Different models of occupational health service provision and their activity profiles

The article by Bråtveit and colleagues in this issue of *Occupational Medicine* raises a number of important issues about the provision of occupational health services [1]. The range of activities undertaken by separate occupational health departments operating within different businesses within a single multinational company was examined and compared with an accepted standard defining the range of services that should be provided [2,3]. The authors also considered their findings in terms of the need of companies to have an equitable provision across all their businesses, regardless of the place or country in which they are situated.

Twenty departments completed an initial questionnaire about their location and personnel. The investigators then visited each site and completed a structured interview with a number of staff to determine the personnel employed and types of activity undertaken by each department during the last 3 years, including an estimate of the time allocated to each activity type. Essentially, this constituted an audit of the structure and processes of the participating departments. The structure of a department was defined as belonging to one of a number of categories, although these were eventually reduced to two broad groups: inter-enterprise multidisciplinary services; and ‘stand alone’ services of individual doctors and nurses. Work processes or activities were also categorized into a number of broad areas, which comprised: curative services for non-occupational diseases; curative services for occupational diseases; health surveillance specifically related to workplace risks; workplace assessment and advice; and health education and promotion not specifically related to workplace risks.

The authors’ reported findings suggested wide variations in the structure and processes of the different departments, despite the fact that they all operated as part of a single multinational company within a fairly limited geographical area. Interestingly, they also reported that certain types of service structure were associated with the types of service activities undertaken. Inter-enterprise multidisciplinary services were more likely to provide health surveillance and workplace assessment (preventive) activities, and less likely to provide curative services for non-occupational diseases, whereas services provided by a ‘stand alone’ doctor and/or nurse were more likely to provide curative services for occupational and non-occupational diseases.

The authors conclude that the inter-enterprise multidisciplinary type of service structure tends to be associated with activity profiles more closely in compliance with International Labour Organization recommendations than a service provided by ‘stand alone’ practitioners. However, as with all data, there are caveats. Local factors do exert an influence, so that, for instance, in Turkey the occupational health service has to provide some general medical services for employees, and this naturally affects its activity profile. In addition, all the data on activity were collected by questionnaire methods and so are largely subjective, and consequently there may be significant errors in allocation of time to different activities. The generalizability of the data from a single company to the broader working environment must also be questioned. Few details of the multinational company in which the audit was undertaken are given in the paper.

The authors additionally pointed out differences between the service types and levels of occupational health specialization of the doctors involved, doctors who had specialized in occupational medicine tending more commonly to work in inter-enterprise multidisciplinary services than the ‘stand alone’ services. This could confound the results, and it is entirely plausible that the differences in activities undertaken reflect the levels of training in occupational medicine of the staff rather than the structure of the service. It is also plausible that training and service structure are not independent, and doctors with specialist training tend to be concentrated in inter-enterprise multidisciplinary services rather than ‘stand alone’ services.

Despite these limitations, a message emerges from this paper which will be familiar to many readers. There are wide variations in the provision of occupational health services, even within the same company, a situation likely to contribute to the inequities in occupational health that are seen [4]. Not surprisingly, occupational health service provision is dependent on the structure that underlies it, and on the training of the practitioners providing it. Intuition would suggest that service structure and specialist training are not independent. More practitioners who are specialists in occupational medicine may practice as part of an inter-enterprise multidisciplinary service, and this structure probably tends to facilitate training for a number of reasons. Importantly, standards, audit and equity remain key issues in occupational health service delivery, and all occupational health practitioners, regardless of the service structure they find themselves working within, need regularly to consider the types of work...
activity they undertake to ensure they continue to provide a relevant service.

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References