Health Services for Government Employees

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IF I WERE asked to write a television "spectacular" to dramatize the subject of health services for government employees, I would start with two pictures, each to be flashed on the screen ahead of the story.

In the first picture I would show a government officeworker opening his desk drawer. Hidden in the drawer are a few half-used bottles of patent medicines, an aspirin bottle, and a plastic container of a prescription medicine. Next to them are a few band-aids, a half-full iodine bottle, and a bottle of eyewash. You would watch this employee take a pill out of the bottle and hand it to a fellow worker.

The second picture would take you into a well-equipped dispensary in a large government office building. A nurse is treating an employee who has a cut finger; another nurse is counseling a rather obese young stenographer; the medical secretary ushers a job applicant with a physical impairment from the waiting room to her desk, while another employee is leaving the physician's consultation room after a health maintenance examination. On the wall is the framed certificate of the Occupational Health Institute.

These two pictures delineate our subject: health services provided for government employees. A natural question arises at this point: Are we practicing what we preach? Now we have to ask which of the two pictures reflects our own situation.

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The fairest reply to the question is, "Not yet, but we try." In private industry, medical departments have for many years been an integral part of many companies with large employee populations; the picture is spottier regarding the small plants.

But in government, be it the Federal, State, or the city-county level of metropolitan centers, the concept of employee health services is an innovation which is only slowly making headway.

Before examining some of the problems which seem to hamper a rapid spread of employee health services over the Nation, you might find it of interest to take a bird's-eye view of the employee health service which I direct.

Pennsylvania Health Service

The Commonwealth of Pennsylvania has more than 73,000 persons on its payroll. Of these, about 12,000 are employed in the capital, Harrisburg. The State government functions through 32 departments, varying in number of employees from a few to many thousands. In 1947, following the heart attack of one of its members, the State legislature approved the establishment in the capitol of a first-aid room staffed by a nurse.

Some of the larger departments followed, each organizing a first-aid room staffed with one or two registered nurses who worked without medical supervision. Since the lack of such supervision materially limited the scope of their work, in the fall of 1957, four State agencies which together have about 7,000 of the 12,000 employees in Harrisburg agreed to set up an employee health service for their workers. This started in early 1958.

At present, the staff comprises a full-time medical director, a part-time psychiatrist, six registered nurses, and a part-time medical secretary. Four health units are maintained. The nonparticipating departments receive only emergency service because of staff limitations.

In the near future, however, this inequality of service will cease. The expansion of the employee health service to cover all State employees in Harrisburg has been approved. When it is completed, the staff will comprise 2 full-time physicians, 1 part-time psychiatrist, 12 registered nurses, 1 nurse supervisor, and 2 medical secretaries. The number of health units will increase to eight. An enlargement of the staff might be necessary in the future. Then all of the State employees in headquarters will receive the same treatment.

Once this expansion at Harrisburg is functioning properly, employee health services will be set up for the two other centers of heavy State employee populations, Philadelphia and Pittsburgh. There are at present nurses working without adequate medical direction in the State office buildings in these two cities.

The scope of our work does not differ materially from industrial medical departments of private industry. In the curative phase we treat occupational injuries and occupational diseases, providing emergency treatment for illnesses and accidents of employees and visitors, and treat minor health impairments for which ordinarily no medical care is sought from the family physician. We also treat an employee temporarily to enable him to finish his workshift until he can see his own physician.

In the preventive phase, health maintenance of our employees is encouraged. Periodic health examinations, special examinations in problem cases, mass inoculations, special health projects, health education and counseling, and protection against environmental hazards are the tools.

Staff limitations still curtail the full implementation of the program at the present. Preplacement examinations are in the planning stage. Our employee population is unique in several aspects. Since the State has no compulsory retirement age, there are many aged employees who pose geriatric problems. We employ successfully several hundreds of physically impaired workers, epileptics, and discharged patients of mental institutions, a practice that sharpens our alertness for proper job placement.

A considerable number of our employees are daily commuters, making round trips of up to 180 miles. This influx of commuters is largely caused by unemployment in the coal regions of our State. Since these employees ride mostly in car pools of up to nine persons (in a station wagon), perplexing problems often result when one of them gets sick during the day and is too ill to carry on, but not sick enough to be hospitalized at Harrisburg. About one-third of the employees are on civil service rosters; the rest are patronage workers. This describes our service in a nutshell.

The Challenges

If we look across the Nation, we find relatively few adequate government health services. So far they are rather the exception than the rule. A critical look at the problems of the existing health services might explain why they are still a novelty. We might group our problems in (*a*) general categories also existing in other industrial medical departments and (*b*) those derived from the official character of our enterprises.

The most urgent of the general problems has to do with communications. People do not really know what industrial medicine is and what industrial physicians are doing.

This lack of knowledge is about as widespread among our fellow physicians as it is among lay people. Both groups have some strange notions about the scope of our work. We should try to define our place as supplementing the practicing physician but not replacing him. This education should start with our colleagues working in the field of public health, some of whom represent the executive management level of our organization, and then extend to the rest of the medical profession. I see an urgent need for a "Madison Avenue type" campaign by the organizations represented in the Industrial Health Conference.

In spite of the existence of the Council on Occupational Health of the American Medical Association, and the corresponding committees

of the State and county medical societies, the practicing physician often views the industrial physician as his enemy who will undermine his practice. We must do more advertising for occupational medicine. We are not the precursor of "government medicine." We do not pave the way for "socialized medicine."

We should tell more about the preventive phase of our work. We should stress that we actually increase the caseload for the practicing physician by our efforts in detection of early disease. We should emphasize that our work tends to foster better relations between the employee and his family physician.

We try to give better health maintenance to our employees. This increases the number of patients who will seek the remedy from the family physician for the ailments occupational physicians detect and diagnose. We can do the motivating to seek treatment, frequently in a much more forceful manner than anyone else.

To the employee, we represent, in a sense, management, with its power to continue or stop employment within established regulations. The asymptomatic disease in its very beginning does not make the employee see his family physician, but we are able to find it and successfully persuade him to seek treatment and cure. We supervise the most important 8 hours of the breadwinner's day, on which the successful completion of the other 16 hours depends.

Once the practicing physician realizes that the scope of our work in industrial medicine does not compete with his goals, any hostile attitude that he may have will give way to a better understanding of our specialty. We should not stop with the medical profession. Our educational campaign should extend to the general public. Once people learn that there is more to occupational medicine than dispensing aspirin and band-aids, the concept of health maintenance will be more universally accepted.

In this respect, such an effort will not only alleviate our own problems derived from being in a little-known specialty of medicine, but it will raise the health status of the population. We must speak for ourselves, however. No one else will.

What special problems are created by our position as government enterprises? In contrast with private industry, government is a nonprofit organization and its operational funds are obtained from an elected tax raising and appropriating body. Government operations are, of course, in the public spotlight and are often exposed to pressure groups who sometimes work in the open as lobbies, sometimes more subtly. Health services for government employees are an especially inviting target. Activities which are completely within the approved scope of health maintenance and which are routinely done by private industrial medical departments are singled out by some physicians as competitive with private practice, and pressure is brought upon the government medical department to stop them.

This puts us on a spot. I feel we ought to have the courage of our convictions to do what we think is right, even if we might have to overcome our fear of stepping on somebody's toes. If we do not do this, we betray the trust placed in us by the taxpayers. We are charged by them to give health maintenance to our employees and to prevent occupational disease and occupational injury. If we fail to do so, the results are more lost man-hours, inefficient work by untrained replacements of workers, and lowered work efficiency caused by borderline health.

All this costs the taxpayers money; we all pay in one way or another in higher taxes. We are trying to persuade private industry to provide adequate medical service for its employees. But has not the time come that we should put forward a more forceful effort to do in our own yard first what we want our neighbors to do in theirs?

A government employee health service can be used for many pilot projects. It seems wiser to gain experience in our own organization before suggesting a certain project to private industry at large. If we have a model setup in government service, it can be used as a training center to help physicians and nurses of private industries organize their own medical departments.

Let us turn to another problem which becomes more apparent in governmental employee health services—the battle of the budget. We all know the slogan "Good health maintenance costs nothing, it pays." The publication, "Functions and Objectives," of the Occupational Health Institute of Chicago, gives the finding of the Ameri-

can Management Association that "the medical dollar produces more than any other dollar spent by industry."

The benefits of a medical program, however, are hard to measure in cost. In a government setup it is often harder than in private industry to obtain funds for equipment and for salaries adequate to attract highly qualified personnel. In that aspect private industry is a formidable competitor. Government operations, including the bidding system for filling State orders, are slow and its regulations unyielding. The expression "red tape" originates from government operations.

Funds come from more than one source, adding to administrative difficulties. It is very difficult to educate management that employee health services are concerned with living human beings and not with paper projects and that an administrative shortcut is sometimes vital.

This leads us to another problem, which we share, incidentally, with our colleagues in private industry: the position of the employee health services inside the organization. It is a direct staff service. The Occupational Health Institute, in its "Functions and Objectives," suggests that the "medical director . . . report to some responsible member of management who is familiar with the managerial interpretation of medical policy, and whose assistance can be relied upon in implementing that policy."

A close liaison with the personnel department seems imperative. The problems of the medical and the personnel departments often overlap. By close cooperation and mutual respect for each other's prerogatives, maximum benefits for the employees result. Another strong force which in private industry is often very useful for an improved health program, the labor union, is not very powerful in government services.

Let me touch briefly on another problem. Employees in a health department have as their superiors many administrators who are physicians. These medical men cannot always successfully resist the temptation to treat their own employees in a makeshift manner, even though their offices lack the necessary equipment and the professional sample just received in their mail might be inferior to the medication a well-equipped dispensary might have available. Besides, the confidential nature of medical records should be preserved, even when the "boss" happens to be a physician.

So far I have stressed exclusively the external problems of employee health services, the relationship to the "outside world." A final word about an internal question. It is a mistaken belief that government employees are mostly desk workers. While desk workers constitute a great number, we should not overlook the many other occupations, the air pollution specialist, who has to climb smokestacks, the printing press operator, the gardener, or the radiation physicist. There are also machine operators and truckdrivers. All these varied occupations present a challenge to the medical knowledge of our personnel.

Adequate space, up-to-date equipment, and effective medication are prerequisites for a modern employee health service. Lay-advertised patent medicines should not be used. Continuous postgraduate training of the personnel is important. On all levels the expert knowledge of other health department divisions should help toward inservice training.

I have deliberately put the spotlight in my presentation on the problems facing health services for government employees. This should not be interpreted to mean there are no achievements and that no progress has been made. But I feel it is not well to present a glowing recitation of a chamber of commerce type report of local happenings which would have little practical value.

The sum of these statements points out that we have to make a choice. Do we want the working places of government employees to be nests of ill-advised self-treatment, or are we ready to equip them with the facilities of a modern occupational health center? If we make the right decision, we will be able to answer the question of whether or not we are practicing what we preach with a proud, "Yes, we are."