Improving Occupational Health in Scotland

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POLICIES FOR **A BETTER SCOTLAND**

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Introduction

The STUC has for many years been of the view that occupational health provision should be funded by the state and delivered through the NHS in the same manner as any other health related issue.

More recently, there have been moves in the United Kingdom to take a far more holistic approach to workplace ill-health, focusing on the wider health and wellbeing agenda moving towards adopting some of the best the practices from Scandinavian countries, most noticeably, Sweden and Finland. Their occupational health systems, developed over two to three decades, are seen as among the best in the world, and focus on health interventions that ensure that workers stay in work and have appropriate occupational health support, helping them adapt to the physical and psychological demands which workplaces place on them as they get older.

The United Kingdom occupational health provision has never been mainstreamed into the wider health agenda following the decision, at the outset of the National Health Service in 1948, to retain the responsibility for workplace health and safety with the factory inspectorate. This decision was taken, despite strong protests from the medical profession who called for integrated occupational health provision to be the responsibility of the newly formed National Health Service[1].

This situation continues to this day, with Scotland's health boards mainly providing occupational health services for their own employees, with one or two exceptions where excess capacity is sold on to other public or private sector employers. NHS Lanarkshire and NHS Fife and Tayside generate income by providing a wide range of occupational health services to public and private sector employers.

Other employers have taken advantage of the growing number of private sector occupational provision, taking decisions to outsource in-house provision invariably on the grounds of cost.

[1] 1 http://www.gcal.ac.uk/historyofhealth/staff/ronnie-johnston.html

While these arrangements may deliver cost savings for the employer, it is questionable whether the free market approach to occupational health can be of benefit in terms of quality, the range of services provided, or accessibility that could be achieved through integrating occupational health within the NHS or through in-house provision.

Trade unions have to consider how we contribute to the debate on workplace health, ensuring the issue of occupational ill health does not become confused in the wider health improvement agenda, while, at the same time, recognising the importance of improving Scotland's general health and the impact that both could have on the Scottish economy.

The STUC continues to work with a wide range of stakeholders to promote Scottish Government initiatives to improve the health of the working age population for those in work and those out of work. However, while these initiatives are welcome and seen by some to be leading the way in the United Kingdom and Europe, we are still some way from a comprehensive, occupational health service delivered through the National Health Service, the policy position of the STUC.

Given the wider ongoing political debate in relation to health and safety, it is an appropriate time to examine health provision in Scotland and other countries, the cost to the economy of occupational ill-health and how trade unions can be involved in shaping the occupational health service of the future.

The Scottish Government has recently submitted its response to the Dame Carol Black's report on the Health of Britain's Working Age Population, and the Scottish Government is working with the STUC to identify suitable participants in a workstream, which is currently being set up looking at client pathways. Included in this work is an examination of current occupational health resources, and how occupational health and rehabilitation services can be developed.

Provision of Occupational Health

There are five main aims of any comprehensive, occupational health and safety system:

- Prevent and control risks to health at work
- Promote good health
- Reduce the impact of ill-health in the workplace
- Provide support for those with conditions made worse by work
- Facilitate a return to work following illness or disability.

As stated in the introduction, the responsibility for enforcement of legislation in relation to preventing ill-health in the workplace and controlling risk lies with the Health and Safety Executive. However, the duty to prevent occupational ill-health and disease lies with the employer and, to a lesser degree, with the workers they employ. Therefore, an employer has a legal duty to protect, as far as reasonably practicable, the safety and occupational health of their workforce. Given that very few workers have access to comprehensive, occupational health provision; with many having none whatsoever, it is concerning that the majority of Scottish employers may be ignoring, unintentionally or otherwise, their legal obligations.

There are two definitions that the HSE uses when assessing occupational health services and their effectiveness[2]. The first includes hazards identification, risk management and provision of information. According to HSE research, 15% of UK companies provide services at this level. A more stringent definition includes additional factors, such as modifying work activities, providing training on occupational health related issues, measuring workplace hazards and monitoring trends in health. The HSE study in 2002 showed that roughly 3% (31623) of employers provide services using this definition.

The HSE suggests that using the broad definition tends to result in an over estimation from employers in relation to the services they provide. While they do not provide a reason for this assertion, it may be that employers only provide some of the services and, therefore, could not be considered as only meeting the basic definition of occupational health provision or the broader definition favoured by trade unions.

[2] Survey and Use of Occupational Health Support; Contract Research Report 445/2002; HSE http://www.hse.gov.uk/research/crr_htm/2002/crr02445.htm

The HSE report also showed that pressure from unions to introduce occupational health support is one of the most common reasons for introducing occupational health provisions, with 19% of employers surveyed giving this as the main reason. The most common reason for providing occupational health provision was concern for the health of their workers, with between 97% and 99% of respondents stating this as a reason for accessing services. Scotland, with a rate of 57%, gave the lowest response to the question on cost of absence as being the main reasons for seeking occupational health advice. However, it should be remembered that this report dates back to 2002 and we have seen increased moves by employers in recent years to maximise staff attendance through the implementation of, sometimes punitive, sickness absence management procedures.

The STUC recognises the link between good health and work and the role that comprehensive and accessible occupational health provision can play in ensuring individuals stay in work or are rehabilitated back into the workplace. It is vitally important that employers ensure that occupational advice is sought at an early stage and for all health conditions, irrespective of whether they are work related or not. By being open and transparent on the purpose and use of occupational health, support workers will have more confidence in the motives behind the employer's actions and more likely to engage positively in the process.

Trade unions are equally concerned that a number of workers lose their jobs every year after developing a sensory impairment, with little support being given by employers to maintain their employment. It is estimated that around 100 workers are dismissed every year as a result of developing visual impairment alone and will be far higher, if similar dismissals for other impairments, such as hearing loss or epilepsy[3], are taken into account. It should not necessarily follow that dismissal on capability grounds should result from any impairment, and employers should consult occupational health specialists and seek advice on reasonable adjustments or suitable alternative employment.

[3] Disabled Call Centre Worker Wins Unfair Dismissal Case
http://www.inclusionscotland.org/newsletter/IS_newsletter_July_2005.doc

Trade unions recognise the benefits of employers implementing properly negotiated policies that are designed and implemented in a fair and constructive manner. However, affiliates frequently have to deal with complaints from members facing dismissal as a result of being subject to overzealous application of sickness absence and performance improvement procedures.

If sickness or attendance management procedures are properly implemented by competent and properly trained line management, the data compiled can be of significant advantage in identifying and supporting workers suffering from occupational and other ill-health conditions. Unfortunately, on occasions, management incompetence and the organisational drive to reduce absence rates are the cause of the problem and do not deliver the solution they were designed to provide. Neither are they implemented with enough flexibility to make allowances for long standing health complaints or gender considerations, such as the menopause or post menstrual tension. In relation to the latter, organisations often fail to recognise the difficulty women workers have in raising women's health issues with male managers. This results in women being exposed to sickness absence procedures and the associated pressure and stress that, potentially, put them at risk of occupational ill-health including mental ill-health.

In relation to performance improvement measures, it is not unusual for a 'poor performer' to be moved through the process in 12 to 13 weeks and face disciplinary action and the threat of dismissal and demotion. These procedures are target based and as soon as the poorest performers are dismissed or adjudged to have improved to an acceptable standard, the employers demand and targets are increased and a new cohort of workers are put under pressure.

Far from being constructive, the threat of being moved through these procedures with undue haste by untrained and unqualified managers is likely to lead to the employees being subject to unacceptable pressure and at risk of occupational induced mental health conditions.

As Dame Carol Black said in a presentation to Scottish Government Client Pathway Workstream, consisting of a wide range of stakeholders:

"Employees leave line managers, not jobs".

Trade unions believe that this is particularly pertinent to management of absence and performance and access to occupational health problems. If line managers are adequately trained to manage and support staff, then there is a greater chance that workers suffering occupational ill-health will be more likely to remain in or return to work.

Under the European Directive 89/391/EEC[4] introduced in 1989, there is a legal requirement on all employers in European Union member countries to provide access to occupational health provision. However, the transposition of this directive into UK law does not put explicit duties on employers to provide services, and the UK Government relies on NHS Direct in England and Wales to plug gaps in provision.

Even where employers provide access to occupational health provision, the independence of employer funded provision is quite often questioned by workers and unions alike. Not only is intervention provided, but decisions are taken on future employment by private sector providers, who receive remuneration for providing services and reports that affect workers livelihoods.

It is not only unions who question the independence of private sector occupational health provision. In a UNISON supported complaint to the Pensions' Ombudsman, following the refusal of Glasgow City Council and the Scottish Public Pensions' Agency to provide ill-health early retirement to one of their members, the Ombudsman voiced concerns on the role of BUPA Wellness as a medical practitioner as defined in the Local Government Pension Scheme (Scotland) Regulations 1998.

In the determination the Ombudsman states:

> *"BUPA Wellness may employ medical practitioners, but is not itself a medical practitioner of the kind required by the Regulations. The Council is in error in thinking otherwise. It seems that BUPA Wellness is involved in advising the Council as an Employer, including on whether or not staff are unfit for service.*

[4] http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31989L0391:EN:HTML

If a medical practitioner has been involved in that role, I very much doubt whether that same practitioner can be regarded as independent in the way required by the Regulations governing the scheme".[5]

The consistency of provision is also often questioned. On one occasion, a provider preparing a report for the employer stated that the workers remained incapacitated and continued to be unfit for work. The same provider preparing a separate report on behalf of the Department of Work and Pensions to assess continuing entitlement to Incapacity Benefit stated that the worker no longer met the incapacity criteria and was fit for work.

Trade unions believe that consistency and independence of occupational provision can only be achieved through a publicly funded and delivered occupational health service.

In Scotland, the Scottish Centre for Healthy Working Lives provides information and advice to employers and workers mainly in the small and medium enterprise sector. However, it is questionable if the service they provide would meet the requirement of the European Directive, or Regulation 5 and 6 of the Management of Health and Safety at Work Regulations 1999.

Regulation 5 of the management regulations states, "employers should make arrangements to manage effectively health and safety", while Regulation 6 places duties on the employer to provide employees "such health surveillance as is appropriate".

In September 2006, an Employment Tribunal found that Dundee City Council breached the Management of Health and Safety at Work Regulations 1999 by having an inadequate management system to deal with occupational health risks and that an 'Improvement Notice' issued by the HSE was justified. The Council didn't have in-house occupational health specialists or a contract with an external occupational health provider.

[5]Determination by the Pensions Ombudsman; Mr J Barnwell, 16 July 2007
http://www.pensions-ombudsman.org.uk/determinations/docs/2007/jul/p01360.doc

The Tribunal ruled that this breached Regulation 5 of the management regulations, which states that employers should make arrangements to manage effectively health and safety, even though the regulation makes no specific reference to occupational health.

Dundee City Council had appealed an original Improvement Notice issued by the HSE, regarding lack of occupational provision, although they had complied with the notice and introduced workplace well-being services. At the time the Notice was served, sickness absence was costing Dundee City Council £5.6 million per year - a cost that, in itself, might have been expected to raise questions on the kind of occupational health provision that was required to tackle the problem. On the other hand, South Lanarkshire Council, in a similar situation, aims to cut sickness absences by providing staff with free access to a physiotherapist and occupational health team.

The Tribunal ruling should be seen as a warning to other local authorities and all employers. However, given that so few workers have any kind of access to occupational health whatsoever, it is clear that the majority of employers are ignoring their legal responsibilities. This also provides unions with a strong precedent to argue for occupational health provision in workplaces where no such arrangements exist.

An ongoing workplace challenge for unions is to ensure occupational health services work in the interest of the workforce, and are not the sick leave police. They should be consulted on the design and operation of OHS, and in the selection of competent persons, consultants and advisers. Adopting this kind of approach and working with employers to develop occupational health provision will ensure services are accessible and, more importantly, trusted by workers who have to access the service.

Occupational Health Resources

In 2002, the Scottish Executive carried out a mapping exercise of occupational health resources in Scotland.

At that time, the NHS in Scotland employed 70 occupational health physicians, (46 on part time contracts), 153 occupational health nurses (38 part time), and only one employed an occupational therapists. In addition, 6 boards offered access to fast track physiotherapy services, in addition to other occupational health and safety specialists, such as ergonomists, manual handling advisors and counsellors.

These services were primarily to meet the needs of the health board's own employees, although across all the health boards, over 400 non NHS organisations accessed services providing access to occupational health provision for over 200,000 workers. The majority of this external provision was in four health boards, Fife and Tayside through OHSAS, Lanarkshire through SALUS Occupational Health and Lothian Health Board providing services to 70,000, 36,000 and 40,000 respectively.

This mapping exercise also identified the main private sector providers as BUPA, Aon (now Capita) and the Institute of Occupational Medicine. This is still likely to be the case with the addition of ATOS Origin. In 2002, the three main private sector providers employed between them 13 occupational health physicians, and 34 occupational health nurses. BUPA employed a further 30 nurses, although they state not all had an occupational health qualification.

The STUC believes that there should be a comprehensive occupational health service, funded by the NHS, that is accessible to all workers and employers who chose to source their occupational health provision in this way. This will clearly involve increased resources and recruitment of occupational health specialists in the NHS. However, the benefit would be that Scotland had an occupational health service that was seen as being independent from employers, a growing concern in reaction to private sector delivery for trade unions and sick or injured workers.

Recommendations

A mapping exercise should be undertaken, drawing on unions' experience to assess the provision and accessibility of occupational health provision within their recognised employers.

The Scottish Government should carry out an audit of occupational health specialists in health boards throughout Scotland and in private providers, such as BUPA, to allow comparison with the 2002 report.

Further work should be developed looking at occupational health or ill-health within specific sectors, such as education, transport and construction.

The Scottish and Westminster Governments should encourage trade union involvement in developing occupational health requirements in the workplace, including in the tendering process, especially where employers use private sector provision.

The Scottish and Westminster Governments should examine funding mechanisms for occupational health provision, including employers' contributions, reflecting their duty of care to workers.

The Economic Cost of Occupational Ill-Health and General Sickness Absence

The most recent study of the cost to the economy of ill-health covered sickness absence, in general, including the cost of work-related ill-health and injury. In "Working for a Healthier Tommorrow"[6], the report prepared, following the work of Dame Carol Black, National Director for Health and Work, estimated costs for all absence in 2007 to be between £103 and £129 billion broken down as follows.

[6]Dame Carol Black, Review of Britain's Working Age Population http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf

Costs of working age ill-health 2007(billions)	
Government	
- Benefits	29
- Healthcare	5-11
- Foregone Taxes	28-36
Total Government	**62-76**
Worklessness – Lost Production (Absence)	63
Sickness Absence	10
Informal Care	25-45
Health Care	5-11
Total Economy	**103-129**

(Working for a Healthier Tomorrow, The Stationery Office)

These figures do not include the costs of ill-health resulting in absences from work, or presenteeism as it has become known, where workers attend work when they are clearly unfit to do so. Many workers feel obliged to report for work, when they are suffering from ill-health either through a sense of loyalty to employers or colleagues, or as a result of pressure from employers. Presenteeism often relates to the insecurity workers feel as a result of draconian sickness absence management and attendance improvement procedures that threaten dismissal as the ultimate sanction for absence from work. Dame Carol Black, in her report, suggests that preliminary estimates for loss of productivity through presenteeism could be as high as £30billion per year.

In 2004, the Health and Safety Executive Economic Advisers' Unit published an interim update of the costs of occupational ill-health. The HSE figures provide a broad estimate of the costs to three key stakeholder groups, individuals, employers and society. This work used the figures available from the HSE reporting year 2001/02, and the following table highlights the lower and upper estimate for various cost categories and the individual stakeholder groups.

Economic Effect by Cost Category

	£million		
Cost Categories	Ill – Health	Injury	Total
Lost Earnings	2,560 to 4,020	1,180 to 2,370	3,730 to 6,390
Human Costs	3,680 to 5,700	2,670 to 4,480	6,340 to 10,180
Sick Pay	960	310	1,270
Loss of Output	7,010 to 10,240	2,970 to 5,580	9,980 to15,820
Medical Treatment	230 to 970	70 to 320	300 to 1,280

Total Costs to Stakeholders

	£billion		
Stakeholder	Ill – Health	Injury	Total
Individuals	5.9 to 9.4	3.3 to 6.3	10.1 to 14.7
Employers *	1.5		3.9 to 7.8
Society *	11.3 to 17.3	5.9 to 10.7	20.0 to 31.8

* An additional cost has been factored in to account for incidents that have not resulted in injury or ill-health to workers. These are events that may lead to loss of output and material damage to the assets of a company, such as plant and machinery. The HSE takes the view that such incidents have the potential to cause human harm and are caused by the same management failures that actually result in injury and ill-health and, therefore, should be included.

In 2006, the Inter Institutional Group on Health and Safety[7], a body consisting of employers, workers and other stakeholders in the manufacturing sector, calculated that the effect on a company employing a worker around age 40 with 20 years service, retiring on grounds of ill-health after one year's absence, could be as much as £250,000 to £350,000.

The factors that this report urged employers to consider, when considering occupational health support, are as outlined in the following table:

[7] http://www.theiet.org/publicaffairs/panels/iig/

Factor	Potential Cost (Approx).
Direct cost of Sickness Absence	£17,000
Indirect cost of replacement agency labour	£30,000
Cost of ill health retirement to the pension fund	£300,000
Direct business contribution to the pension fund	£100,000
Cost of management time	£15,000
Cost of losing unfair dismissal case	£50,000
Cost of losing potential DDA claim	£100,000
Personal Injury Claim (lower Court)	£35-50,000

The report also adds that failing to ensure the safety and health of workers can have other long term effects on the organisation, such as increased premiums for employers' liability compulsory insurance, reputational damage and the resultant impact this has on public and client opinion of the company and the possibility of higher damages awarded by the Court of Session, where there is potential for trial by jury.

Although the publishers of the report emphasise these are approximate figures, it is worth comparing these estimated costs with the average spend on occupational health by employers in the United Kingdom.

According to HSE research[8], 37% of employers surveyed spent less than £5,000 per year on occupational health support, equating to 67% of all UK employers, 40% of those spent less that £1,000. It was estimated that only 4% of UK companies spent over £30,000 on occupational health provision. In some cases, the spend was significantly more, but this tended to relate to more hazardous industries, such as offshore, mines and quarries.

[8] Survey and Use of Occupational Health Support; Contract Research Report 445/2002; HSE http://www.hse.gov.uk/research/crr_htm/2002/crr02445.htm

Given that Scottish Courts estimate that they can provide extensive, occupational health provision for approximately £100 per worker (2002 estimate), it does not seem unreasonable that every employer in Scotland should at least invest this amount in occupational health.

Quite clearly, there are significant differences in relation to investment in occupational health and the estimated cost to individuals, employers, Government and the economy as a result of occupational ill-health, injury and general absence from work.

Job Retention and Rehabilitation

Some occupational health physicians believe that the work already being undertaken in Scotland is superior to the Scandinavian model, in that we focus on the general health and wellbeing of the working age population, as opposed to solely ill-health caused by the work environment, or affecting the workers' ability to remain in employment.

However, is it that we are still lacking in specific areas of occupational health including job retention and rehabilitation? In Sweden and Finland, the emphasis is on keeping people at work by assessing their functional capacity as they go through working life, adapting their job content to meet their physical and mental capacity at specific times of their lives.

In 2005, UNISON estimated that 73% of paramedics were forced to retire on health grounds[9]. In evidence to the Westminster Health Committee in 2006[10], UNISON welcomed the commitment from the NHS in England and Wales to flexible retirement, but raised concerns as to why workers were retiring voluntarily, or having to retire from the health service earlier than their normal retiral age - posing two questions:

1) Why do people retire early from the health service?

2) Is this linked to the stress of work in the health service?

[9] http://www.unison.org.uk/asppresspack/pressrelease_view.asp?id=578
[10] http://www.unison.org.uk/acrobat/B2493.pdf

UNISON suggested that it was important that health service employers work with trade unions to meet the future demands of the health service, by developing the skills of existing workers and changing their roles to improve retention of experienced health workers. This is an example of trade unions wanting to ensure that employers assess the demands of work on their employees and provide development, redesign jobs or make reasonable adjustments to retain members in work.

In 2002, the TUC commissioned the Labour Research Department to carry out a survey of health and safety representatives[11] in 2,000 large and small workplaces in Scotland, England and Wales.

At that time, the report concluded that there was a growing acceptance that greater effort was needed to retain employees who have been affected by poor health, injury or disability, in paid employment.

It outlined the key role employers have in assisting and facilitating return from absence and the research by which this can best be achieved where they:

- make rehabilitation a policy goal
- invest in employee health, providing access to good occupational health
- provide facilities and workplace health initiatives
- are responsive to absence: monitoring health, keeping in touch with sick employees, responding early with referral for medical checks, being alert to disability issues, and applying practical rehabilitation measures
- do not make health a disciplinary matter
- investigate work-related health problems
- involve all levels of management in rehabilitation, including line managers
- provide personnel/human resources (HR) managers, occupational health (OH), and senior managers
- work with unions and their members, being open on health and absence issues, and involving them fully in the development of relevant policies.

[11] ***TUC*** July 2002: Rehabilitation and retention: the workplace view http://www.tuc.org.uk/h_and_s/tuc-5271-f0.pdf

Approximately 1,300 workplaces responded to the survey and, of these, 23.7% definitely encouraged rehabilitation, 19.8% were likely to apply five or more rehabilitation measures and 12.5% had rehabilitation services available.

However, these best practice employers tended to see rehabilitation not as a separate policy issue, but something that could be tagged onto one or more of the following - sickness absence management, health and safety or equal opportunities policies. At that time, only 1.5% of the employers surveyed had a separate policy dealing with rehabilitation.

It was also noted that, in workplaces where the employer invests in the health of their employees, more developed rehabilitation practices were likely to be in place, including case management of absence, non medical staff including counsellors and welfare officers, all of whom have a part to play in rehabilitation.

The role of trade unions in facilitating return to work programmes was also recognised and, where trade unions were present, it was found that less threatening sickness absence procedures were evident. Even when employers adopted a disciplinary approach to sickness absence management, access to trade union advice and representation was more noticeable in good practice workplaces (21%) than in others (14%).

Employers willing to work together with employees and their unions are more likely to make a success of rehabilitation. One example of this is sickness absence statistics, which are more likely to be made available in good-practice workplaces, and are generally given to health and safety committees or union reps, rather than the workforce as a whole.

While unions were recognised at nearly all the survey workplaces, their involvement with health issues varies. Where there is good practice on rehabilitation, unions are more likely to be involved in reviewing information on sickness absence jointly with management. This was the case at 38.1% of good-practice workplaces and 23.2% of other workplaces. Unions were also more likely to be involved in policy changes in areas relevant to rehabilitation at good-practice workplaces, than at other workplaces in the survey.

The case studies in this survey included two Scottish employers:

Scottish Courts Service: Public sector, 900 permanent staff. Total cost for occupational health provision including welfare services £80,000 or about £100 per employee.

The service had a positive commitment to rehabilitation. Its approach is "business driven", with a fall in sickness absence attributed to the absence policy and the Occupational Health Service.

Scottish Power: Private utility, 13,000 staff. No scientific evaluation of costs, although stress alone in the company's customer services business was calculated to be costing £500,000 in 2002. Guidance issued to managers.

Rehabilitation is promoted by the Group Occupational Health Department, working in co-operation with management of the legally separate businesses that make up the Group. Policies relating to the management of capability and employee health are formulated at Group level, but adapted by the businesses. Health and safety law and the DDA underpin the approach, but health promotion takes a high profile, and specific initiatives (e.g. on stress), involving the unions, add to the general momentum.

Full details on the occupational health and rehabilitation arrangements in place in these workplaces can be found in the following TUC publication, *TUC July 2002: Rehabilitation and retention: Case studies*[12]

In Scotland, the STUC has, in the past, worked with Healthy Return, a Department of Work and Pensions Job Retention and Rehabilitation project. During the two years of the project, around 500 individuals were given some level of assistance in developing return to work plans and their reintegration into the workplace. As part of the control study, one group of clients was given the most comprehensive package of assistance, including case management, health and workplace interventions. The STUC would see this level of service as being vital in ensuring that individuals, who have been off work for some time, often with severe mental health problems, can return and, more importantly, remain in work.

[12] http://www.tuc.org.uk/h_and_s/tuc-5264-f0.pdf pp 47-61

Despite the success of this project and two others in England and Wales, the DWP stated that the results were inconclusive and the models used were unsustainable. This has to question how committed the Government is to assisting the workless into good work, and trade unions should be concerned that the Welfare to Work initiatives could result in individuals with long standing health problems being placed in unsafe workplaces.

The Scottish Centre for Healthy Working Lives is currently providing free occupational rehabilitation services to SMEs in Dundee through the Working Health Services project. This project provides access to occupational health specialists, counselling and complementary therapies. Of 26 workers who responded to a question on use of the service and had accessed the service between February and October 2008, 54% felt their condition had been fully resolved, while 38% felt their condition was partially resolved on discharge.

This project still has 16 months to run and continues to grow as the profile increases. GPs are still not fully aware of the service and, therefore, referrals from this group may not have been as they could be. Similar pilots will be launched in Lothian and Border in 2009 running for twelve months and all will be subject to evaluation.

The negative aspect of this approach is that it is only accessible to SMEs and their workers and it is another example of the continual short term project and evaluation approach to developing rehabilitation services.

What Works?

There is no better example of positive stakeholder engagement in developing comprehensive, occupational, clinical and research capacity than Sweden. From 1975, Sweden began introducing a number of pieces of new legislation to develop a national occupational health service, involving trade unions, employers, Government and health services. Finally, in 1995, they launched the Swedish National Institute for Working Life that grew to become a world leading facility in occupational health research.

The foundation of the Swedish occupational health service can be found in a document presented to the European Conference of the International Labour Organisation.[13] In this presentation, two Swedish Trade Union Federations, the Swedish Trade Union Confederation (LO) and the Swedish Central Organisation of Salaried Employees, presented their programme for a national occupational health policy. They focused on the changing world of work, identified the potential for rapid change in industrial policy and introduction of technologies and a move to new industries, and equally increased demands for improved working lives influenced by Swedish workers. Most importantly, they identified the need that it was vitally important to foresee the repercussions in the work environment brought about by rapid industrial change.

The policy presented to the ILO became accepted by Swedish trade unions and the Government and underpinned the growth of the occupational health service into a world leading resource over the next 20 years.

However, in 2006, the election of a centre right Government in Sweden proved disastrous for the Institute, as the new Government almost immediately took the decision to close the centre with the loss of over 400 research posts. At that time, the annual cost of running the centre was 40 million Euros.

Thankfully, the methods of delivery of occupational health provision suggested by the trade unions at the time survived the Government purge. The key argument put forward by the unions was that occupational health should live within organisations, be part of the decision making process and allow employers and trade unions to address the problems that arise within workplaces as they occur, or preferably to manage risk and change before the problems arise.

Additionally, the trade unions, employers and the Government reached agreement on the resources they could provide, to ensure that workers in all businesses, large and small, trade unionised and non trade unionised have access to occupational health specialists, including doctors, nurses and trade union representatives.

[13] The Politics of Developing a National Occupational Health Service in Sweden, Vicklund.B http://www.pubmedcentral.nih.gov/picrender.fcgi?artid=1653329&blobtype=pdf

These services are delivered through local occupational health centres, and trade unions have had an increased influence in the management and direction of these centres supported by improved legislation increasing their rights.

Finland also has well developed occupational health provision, although the extent of trade union involvement in developing and influencing their model has been harder to ascertain.

The Finish Institute of Occupational Health (FIOH) [14] is a Government funded research and specialist organisation in occupational health, working with partners and clients to achieve the following goals:

1) the management of occupational health hazards at work as part of management practices and corporate risk management;

2) innovative, regenerative and healthy work communities;

3) each citizen equipped to ensure their own occupational health and safety;

4) providing authorities with information for promoting occupational safety and health;

5) developing flowing workplaces, safe and easy to use work methods and tools;

6) providing solutions for increasing participation in working life; and

7) controlling new occupational hazards while exploiting new opportunities.

FIOH publishes much of its research in English, in addition to health and safety legislation outlining the employers' duty to access, and pay for adequate occupational health service. In common with Scotland, services are delivered in a number of ways, including in-house provision, state funded services or through private sector providers.

[14] http://www.ttl.fi/internet/english

The significant difference is that there is a statutory obligation to pay for occupational health services. Clearly, a similar arrangement in Scotland would address the appalling under provision of access to occupational health interventions and research existing in Scotland at present.

In Canada, trade unions have also been actively involved in developing occupational health services and the the Occupational Health Clinics for Ontario Workers (OHCOW)[15] was established in 1989 by the Ontario Federation of Labour (OFL) and is funded by the Workplace Safety and Insurance Board (WSIB). The first clinic opened in 1989 in Hamilton, with subsequent clinics opened in Toronto, Windsor, Sudbury and more recently Sarnia.

Recommendations

The Scottish Government should consider the regional models of occupational health centres as developed in Sweden and Canada, and the potential for trade unions to be involved in developing suitable models for Scotland.

Occupational Disease

Scotland still carries an unwelcome legacy from our industrial past when industries, such as shipbuilding, engineering and coal mining were crucial to Scotland's economy.

This legacy is long latency occupational disease, such as mesothelioma, other work related cancers, asbestosis, pleural plaques and silicosis, in addition to conditions, such as vibration white finger.

Deaths resulting from negligent exposure to asbestos are not expected to peak until some time between 2015 to 2020, and recently workers have been diagnosed suffering from mesothelioma that could have only have been contracted through environmental exposure. These examples have included nurses, teachers and maintenance workers, where inhalation of the fibres could only have resulted from previously stable material having become disturbed.

[15] http://www.ohcow.on.ca/

In the case of teachers, for example, it has been said that this could be down to pinning posters and pictures on walls and disturbing hidden asbestos.

However, other cases of work-related cancers tend to go unrecorded and workers in Scotland could potentially be exposed to carcinogenic materials on an ongoing basis. Rory O'Neill from the Occupational Health Research Group at the University of Stirling and Hazards Magazine suggests that between 8% and 16% of all work-related cancers are occupationally related.

At an international conference on occupational cancer in April 2008, [16] Rory O'Neill acknowledged the role trade unions have played in identifying specific workplace cancers, but identified the absence of any co-ordinated campaign to highlight the issues.

We have seen individual campaigns, such as the asbestos cases and PHASE 2, a campaign in relation to the effects of exposure to carcinogens in "wafer" production at the National Semi Conductor Plant in Greenock.

The conference heard that the HSE, following a re-evaluation of occupational cancer statistics suggested that figures for instances may have been underestimated by thousands per year over a whole working generation. They also estimated the cost of each case of occupational cancer to be around 3million Euros per case.

These figures alone suggest that there are strong economic arguments for greater emphasis to be given to preventing exposure to carcinogens and the potential occupational cancers arising from this exposure.

Unite is currently campaigning for the UK computer components/ semiconductor industry to initiate industry-wide research into cancer risks in the industry. The union, in particular, wants the industry to institute the research proposed by the HSE/DTI Feasibility study published in 2005. This follows new evidence from the United States.

[16] http://www.nm.stir.ac.uk/research/oecp-presentations.php

The industry continues to deny there is a problem and the PHASE 2 campaign has been campaigning for over 12 years for an industry study in relation to cancer risks, initially as a result of increased incidences of miscarriages and then following higher than anticipated numbers of certain cancers in men and women, who work or have worked at National Semiconductor.

Recommendations

There should a broad based campaign to highlight the issues of occupational cancer and the costs to Scottish society involving unions, asbestos groups, Thompsons Solicitors and the research group at the University of Stirling to develop future preventative strategies.

The Scottish Government should carry out research into the costs of treating occupational disease in Scotland and raise awareness of conditions, such occupational asthma and dermatitis.

The Scottish Government should engage with trade unions and academics to identify potential health risks from new technologies, such as exposure to nanomaterials and implement adequate health screening procedures.

Occupational Health Research

Dame Carol Black in her report suggested that there was a significant lack of capacity in the United Kingdom for “traditional” occupation health research, with more focus on health and well-being than occupational disease and exposure to workplace risks. While the STUC realises the benefits of improving health and wellbeing in the workplace, there is still the need for robust academic research, especially into new and emerging technologies, such as nanomaterials and the potential hidden dangers they may pose.

As outlined earlier, trade unions have connections with the Occupational and Environmental Health Research Group at the University of Stirling and they have supplied a position paper with suggested actions that might address some of the issues raised in this paper.

Members of this Group were involved in preparing the independent study into working practices at the ICL plant in Maryhill in the period leading up to the explosion on May 2004.

In addition, the Healthy Working Lives Research Group at Glasgow University looks at issues in relation to health and wellbeing, and the contribution of improved health and activity in keeping people in work and living longer. This research should not be discounted and much of the research papers posted on the FIOH site related to health and wellbeing and the impact this has on the functional capacity of workers, the cornerstone of the Scandinavian occupational health system.

Recommendations

The Scottish Government and the STUC should work with the Occupational Health Research Group and other bodies to identify research opportunities within the devolved powers of the Parliament for independent research in the areas identified.

Conclusion

There continues to be significant gaps in the coverage of occupational health provision, accessibility to and consistency of services available to Scottish workers.

It is important that we do not separate the important aspects of occupational health, interventions, rehabilitation, occupational disease and research. These are central to trade union values and should not be overshadowed by the health promotion agenda, although this component on its own has an important part to play in the wider workplace health and wellbeing agenda.

The STUC and affiliated organisations will continue to push for the Scottish Government to develop an NHS funded occupational health service, accessible to all. The quality of private sector, occupational health provision should also be examined, along with a campaign to ensure that trade unions are involved in planning discussions, when employers are procuring or retendering for occupational health services.

Occupational Health and Safety Research in Scotland for Trade Unions and Workers. A position paper from the Occupational and Environmental Health Research Group (OEHRG) (Andrew Watterson, Tommy Gorman, Jim McCourt, Rory O'Neill) 12th December 2008

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Introduction

Whilst at one level there is recognition of the enormous toll that injuries and diseases have on Scottish workers, at another level, current UK governmental policies and initiatives fail to address these problems. Indeed, current policies of HSE and related UK-based Governmental departments have been framed and presented to move resources and staff away from the major problems. At the same time, cuts in HSE budgets and staff, serious across the whole of the UK, have been even deeper in Scotland than elsewhere.

These relate to the 'work is good for you' agenda, rather than 'good work that you can control is good for you' approach. This is linked to pressure on vulnerable people, and vulnerable communities where employment prospects are poor and likely to decline even further, to cease receiving incapacity benefits and move into schemes that often cannot deliver healthy work or any work in the short, medium and long term.

Population health in Scotland is poor and one important and neglected part of that picture is poor occupational health and safety.

Research on Scottish occupational health and safety

Scotland contains a number of institutions that have carried out research on UK-wide and also Scottish occupational health and safety subjects. Institutions outwith Scotland have also conducted studies within or including Scottish workplaces. Much, but not all, of this research has focussed on promoting health at work and is linked to lifestyle, rather than workplace hazard research.

There has also been an emphasis on behavioural safety. Additionally, what research there has been has often been funded by HSE, other government departments or industry. Such research often, but not always, answers only the questions that the funders wish to be addressed and is not 'independent research'.

The OEHRG at Stirling University, which is independent of both industry and HSE-funded research, has since 2000 produced a series of reports, peer reviewed papers and conference reports that have addressed workplace hazards both in Scotland and elsewhere in the UK. The group's papers include studies on the economic costs of asbestos-related diseases in Scotland, major workplace disasters, the occupational cancer burden in Scotland and policies to prevent such diseases, nanotechnology, the hazards of the electronics industry and the assessment of risks, particularly to shipbuilding, engineering, local authority, agricultural and forestry, fisheries and construction workers. In addition, the group has developed participatory action research (PAR) and observational methodologies that can be used by trade unionists, other workers and NGOs to address work environment and wider environmental hazards. Funding for such research has included IUF/ILO and EU grants, but most work has been funded within the University.

The group has additionally offered information, advice and support to many trade unions, including the BWI, IUF, IMF, ETUC bodies, STUC, TUC, GMB and Unite at international, national, regional, local and individual level.

OEHRG funding

Work for external organisations has, in most circumstances, to be covered by grant income. In certain limited cases, it is possible to subsidise some work informally by redirecting funds from other budget heads, but the scope for this is limited. Our international Cancer Prevention Conference in April 2008, for example, was financed by registration fees and monies donated in sponsorship.

Actions

We, therefore, believe the research agenda in the UK with regard to matters affecting Scotland and within Scotland should be:

1. to address workplace health and safety inequalities;
2. to identify effective and ineffective policies and enforcement on OHSE;
3. to contribute to an evidence base on hazard removal and reduction;
4. to ensure workers - in unionised and non-unionised workplaces - have access to high quality information and support on occupational hazards; and
5. to promote research and action leading to greater awareness of, and prevention strategies on, occupational and environmental carcinogens.

Greater research funding would permit more extensive work on the impact of workplace health and safety hazards, evaluation of workplace initiatives, such as toxics use reduction and sunsetting of hazardous materials, as well as the monitoring of new materials and processes, for instance nanotechnology, and development of PAR and other tools to contribute to the prevention of workplace ill-health. In the USA, a NIOSH new directions scheme funded exactly such work through trade unions on OH&S. In the UK, the Beacon projects that relate to public engagement activities by Universities may also offer a way forward, although trade unions do not appear to have shaped their current work.

Funding work of relevance to trade unions and NGOs has been marginalised in the UK and should be prioritised in the future as an important strand of the evidence base needed in civil society to reduce the human and economic burden of workplace and related wider ill-health . The Scottish Government is well placed to correct past mistakes in this field. It can link research on health policy and practice, which is within its control, to occupational health and safety that is reserved, and to enterprise and environmental activity also within its control. All these activities impact directly and indirectly on worker health and safety.