Occupational Health

Small Plant Health Services and the Health Officer

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THE PROGRESS made in occupational health in the past 50 years has been tremendous. Services that started out to provide traumatic surgery alone now encompass such elements as preplacement, periodic and return-from-illness examinations, treatment of occupational illnesses and injuries, emergency treatment of nonoccupational conditions followed by referral to family physicians for definitive care, health counseling and education, the prevention and control of job-related environmental health and safety hazards, and proper recordkeeping with the provision for confidentiality of personal health files. Through the application of the principles of preventive medicine and public health, we are now in a position to prevent illness, disease, and disability and to maintain optimal health of employed persons.

In addition to the emphasis now being placed on prevention, a most significant development in this field is management's growing recognition of its obligations to provide a safe working environment and its opportunity to promote better health for workers. This attitude is more than the response to a humanitarian impulse. Experience has shown that occupational health programs, properly organized and conducted, lead to reduced absenteeism from sickness, improved employee morale, increased productivity, decreased personnel turnover, and lowered compensation-insurance rates.

And yet, despite this notable progress, the fact is that occupational health services are at present available to comparatively few workers. Particularly lacking are services to employees of small plants—those with fewer than 500 employees. Seventy percent of all workers are employed in plants of this size. Less than 5 percent of these employees have available to them any type of inplant, on-the-job medical services. This situation is and should be of concern to all public health workers.

To what can we ascribe the relatively slow acceptance, especially by small plants, of programs so mutually beneficial? Three main reasons can be cited:

- Lack of appreciation (and perhaps knowledge) by management of the many benefits and advantages to employer as well as employee.
- Belief on the part of management that costs of such programs are excessive.
- Difficulty in obtaining advice and assistance in developing such services.

What can the health officer do to rectify this situation? By adding to his own knowledge of local factors an acquaintance with the efforts being made elsewhere to provide health services for small plant workers, the health officer can choose the approach—or approaches—that might best succeed in his community and then attempt to stimulate appropriate action.

Practical Programs

Experience offers a variety of practical methods for providing health services to employees of small establishments. Here are five of such programs which have seen successful operation.

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Part-time inplant medical services have been sponsored cooperatively by managements of several companies in a community. Typical programs are the Hartford (Conn.) Small Plant Group Medical Service and the New Haven (Conn.) Small Plant Medical Program, which have been operating 11 and 3 years respectively. Organization of the Hartford group was spurred on and the program continues to be supported by an official of one of the member companies. In New Haven the chamber of commerce took the initiative. In both communities, the bureau of industrial hygiene of the Connecticut State Department of Health has lent its active support and guidance.

In both programs one full-time physician is employed by the member companies, each of which maintains its own dispensary and full-time or part-time nurses. The physician visits each plant at a scheduled time and is available for emergencies at all times. Each member company designates one employee as "coordinator" with responsibility for the program's administration in his company. At least once a year the coordinators from all member companies meet to transact joint business.

Experience in these two communities indicates that this type of program works well when some one person in the community is actively interested in the program, the chosen physician is "dedicated," and there are health facilities and personnel in each plant readily available to the employees.

Union health centers provide varying health services for their own members. An increasing number of such centers are now providing services to members of other unions in the community or are being organized jointly by two or more unions. The services include definitive medical care and, increasingly, preventive services. Many centers also serve families of members.

Individual physicians or groups of physicians themselves have provided part-time, inplant medical services. Some physicians are limiting their practices to industrial medicine and serving a number of plants. In such cases they usually visit the plants and are concerned with on-the-job environmental conditions as well as with provision of emergency care and physical examinations. In many instances, however, the physician is "on call" for emergency care only. Plants with this type of program may or may not employ nursing personnel or contract with a visiting nurse association for inplant service.

It is estimated that more than 25,000 physicians are doing industrial medical work—5,000 full time, 10,000 part time, and another 10,000 on call. But only 164 of these have been certified in occupational medicine by the American Board of Preventive Medicine, and only 3,400 are members of the Industrial Medical Association.

Mobile clinics have been established in a number of communities under various auspices. Nonprofit organizations have been established to operate such clinics in at least two communities (Birmingham, Ala., and Atlanta, Ga.) with the support and guidance of health department personnel. In Asheville, N. C., the privately owned and operated Occupational Health Service has several mobile units which provide comprehensive physical examinations at the plant site, with the necessary adjunctive laboratory and X-ray studies. A number of the locals of the International Ladies Garment Workers Union are using mobile units to provide examinations for their members near or at their place of work.

Insurance companies have assisted many establishments in developing occupational health programs. The varying types of such assistance have included the provision of inplant nursing services.

Role of the Health Department

Health department interest in the promotion of occupational health services has been largely confined to the activities of approximately 40 States and 20 local health departments which have special units for this purpose. A recent count, including the three State labor department programs in Illinois, Massachusetts, and New York, reveals that a total of 355 employees are engaged specifically in occupational health activities. It is significant, however, that 289 of these are engineers, chemists, physicists, or other nonmedical workers, while only 31 are nurses and 26 are physicians. It may be concluded, therefore, that in some of the State and

local occupational health programs there is underemphasis of preventive medical aspects.

It has been said many times before and should be repeated and repeated again—health on the job is and must be related to health away from the job. This seems obvious enough, but it is amazing how often this interrelation is disregarded. It is important for those planning occupational health programs to do so with an understanding of community health activities and an appreciation that integration of the two is the essential program ingredient. The current emphasis on prevention and early diagnosis of long-term illnesses makes more apparent than ever the need for concurrence in approach and operation of all health programs.

It appears obvious that the health department, of all community health agencies, is best equipped to provide this holistic approach. Is it not timely for health officers to take a fresh look at their occupational health activities, particularly from the viewpoint of relating them to their other program activities? It is possible that a health department's consideration of these questions may reveal activities that need strengthening, areas that need exploration:

- What information have we about the size, number, and kinds of industrial and business establishments in this community?
- How many of them have occupational health programs? Which elements of a comprehensive program are being neglected?
- What services does this health department now provide to industrial and business establishments? Are our nurses, sanitarians, nutrition consultants, and health educators visiting them?
- Are the accident programs in plants adequate? Are toxic agents well controlled? Are health department services in these areas being utilized? What additional services are required? Should we provide them? What services and information are available through other official sources—State labor departments and workmen's compensation agencies, for instance?
- What services are voluntary agencies providing to industrial establishments?
- Is the health department providing chest X-ray and serology services to plant health programs?
- Have we conducted any surveys—diabetes, glaucoma, tuberculosis, syphilis—among employees?
- What more can the health department together with the medical society, the chamber of commerce, the trade associations, unions, and other voluntary agencies do to assist establishments in organizing effective occupational health programs?
- Are we setting a good example by providing the services of a good occupational health program for State and local government employees?

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