Social Relevance of the General Check up in Occupational Health

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SUMMARY

THE emphasis of medical examination have evolved along with the history of medical sciences, and adapted itself to various social frameworks. The interrelationships between changing forms of medical acumen and social relevance, have in the past half of this century brought about new paradigms like occupational medicine and medical insurance both of which have certain common interests. In this review an attempt has been made to re-emphasise the reasons for, and the feasibility of, the general medical check up and medical insurance schemes, which can promote occupational health. Occupational medicine is an interdisciplinary area, involving (i) the worker, (ii) his employer, (iii) their occupation, and (iv) the doctor. The doctor-patient relationship is then, unconventional, and a new medical-socio-economic relationship must emerge. It is related to a large extent to changes in standards of productivity of a society and its consumer service potentials. Medical insurance is one such consumer service, with the help of which occupational medicine can be shown to be socially relevant.

Historical Note

The first screening service, which commenced in Peckham (1926) laid the foundations from which WHO derived the definitions of ideal health, incorporating physical, mental and social well being. The extensive studies of the Peckham Pioneer Health Centre lead Pearse & Crocker (1943) to remark that "nothing short of periodic health overhaul on a national scale can lead to the national application of medical science for the elimination of disease". Inspite of this categoric and clear statement, ambiguity has over shadowed all medical thinking regarding the periodic medical checkup over the past 40 years. It is perhaps time to re-emphasize the importance of the lessons learnt from the Peckham experiment, and transform its successful applications to the now well defined work place and occupational activities of the working community.

Introduction

The working communities in a work place, are to a large extent the workers or employees, and also consist no less of the employer and managerial strata. Undoubtedly both these classes of workers are interdependent and are parts of a process subservient to industrial growth and competitive production. The employers are a vulnerable group of people who handle key processes of competitive production, and are highly stressed individuals in such a community. They can therefore ill afford an incompetent work force be it technical inefficiency, or, worker health problems. Even as the soldier is well screened before and during his tenure in the defence forces, the same principles are relevant in maintaining a healthy industrial work place.

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Industrialisation is the best example of social revolution, which has kept mankind almost totally engrossed with the activities of production. This has resulted in the creation of large labour forces, being maintained beyond national barriers and political opinion. Their success has depended upon the social structure within which they operate. One such exemplary system is the Japanese success story within the Theory Z management which balances a concern for profitability, with a concern for people (Ouchi 76).

It also balances explicit and implicit approaches with trust and social subtlety which are equally important components of this equation (Brown' 83). Based on this social infrastructure, Japan is a possessor of a highly disciplined and efficient labour force.

It is imperative therefore that within any managerial system of social relevance, to include ways and means of caring for the workers/employers. Occupational health management is one such means provided it is woven into other socially relevant matters like consumer service potentials.

The periodic medical examination — State of the art

The pre-placement examination, has so far been successfully carried out for well defined communities like the defence forces. Furthermore one of the largest private companies, the Kaiser foundation took up the small scale health service and medical insurance for its in house well defined community. In doing so, they demonstrated the importance of linking health data to insurance data, and the health insurance systems spread rapidly from the USA to at least 20 other major countries. It is a misconception that only the wealthy developed countries are capable of

withstanding the expenditure of vast medical screening. Similarly it is a misconception to extend this bias about indefinite cost benefit in economic or health terms to individuals or group of individuals. In spite of the many cost benefit studies undertaken with services like Kaiser, BUPA, the Nuffield Provincial Hospital Trust and others this is one of the most challenging open ended questions in medicine. None has shown that there is no benefit from the periodic medical examinations. Each has left behind a wealth of information on how to conduct a general check up with specific questions and possible answers in mind. These studies have eliminated a lot of ambiguity in medical semantics like screening and survey. They have also defined very well the doctor-patient relationship and its limitations.

Occupational medicine and medical insurance

In occupational medicine it is essential to extend the conventional doctor-patient relationship to the worker/employer — occupation — doctor. No longer is it encumbent on the patient alone to approach the doctor. As in some other areas of community medicine, for preventive measures, it is the population at large which is being approached by the doctor. Clearly there is public demand for screening, but social services must also have established scientific support for their effectiveness.

Occupational medicine is a consumer service and can be shown to be more meaningful it is linked with the consumer potential of an industry or workplace. When accepted as a part of the consumer service it can be of better social relevance and of reassurance to both the employer and employee. It helps in the agreement that there should be informed medical concern, and in the creation of self supporting healthy working communities. One of the ways of doing so would be to base health standards on employer-sponsored periodic medical screening.

The definition of screening as laid down by the WHO Regional Committee for Europe and U.S. Commission as Chronic Illness (Wilson 1968) is "the presumptive identification of unrecognised disease or defect by the application of tests, examinations or other procedures which can be applied rapidly. Screening tests sort out the apparently well persons who probably have a disease from those who have not. A screening test is not intended to be diagnostic. Persons with positive or suspicious findings must be referred to their physicians for diagnosis and necessary treatment". The number of screenings procedures have since then been based on certain screening criteria with a predominantly clinical and therapeutic bias in selected populations in family practice (Frame 1979) and epidemiological criteria to identify specific health goals, well within the conventional patient physician relationship. (Lester Breslow 1977).

The reasons for occupationally linked screening procedures must be well defined. The differences in the emphasis for these has been incorporated into the following (Sachelt-Holland 1975) :-

1. To protect the people other than the patient, as is the limitation in industrial and public health screening. A work place is a place for social contact by virtue of the job similarities and team work involved in production processes. It is essential to maintain occupational health standards in such situations involving the community and must go beyond individual primary care.

2. To obtain clinical base-lines for susceptible individuals, and standardise sub-threshold biological limit values, in production processess.

3. Screening processes tend to select out only chronic and least severe diseases, which would by definition have a more favourable course.

4. To influence the cost of life insurance, in relation to occupational disability and disease compensation. It is also profitable to any medical insurance organisation to divert successfully the benefits of low compensation in chronic illness from high compensation in death disasters. The calculated risks in insurance investments can then be better related to meaningful cost benefit formulations.

While the aforesaid are the undeniably gainful arguments in favour of occupational health screening, there are some other, doubtful reasons, which need to be clarified. The apparent paucity of medical benefit, and therapeutic end points, derived from the huge outlays in human effort and financial support is based on the following arguments (Micheal D'Souza 1979):

1. When many diseases are discovered on screening, doctors do not believe there is much useful medical aid to be offered.

2. Even for those conditions such as raised blood pressure for which useful treatment do exist, many patients find that sticking to treatment over long periods of time is more than

they can stand, and they often loose interest in continuing it.

However, when looked at critically these same arguments fit well with the benefits that can be gained in relation to Occupational medicine. In the first instance a spectrum of diseases may be seen in clinical findings, the causation of which may be but a single or few controllable factors in the work place. For instance respiratory, dermatological & opthalmic symptoms may be caused by a single chemical which when identified and eliminated from near the individual, will not only result in his cure but also benefit his co-workers, who were at a subclinical exposure. Similarly the second argument is again a benefit in the occupational context where in the individual is no longer left to idiosyncracies of his own, and the employer or health inspector imposes a regulation to cover for the workers carelessness.

Occupational medicine is therefore medicine for the many, and must be woven into the social structure of a working community. The emphasis of "medical usefulness" itself changes in such a context, and is no longer limited to what has prevailed in all medical thinking by doctors, be they specialists or general practitioners. The doctor who does not step out of the attics of his own speciality, and out of his cocooned hospital and look beyond his therapeutic skill, is obviously blind to the benefits of an emerging form of social and medical benefit. In occupational medicine where the very parameters of medical benefit assume a more holistic approach, screening can no longer assume the status of a low priority superfluous service. The modus-operandi, must be worked out for specific communities, living with identified hazards and the cost-benefit linked with the local social insurance scheme of any country. The social insurance scheme, its legislation, benefits and drawbacks, can lend us a parameter by which to judge the fitness of the people contributing to and benefiting from it, in terms of medical usefulness and social relevance.

The principle then to be followed can be small benefits to larger number of people, than the crisis identified few. The employer too would then be able to get better returns from their kind of insurance distribution with a wider population base, and help in boosting the morale of his labour force. The insurance premium could then be linked up with the bonus incentive and sports facilities in maintaining high standards of health. Ways and means of promoting worker health, with the help of the periodic medical check up, subsidised sports facilities, and work place monitoring can be worked out to the benefit of all concerned.

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