Special Commission on Prevention

Could the prevention of occupational risks be proposed as a kind of model for prevention in public health?

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Some reflections

At both the national and international levels, the prevention of occupational risks, involving mainly occupational health doctors, technicians and multi-disciplinary teams, constitutes one of the cornerstones of social policy. However, concepts of its composition (both in terms of content and methods of implementation) vary in the different branches of social insurance to which it contributes. In order to improve the efficacity of social protection systems further, a legitimate question is whether the experience acquired in certain sectors could be useful in others.

Could organizational models for the prevention of occupational risks be transposed to public health?

Could the methods and steps taken for the prevention of occupational risks, wholly or in part, be transferred or transposed to other sectors? The problem is to define how organizational models for the prevention of occupational hazards could contribute to prevention in public health. In fact the two sectors face similar challenges, in particular risk evaluation, a necessary prerequisite for all prevention measures, but also the definition of a social strategy to preserve the health, physical and mental integrity of human beings, whatever the origin of the health risks.

As in occupational health, prevention strategies in the other sectors should take into account, systematically and in parallel, technical, behavioural and organizational aspects.

Past experience in training for the prevention of occupational risks reveals that an adult relies on behavioural habits in the face of risks. Early training in prevention (from infancy or adolescence onwards, in the school environment, as for example information of mouth-dental hygiene, the risks of tobacco, AIDS prevention etc.) may prove effective later and contribute towards behavioural development. This is the attitude which has been adopted in France in the field of occupational health, i.e. integration of knowledge and prevention in technical teaching programmes, under an agreement between the National Insurance Fund and the National Education.

Are the health care “providers” structured to carry out prevention in public health? Are they able to do it?

Firstly, one should recall that prevention must be a response not only to social and ethical concerns, but also to economic considerations. The aim is to try to reduce human suffering and financial losses due to accidents and ill health, through effective prevention.

The next issue is the place of prevention in public health. To provide the most effective and widest possible coverage, it must be incorporated into the framework of public health policies defined by the political decision-makers (ministers responsible for health, who can rely on support from specialized agencies e.g. in food hygiene, health promotion, etc.).

This policy may be based on statistical data on mortality and morbidity, high-risk behaviour, hygiene and eating habits, etc., but also on the observation of increased social demand in health matters, conveyed by the media. Thus, it may define the criteria for national priorities. The effect of these choices on prevention activities may be diverse (public campaigns to heighten awareness or provide information, targeted detection, vaccination of specific population groups, etc.).

However, “health providers” (medical and paramedical) are often under the administration of the “Sickness” sector of social insurance, whose main vocation is to repair damage to health; are they structured, trained, obliged to actively transmit and/or take part in the various types of preventive activities? Do they have the time and the resources to do it, within their day-to-day practice? Does their method of remuneration, which is often based on acts and prescriptions, encourage their involvement in these activities?

Is the information and experience acquired in the area of the prevention of occupational health hazards transferable, or adequately transferred, to public health?

The risks which exist outside the workplace are considerable, both qualitatively and quantitatively (road traffic accidents, leisure activities, sports, domestic do-it-yourself and manipulation of dangerous products, eating and alcohol-tobacco habits (AT) etc.), and interactions between the occupational and other activities of man, as well as with the protection of the environment, are increasing.

Knowledge acquired in the multifactorial approach to professional risks could be used to direct public health prevention measures targeting certain illnesses.

The following are some examples of prevention practices in the working environment which could be transferred to activities outside work:

- information on traffic accidents at work ÿ awareness of accidents outside work, particularly among young people under 25;

- studies/research on the effects of electromagnetic fields and waves ÿ information on reasonable use of portable telephones or proscribed use by those equipped with cardiac pacemakers;
- work on the evaluation of risks in the food and agriculture sector ÿ public information, tracking to avoid illnesses but also to provide reassurance on the risks involved in food;
- training activities for do-it-yourself stores which have a relatively high AT rate ÿ instructions for Sunday "do-it-yourselfers" to avoid accidents and intoxication;
- education on posture and safe handling;
- ergonomy at the workplace ÿ study of ergonomic products for domestic or school use;
- design of the workplace ÿ training for architects to design low-risk living accommodation, etc.

Should "health providers" be included in a public health policy placing more emphasis on prevention?

Follow-up by the same doctor, who knows the habits and living environment of his patients, may be an advantage in improving health. However, he/she must be allowed more time for dialogue with patients, to collect the information indispensable to evaluate risks and provide the necessary information to reduce them, which may lead to inflation in both acts and prescriptions (I refer to the cost of sickness, not of health) as a result of the way in which the health care system is financed.

Would it be possible, by using the model provided by occupational accident and health insurance and the protection of health at work as an example, to provide improved sickness prevention, in the wider context of public health? While at the same time preserving the specificities of the occupational health and public health sectors, the strategies of the different branches of social insurance could then reap the rewards of a certain synergy.

In the minds of insurers, would increased investment in prevention on the part of the "Sickness" sector of social security, through the integration of the "health providers", lead to reduced costs? Are these "health providers" trained to act as the essential vehicle for such prevention, or should they be? And if not, who should be the protagonist?