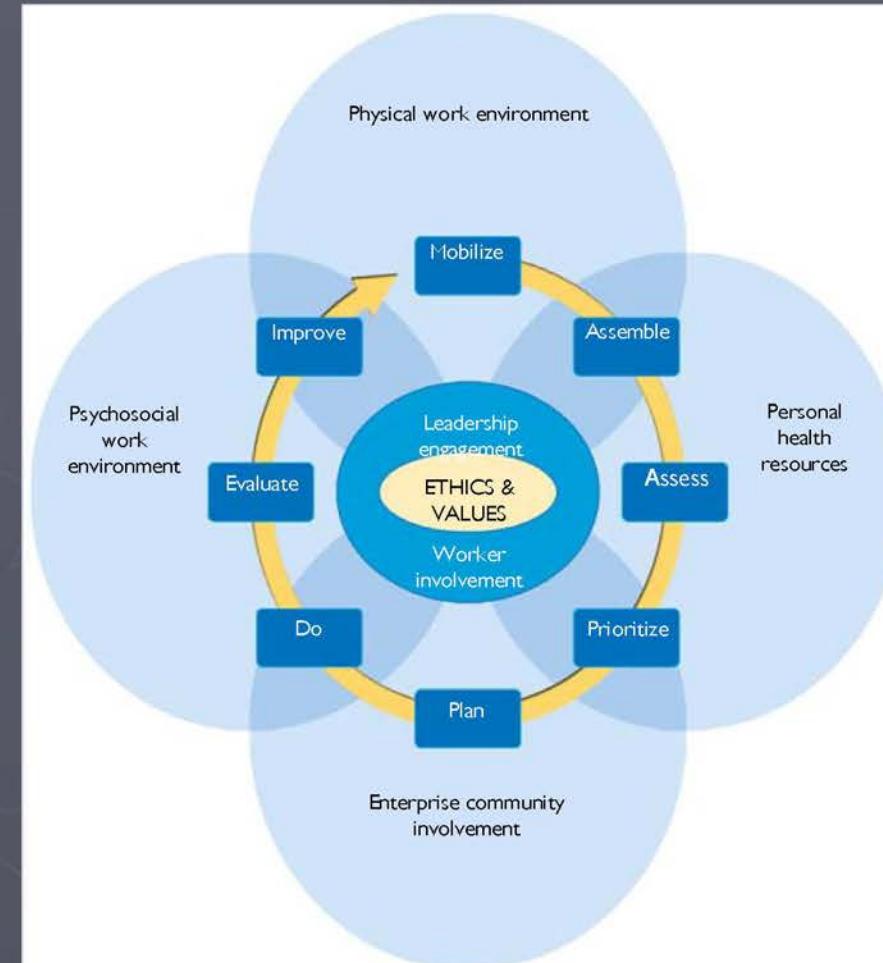


Source: NIH and CDC workshop,
2010, Am J PH

VI. A holistic framework for action

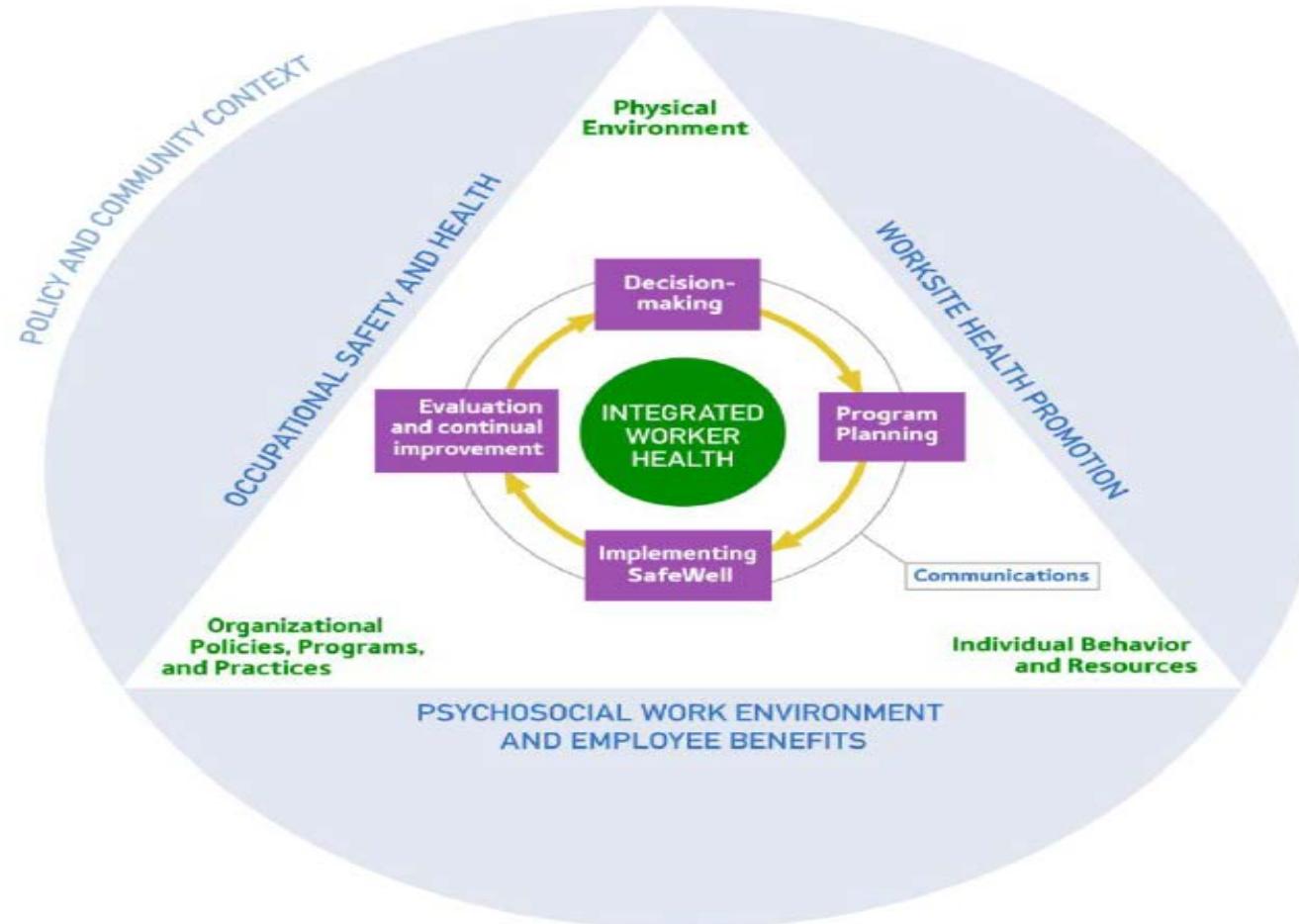
1. Action in four realms:
 - Physical work
 - Psychosocial environment
 - Personal health
 - Community involvement

2. A model of continuous improvement



World Health Organization

Integrated Management System for Worker Health



SafeWell, 2012

Case study – WellWorks

Control group (HP)

-  Smoke free policies
-  Healthful eating policies
-  Health education programs

Intervention group (OHS/HP)

-  Smoke free policies
-  Healthful eating policies
-  Health education programs
-  *Occupational risk identification, assessment and control led by industrial hygienist*

Case study – WellWorks

Possible reasons for greater effect of OHS/HP combined:

- 1 Perception that OHS risks greater threat to health
- 2 Awareness of OHS risks may raise sense of vulnerability
- 3 Addressing OHS risks may give program credibility
- 4 Workers see HP programs alone as futile, but if OHS risks addressed more likely to do their bit too
- 5 OHS interventions require more management engagement – management concern may mitigate fatalism
- Management engagement on OHS may aid HP

Sources: Sorensen et al, *Am J of PH*, 1998, vol 88, 11: 1685-1690; Hunt et al, *Health Education and Behaviour*, 2005, 32: 10 - 26

Findings of Wellworks- 2 borne out in WorkHealth Evaluation:

- A reduction in claims of 5% predicted for those participating in WorkHealth
- Workplaces with OHS Committees reported better health behaviours
- 71% of workplace health promotion programs are run through HR and only 12% through OHS
- Concerns about reduced focus on OHS
- Mental wellbeing activities increased in workplaces participating in WorkHealth grants

Source: ISCRR Evaluation, 2013



- Traditionally, workplace health and safety programs have been compartmentalised.
- A growing body of science supports the effectiveness of combining these efforts through workplace interventions that integrate health protection and health promotion programs.
- Integrating health protection and promotion will create synergy and enhance overall health and wellbeing of the workforce, while decreasing the likelihood of workplace injury and illnesses
- Having a psychologically healthy workplace and a profitable and sustainable business are linked.

Current best practice - Talking Health, Thinking Safety: Parmalat

Motivated by poor Worker Health Check results

“ By offering people advice on healthier lifestyle options, we could not only potentially lower our work related injuries, but also give people the opportunity to embrace a healthier lifestyle and take responsibility for their own wellbeing”



Current best practice - Talking Health, Thinking Safety: Parmalat

Program includes:

- making healthier food choices
- quitting smoking
- dealing with depression
- the importance of exercise and stretching prior to work



Current best practice - Talking Health, Thinking Safety: Parmalat

Impact:

- 54.5% decrease in MTI and LTI during 2011
- Health behaviour changes



Medical ethnologists divide causation theories into:

- ‘Ordinary activities gone wrong’
OR
- ‘Harm wreaked by a human or superhuman agency’

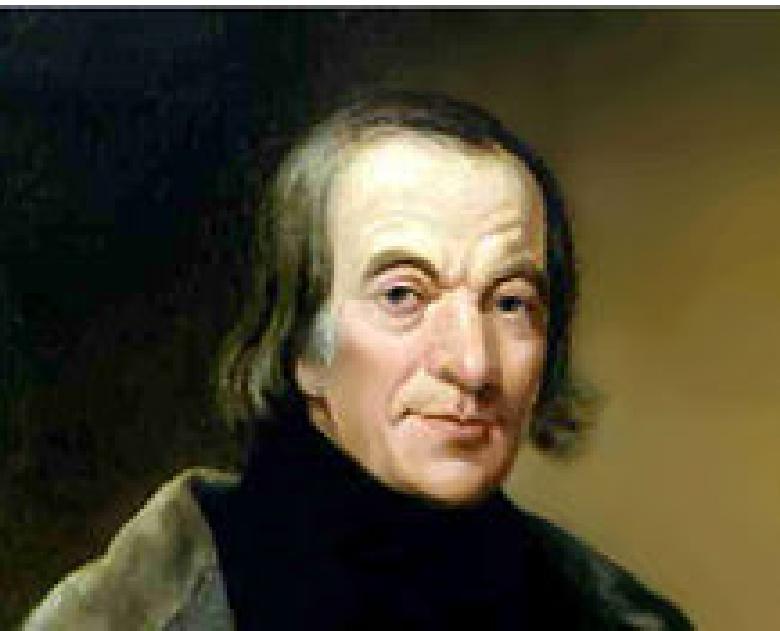
‘Early beliefs ascribed special prominence to social or supernatural causes; illness was thus *injury*, and was linked to aggression’

Roy Porter, *The Greatest Benefit to Mankind*, 1997, p 302

Robert Owen (1771-1858)

A parental philanthropist

- ★ In the first industrial revolution the environmental hypothesis prevailed
- ★ Is the basis for modern-day CSR



Safety metaphors and theories 19th and 20th centuries

- ★ Modern safety theory arose in beginning of 20th century – ‘the second industrial revolution’
- ★ The Safety First Movement, 1906, US Steel: individual hypothesis

Source: Swuste P, van Gulijk C, Zwaard W, Safety Science, 2010

We have always neglected disease in workers'compensation

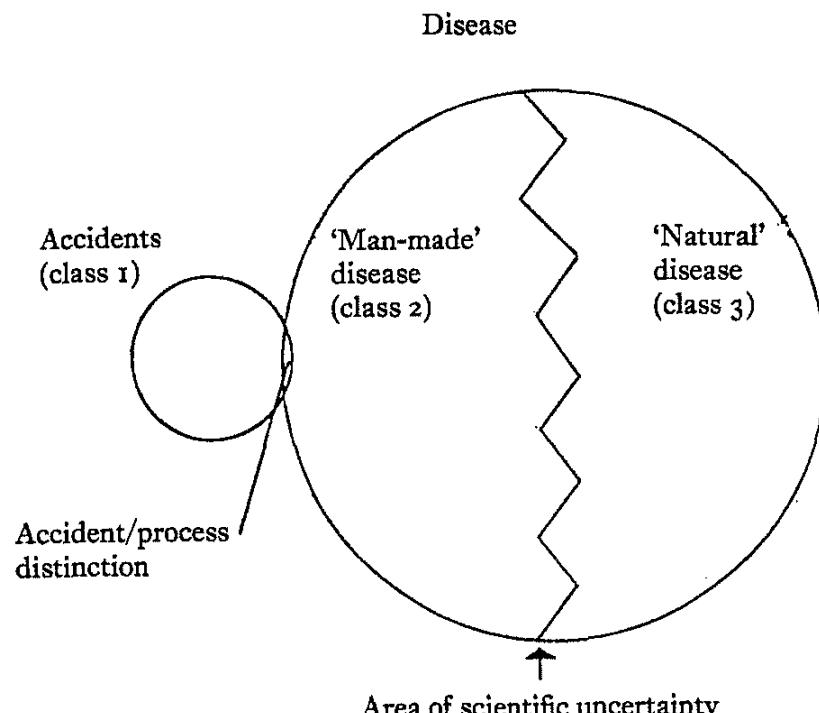


Figure 1. Classes of disablement.



Source: Jane Stapleton, *Compensating Victims of Disease*, Oxford Journal of Legal Studies, 1985

Industry Commission Inquiry into Workers' Compensation in Australia, 1994

Work-related injury and illness:

- appropriate for firms to bear costs and pass on
- provides an incentive for prevention by firms

It is not appropriate for firms to bear the costs of consequences of risks over which they have no control, eg journeys to and from work

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Conclusion

1. Traditional OHS model is being challenged by the rise of NCDs and precarious workforce.
2. There is strong evidence that the integrated model (OHS and WHP combined; shared responsibility) is effective (efficacious?) at the level of workplaces.
3. We know the characteristics of effective interventions: physical and psychosocial environments, individual behaviours, link to community.
4. We do not yet know how the synergy between OHS and WHP works nor poor health and injury

Conclusion continued

5. Currently the quality of integrated interventions tend not to meet best practice: neglect socio-organisational environment, risk of shift in responsibility from employer to worker
6. Deeply held beliefs on individual vs environmental hypotheses need to be better understood
7. We don't yet know how to implement the integrated approach at the macro level



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