ARVO B. EDERMA, M.D.

The Public Health Service received the 1970 Health Achievement in Industry Award of the Industrial Medical Association on April 15, 1970, in recognition of the excellence of the occupational health program provided to Federal employees by the Division of Federal Employee Health.

The philosophy of the division in providing good health services and an overview of the history of its development into a modern occupational health service are discussed in this paper. It is based on a speech given by Dr. Ederma at the Western Industrial Health Conference, October 17, 1969, in San Francisco. Dr. Ederma is assistant director for clinical services, Division of Federal Employee Health, Health Services and Mental Health Administration, Public Health Service.

Occupational Health Services for Federal Employees

Modern health services for Federal employees are now a permanent part of the organizational structure of the Government. In May 1969, the Federal Government had a total of 2,991,355 civilian employees, according to the Civil Service Commission (*1*). Of these, 2,956,097 were in the executive branch, 28,598 in the legislative branch, and 6,600 in the judicial branch.

In 1965, the Civil Service Commission conducted a survey of occupational health programs of Federal employees (*2*). According to this survey, health facilities varied greatly in size, equipment, and personnel. The differences reflected the needs, resources, and interests of the particular installations they were serving. Two major groups were distinguishable.

Some agencies, like the Veterans' Administration and the Department of Health, Education, and Welfare, operate their own hospitals. Military installations provide medical care to military personnel. The Justice Department operates prisons and provides medical care to inmates. The employees of such installations generally have access to the health services of these medical facilities. This type of facility, of which there were 651, was designated as a mission-oriented facility.

Other installations have facilities specifically to provide occupational health services to their employees. There were 227 of these ordinary facilities.

Federal installations are located in every State and in the District of Columbia. The existence of health facilities in any area depends not only on the number of installations and the number of employees in the area, but also on

the mission of the installations. In 27 States and the District of Columbia, 70 percent or more of the Federal employees had access to health facilities.

Background

Before 1946, the Public Health Service had, for many years, made studies and given professional advice to private industry and to agencies of the Federal Government on specific industrial and occupational hazards. By the close of World War II there was no clear-cut policy to guide Government agencies in achieving an employee health program. Such sporadic programs as did exist were the scattered results of individual agency decisions.

Little was being done—and that seldom on an organized, planned basis—to provide Federal employees with the occupational health care services that were steadily becoming commonplace in private industry.

The 79th Congress on August 8, 1946, enacted Public Law 658. This legislation established the basis which enabled all the departments and agencies of the Federal Government to provide health services for their employees. This law designated the Public Health Service as the Federal Government's expert to advise other agencies on employee health standards and criteria.

The law reads in part, "for the purpose of promoting and maintaining the physical and mental fitness of the employees of the Federal Government, the heads of departments and agencies, including Government-owned and controlled corporations are authorized, within the limits of appropriations available to them, to establish by contract or otherwise, health service programs which will provide health services for employees under their respective jurisdictions."

Under the basic charge given to it in Public Law 658, the Public Health Service spent the next several years reviewing existing health service programs for employees, assessing the problems to be solved, and in making studies and reviews that would serve to develop standards and criteria for the kinds of professional services and personnel that would be needed to carry out a typical occupational health program.

Moreover, the intent of the law, and the best concepts of excellence in occupational health, clearly dictated that an employee health service program should be a preventive health program.

The events of the early 1950's led to severe economy moves and retrenchment of the Service's efforts to implement employee health programs. In addition, the policy statement covering the establishment and operation of Federal employee health services approved by the President in January 1950 failed to include what was, for the Public Health Service, the most important element in the Federal employee health service, namely preventive programs relating to health.

In 1957, the Asian influenza epidemic and its threat to the work force in and out of the Government brought urgent pressures to provide immunizations for Government employees to limit the loss in work time. This activity sparked a new interest in employee health programs within the Federal Government.

Since 1958, the staff of Federal employee health programs has sought to establish formal criteria and standards for Federal employee health services, including their nature, content, and scope. These standards have achieved Government-wide recognition and their validity has been demonstrated in the successful upgrading of operations for about 135,000 employees of various Federal agencies. These operations are conducted by HSMHA's (Health Services and Mental Health Administration) Division of Federal Employee Health. The employees receive health services under approximately 600 different contracts with the division.

Recent Developments

In the last 4 years, Federal management and employees have recognized that good health is an important factor in employee efficiency and productivity.

President Johnson sparked renewed interest in occupational health programs within the Federal Government by his statement of June 18, 1965, to the Cabinet setting new guidelines for Federal employee health service programs. The President said, "The efficiency and productivity of Government employees is one of our primary concerns. . . .

"Good health and good work go together.

Within the Government itself, we must do all we can to avoid the waste that results from sickness and disease.

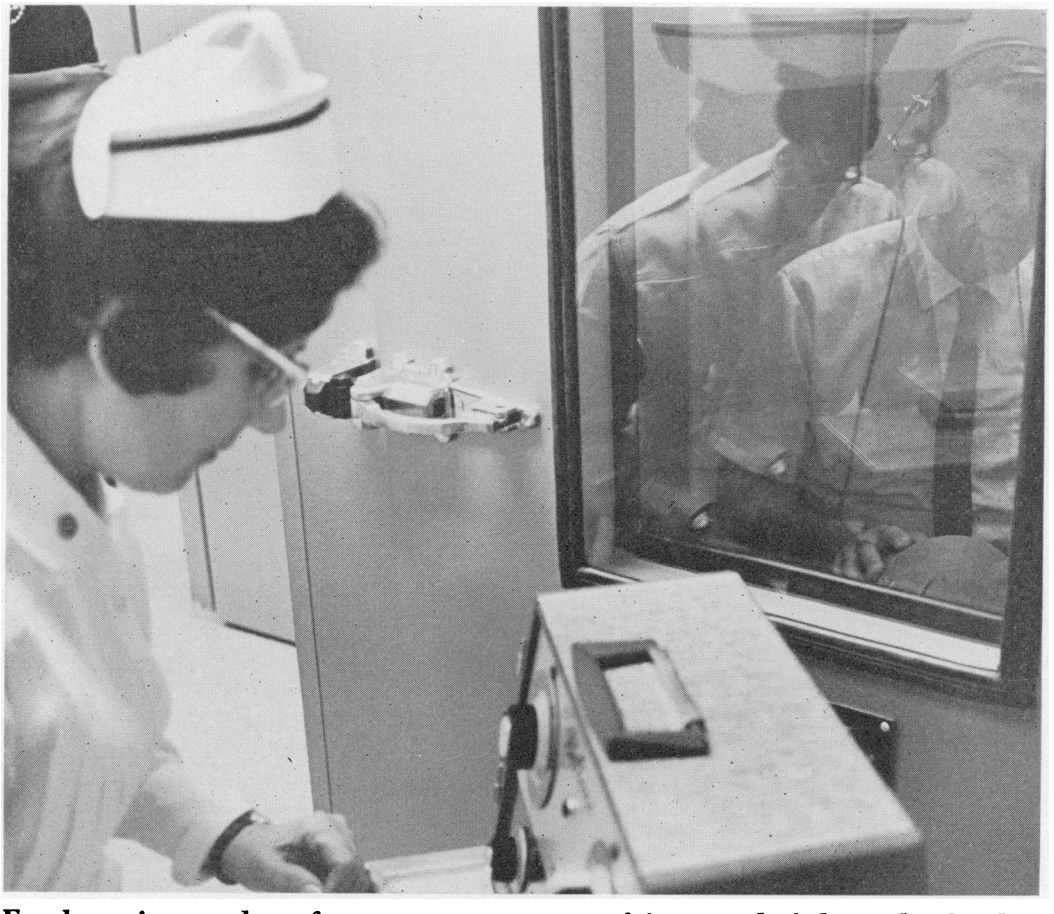
"Each year, about 20 million days of sick leave are taken by Federal civilian employees. If we can reduce the amount of sick leave taken by the average employee for just one half-day, it means the equivalent of over one million man-days per year. . . ."

The President said further, "Private industry in the United States discovered long ago that a good employee health maintenance program is a paying proposition. The Federal Government has not kept up with the example set by private employers. I want the situation to change. I want the Federal Government to catch up with the practices of our efficient private enterprise, and in time become a model."

Also on June 18, 1965, the Bureau of the Budget issued circular No. A–72 (*3*). This circular replaced the 1950 policy statement. It established criteria to be followed by the policy-makers of the executive branch departments and agencies in providing health services permitted by the 1946 act, in relating them to programs established to provide medical and other services, and in eliminating the health risks under the Federal Employees Compensation Act.

The circular states in part, "The head of each department and agency, therefore will review existing programs and is authorized and encouraged to establish an occupational health program to deal constructively with the health of the employees of his department or agency in relation to their work.

"An agency or department, after consulting with the Public Health Service as to occupational medical standards and methods for providing medical services in performance of duty injury cases and for appraising health risks as



Employee in soundproof room concentrates on faint sounds fed into his headset as nurse tests his hearing

Employee's eyes are examined using an Orthorater

authorized under the Federal Employees' Compensation Act, is authorized to establish, within the limits of available appropriations, an occupational health program. . . ."

The scope of the services authorized by circular No. A–72 is essentially that endorsed by the American Medical Association in its statement on the scope, objectives, and functions of a health program for employees.

The language of the new policy statement encouraged the Service's staff dealing with employee health to establish liaison with the Civil Service Commission and the General Services Administration. Mutual interest and responsibility for the promotion of health programs of excellence for Federal employees has been enhanced by collaboration with these agencies.

HSMHA and other Federal agencies are empowered to enter into cooperative arrangements to supply authorized employee health services when convenient and beneficial to the operation of the Federal Government. Thus, HSMHA is authorized to organize and operate Federal employee health services for other Federal agencies. HSMHA is reimbursed for the cost of these programs.

Presently, executives of each department and agency have several alternatives for establishing and operating health programs as they deem necessary.

1. Use existing professional staff or facilities, where adequate, of the department or agency.

2. Enter into an appropriate agreement with another Federal department or agency where

staff or facilities are inadequate and where another department or agency has adequate professional staff or facilities.

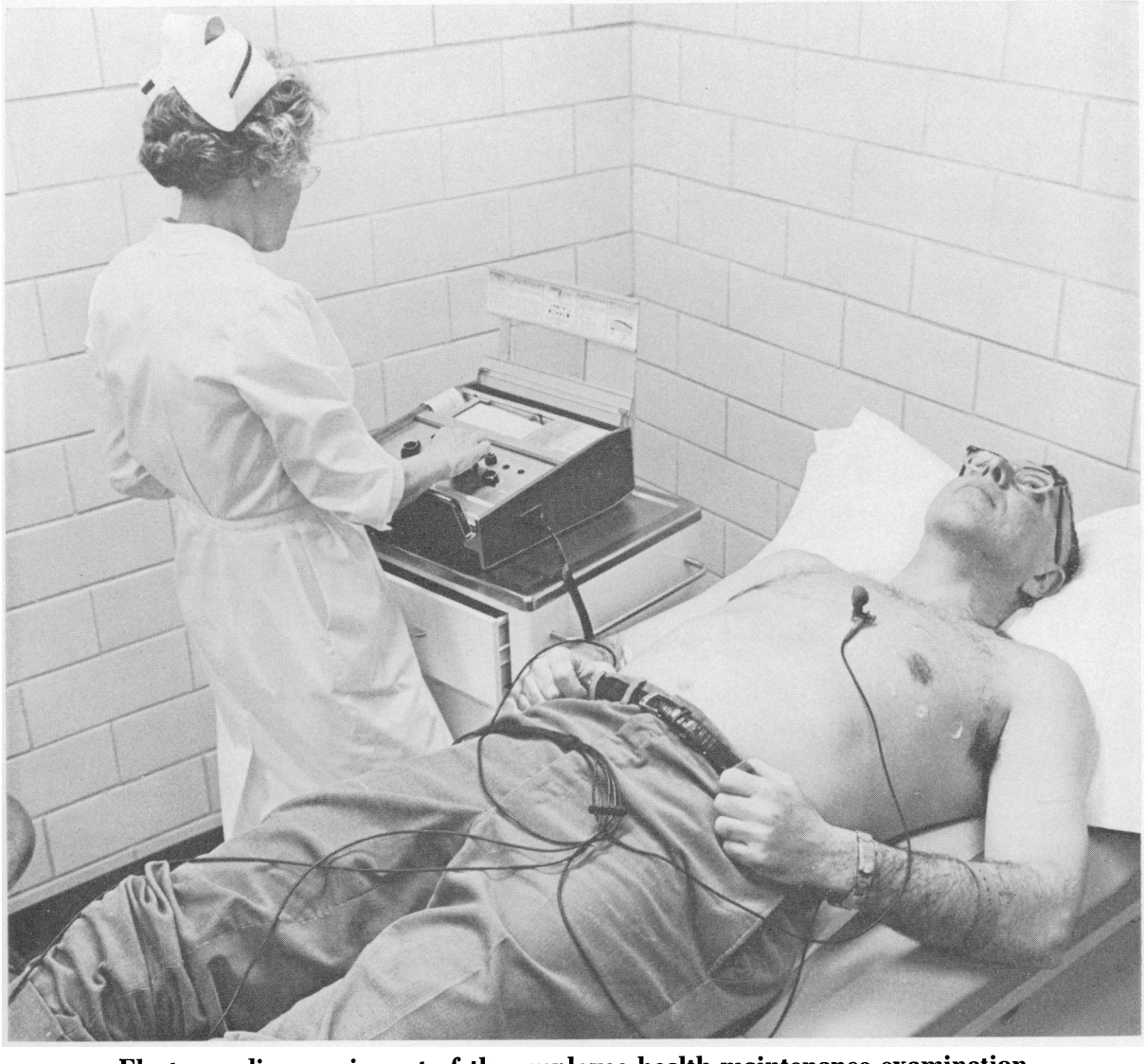
3. Establish their own professional staff or facilities, or enter into an appropriate agreement with qualified private or public sources for professional services, including consulting services and facilities, when neither the agency nor the other Federal department or agency has adequate staff or facilities.

As a result of the 1965 Presidential policy statement, the demand for consultation and for assistance and operation of employee health programs on a reimbursable basis has greatly increased. On June 1, 1966, Federal employee health activities were elevated to division status within the Public Health Service—the Division of Federal Employee Health. The division has the following missions.

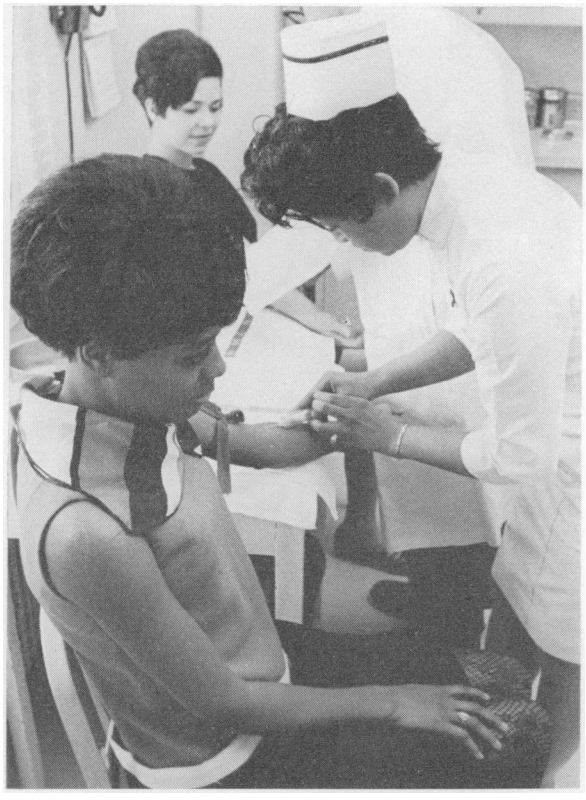
1. It promotes activities designed to protect the working health of Federal employees to maximize their productivity.

2. It conducts research studies, training, and demonstration projects, develops medical standards and methods, and provides consultation on and stimulates the development of improved health programs throughout the Government.

3. It evaluates, upon request, Federal agency



Electrocardiogram is part of the employee health maintenance examination



Nurse drawing blood sample for testing

health service programs for employees in relation to standards.

4. It administers employee occupational health programs for other Federal agencies by mutual agreement on a reimbursable basis.

The consultation services of the Division of Federal Employee Health are varied. The division inspects and reviews physical facilities for compliance with standards for space requirements and gives direct assistance in planning space layouts and functional management. The aid can include making architectural drawings. It supplies information and recommendations on specifications, sources, and cost of equipment and supplies. Professional advice and assistance are given to define the nature, content, and scope of an occupational health program. The division also issues publications and informational releases on standards and methodologies for programs, as well as professional guides and manuals on administration. The division also formulates standards and criteria for professional staffing.

The division has established occupational health service programs in large centers of Federal employment (*a*) to provide prototype health services as demonstrations for other Government agencies in the geographic area, (*b*) to function as a geographic area resource for decentralized division consulting services under the guidance of an area medical consultant, (*c*) to serve in the development and evaluation of new health service program projects, and (*d*) to provide centers for short-term training of professional personnel.

During the past few years the Public Health Service has developed a number of manuals and guides to assist agencies and departments in operating their own employee health services. These guides, although designed for typical Division of Federal Employee Health operations, can be modified to fit the special needs and missions of a particular agency.

A Minimum Employee Health Program

What does the division recommend as the minimum for an adequate employee health program? The following recommendations for a minimum program apply where employees work in a particular building or adjacent buildings, regardless of the size of the participating population (*4*). In other words, the program components will be identical whether there are 300 or more than 5,000 employees.

Periodic employee health maintenance examinations. We recommend biennial examinations, limited to employees whose work involves a health risk and to other employees aged 40 and older, with the agency selecting the specific employee on a voluntary basis. Employees under age 40 may be included in the periodic medical examination program if the occupational situation warrants.

Periodic testing for chronic diseases. Tests for early detection of chronic disease or disorders such as diabetes, visual defects, glaucoma, cancer, and hearing defects are offered. These tests are voluntary. Employees are referred to their personal physicians for final diagnosis and treatment.

Immunizations. Influenza, tetanus, smallpox, and other immunizations are provided at weekly immunization clinics.

Emergency treatment. Emergency treatment is given to persons whose illness or injury

was incurred in the performance of duty or by proximity to hazards caused by employment. Other on-the-job care will be given by the health unit as required to allay pain, discomfort, and anxiety, to allow completion of the work day, and to provide interim care before arrangements are made for medical attention by a personal physician. Emergency ambulance service is initiated by the health unit personnel.

Referral to physician or dentist in private practice. This activity is one of the most important for the health needs of the individual employee. It is the goal of all preventive health programs that involve examination, testing, and screening.

Health guidance and counseling. Health guidance and counseling are given to all employees. Basic principles of health are promoted by presenting and distributing health education materials.

Treatment requested by physicians in private practice. Health units may administer certain treatments, such as allergens and vaccines, requested by the employee's physician. The employee is required to supply the medication.

Safe environment. Assistance is given to detect and solve safety and environmental sanitation problems.

Health unit personnel act as technical and advisory resources in helping to solve problems relating to the work environment and its effect on health. The Service's specialists in occupational hygiene and environmental sanitation will make surveys to determine hazards in the work environment that involve toxic fumes, debilitating noise levels, and other occupational hazards.

Employee health records maintained. Employee health records are strictly confidential and are kept in the health unit. Health records cannot be released except by written permission of the employee and then only to a medical facility or to a physician in private practice. Any record may be obtained by an appropriate court order.

Mental and emotional evaluations. The staff of the health unit assists management in evaluating the relationship of an employee's health to his work performance. This function might include an informal consultation with a psychiatrist available to the health unit staff.

Fitness for duty examinations. Diagnostic facilities are not extensive enough in most health units to permit the staff to perform adequate fitness-for-duty examinations. Management staff may consult with the health unit physician and request assistance in referring the employee to an appropriate medical facility that performs such examinations.

Preemployment examinations. The health unit does not do any significant number of preemployment examinations, since the Federal Government has abandoned preemployment medical examinations for most white collar positions.

Conclusions

There remain gaps and problems in Federal employee health services similar to those arising in the provision of services in the private sector of our economy. Small Federal agencies are poor and cannot afford services. Many Federal employees work in small groups in remote places.

When competition for the available dollar—tax as well as profit—is severe, employee health services are often restricted or reduced. Current efforts to restrict Federal spending will have a short range effect of slowing the growth of the number of health units and employees served. But the trend is clear. Federal employee health services have proved themselves valuable and desired. Management interest—coupled with militant Federal employee unions—will spur program expansion.

Ways will be discovered to provide services to small scattered groups of employees and to upgrade existing services. The vast numbers of Federal employees and agencies make cost-sharing feasible at a price all can afford. Efficient and practical mechanisms only need to be devised. Some of the ideas we are considering include introduction of off line multiphasic screening, mobile units assigned to metropolitan areas, full-time master units, and part-time satellite units.

Government, too, has become production oriented, and Government managers now realize that people influence production. Government has a vital in-house stake in the health of people who work.

REFERENCES

(*1*) U.S. Civil Service Commission: Federal civilian manpower statistics. Washington, D.C., May 1969.

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(*3*) U.S. Bureau of the Budget: Federal employees occupational health service programs. Circular No. A-72. U.S. Government Printing Office, Washington, D.C., June 18, 1965.

(*4*) U.S. Public Health Service: An administrative guide for Federal occupational health units. PHS Publication No. 1325-A (revised). U.S. Government Printing Office, Washington, D.C., 1969.

Tearsheet Requests

Arvo B. Ederma, M.D., Room 14-46, Parklawn Building, 5600 Fishers Lane, Rockville, Md. 20852

Recommendation for Increased Iron Levels in the U.S. Diet

According to the Food Consumption Surveys by the U.S. Department of Agriculture in 1965, the dietary iron intake of the female population between the ages of 10 and 55 averaged about 11 mg. per day, whereas the dietary allowance is 18 mg. per day. The 11 mg. per day can be estimated roughly as 5 mg. from meat and eggs, 3 mg. from vegetable produce, and 3 mg. from grain products. The consumption of grain products approximated one-fifth pound per day (flour equivalent).

To rectify this discrepancy, the Food and Nutrition Board of the National Academy of Sciences-National Research Council considers that the dietary iron intake by the female population in this age group should be increased by at least 5 mg. per day. The forms of iron used for this purpose should insure 10 percent absorption. The Board believes that this can be accomplished most readily by increasing the levels of iron now prescribed by Federal standards for enriched cereal products.

The Board recommends that the standards of identity for flour and bread enrichment be changed to permit the addition of no less than 40 mg. or more than 60 mg. per pound of flour and no less than 25 mg. or more than 40 mg. per pound of bread. The desirable goal is a minimum of 50 mg. of iron per pound of enriched flour and 30 mg. of iron per pound of bread. Present enrichment standards provide for a minimum of 13 mg. and a maximum of 16.5 of iron per pound.

The Food and Nutrition Board further recommends that wherever technically feasible, enriched wheat flour be used for the preparation of specialty bakery products, which are not now enriched. It also recommends that the standards of identity for enrichment of cornmeal, corn grits, rice, farina, macaroni, and noodle products be changed to permit the addition of no less than 40 mg. and no more than 60 mg. per pound.

In 1965, the maximum average consumption of flour by males 18–19 years old was about one-third pound per day. This amount would provide, if enriched at 50 mg. per pound, 17 mg. of iron. The average intake from other sources was about 12 mg. per day. Thus, the maximum intake by males, if flour were enriched with iron to 50 mg. per pound, would not likely exceed 30 mg., and no adverse physiological consequences would be expected at this intake.

The Food and Nutrition Board would not support the widespread enrichment of a large variety of food items. It believes that the recommended increase in the iron enrichment of cereal products could be expected to raise the amount of iron in the American diet by approximately 5 mg. per day. It recognizes that there should be an evaluation of the effectiveness of such increased cereal enrichment in meeting the needs of all population groups.

The full report, entitled "Recommended Dietary Allowances," Publication No. 1694, revised 1968, may be obtained from the National Academy of Sciences-National Research Council, Washington, D.C.