# Occupational medical workforce crisis

## The need for action to keep the UK workforce healthy

**All Party Parliamentary Group on Occupational Safety and Health**

## Executive Summary

The UK faces a major demographic challenge in its labour force. Urgent support is required to keep people in work and to help those with health conditions and disabilities who are not employed into work. In particular, the nation needs 50-70 year olds to stay healthy and in work to avoid a significant reduction in the UK labour force, and significant costs to the taxpayer in terms of welfare payments. Furthermore, we know that good work is good for health, and being out of work is associated with an increased healthcare burden and therefore demands on the NHS.

Occupational health services have long recognised the value of the multidisciplinary team. These professionals provide the necessary expertise to support the protection and promotion of the health of those in this expanded working age population, during and beyond working age. Employers, those in work and applying for work should be able to access well trained multi-disciplinary occupational health services with a breadth of capabilities, and the clinical leadership provided by specialists in occupational medicine. People with complex health problems in particular need the breadth and depth of expertise provided by these specialists.

It has long been known that return to work is a key clinical outcome of healthcare interventions, although insufficiently emphasised in recent years in measures of healthcare outcomes, and which, for most patients, is a positive clinical outcome (and sometimes, an intervention in its own right).

However, there is a deepening crisis of capability available in the UK to meet this need. The occupational physician is the most critically and immediately endangered member of the multidisciplinary team. The age demographic of these trained and experienced professionals is increasing, and retirement exceeds retention, impacting not only access to care but also the capacity to train and supervise new doctors. Urgent measures are required to address the supply issue if the level of capacity of the occupational medicine workforce is to meet the nations' needs.

The following recommendations are proposed to address the issues highlighted in this report:

1. **Health Education England, and the equivalent bodies in the devolved administrations, must fund a model that meets the requirement for occupational medicine training posts to meet the level of demand now and in the future**

2. **Government and insurers should explore how to best incentivise**

**employers to provide workers with access to multi-disciplinary occupational health services**

3. **Employers of occupational medicine specialists within the NHS and private sector should have incentives in place to retain existing occupational medicine professionals as they consider retirement**

4. **The NHS in each of the nations within the UK must ensure that occupational medicine physician posts are part of safe, effective, quality assured multi-disciplinary occupational health teams**

5. **The GMC and the Royal Colleges must ensure that occupational medicine forms part of the core curricula - so that all medical undergraduates and doctors in postgraduate training understand the importance of work as a clinical outcome**

## Background

Effective management of the health of working people and workplaces requires support by multidisciplinary occupational health services staffed by competent professionals each of whom possess unique and complementary skills. The clinical members of this multidisciplinary team includes occupational physicians, occupational health nurses, physiotherapists, counsellors and occupational health technicians. They support employers in ensuring:

- Healthy workplaces and good work;
- Protection and promotion of the health and well-being of workers;
- Provision of early interventions to help prevent people being absent for health-related reasons; and
- Access to improve opportunities for people to recover from illness while at work.

However, a recent DWP commissioned report indicated that only 38% of those employees surveyed had access to occupational health services[1]; whereas only 13% of UK workers can access an occupational physician.[2] Changes in the size of enterprises, the emergence of new work patterns and problems recruiting and training occupational medicine specialists risk accentuating this crisis.[2]

Although the NHS employs occupational health professionals to support its own workforce, occupational health provision does not form part of clinical NHS healthcare provision for NHS staff nor provision for the non-NHS workforce within the UK. NHS OH professionals are employed outside the "mainstream" of health professionals, and receive their postgraduate training and their future employment through their employers in the private and public sectors, of which the NHS is one such employer. Recruitment of doctors into the speciality of occupational medicine has been falling since 2003; with the number of training posts at an all-time low and half the long run average. In 2002 there were 79 NHS-based trainees and 137 trainees in private sector posts[3], compared to a total of 74 trainees in 2015.[4] This has led to the number of specialists falling – it fell by almost 5% during 2010-13 alone.[5]

Occupational medicine also has more doctors aged over 50 years (64%) than any other speciality - half of current specialists could retire within a decade.[5] UK occupational medicine faces a “perfect storm”, in which we not only lack trained doctors to do the work, but we will soon lack the trainers to supervise the future generation of specialists. This makes it even more urgent to implement immediate and lasting solutions.

In 2011 the Centre for Workforce Intelligence reported that there were significant recruitment issues[6] and the Chief Medical Officer England recommended in 2014 that 'the numbers of doctors being recruited into occupational medicine should be extended'.[7] Health Education England committed to an intake of 46 trainees in England this reporting/fiscal year[8], yet this is still inadequate to meet the needs of the UK population.

Restoring the numbers of specialist trainees would create conditions for a more comprehensive and proactive approach to occupational health, alongside increased knowledge and expertise among other health professionals in hospitals and primary care. The occupational physician is one member of the team, but provides specialist and essential expertise - for example related to workplace hazards, health surveillance, fitness to work and reasonable adjustments for people with health conditions and disability.

## Changes in the UK labour market

The world of work in the UK has changed significantly as a result of globalization, "off-shoring" of manufacturing jobs and the growth of employment in the service sector and working from home.

Population ageing and increasing state retirement ages will lead to increasing numbers and proportions of older people, and in particular women, in the labour force. As the workforce ages there will be increasing complexity of health needs, and their impact on work. The prevalence of long standing illness or disability increases with age and in the British working population is approximately one in five 16-44 year olds; a third of 45-64 year olds; and one half of 65-74 year olds.[9]

## Changes in UK employment structure and use of occupational health services

In the past, most large employers provided in-house occupational health services. However, small and medium-sized enterprises (SMEs) now account for the vast majority of all UK private sector businesses and employ 15.6 million people (60% of private sector employment).[10]

It is not practicable for SMEs to employ their own occupational health specialist. Instead, SMEs who are aware that they have a need may contract for a service from an independent OHS provider; this out-sourced model is also now the most common arrangement for larger employers. The

government's new Fit for Work service is aimed especially at SMEs - but is limited in scope, and critically will not provide the proactive advice to employers on promoting and protecting the health of their people that occupational health services can provide, whether in the private or public sector.

## Occupational morbidity and mortality

The shift in the labour market has changed the nature of work and patterns of illness; musculo-skeletal disorders and common mental health problems (including stress at work) are now the dominant problems.

Occupation related illnesses significantly outnumber occupational injuries in both number and cost to individuals and to society. Despite the decline in manufacturing and heavy industry**,** 23.3 million working days were lost due to work-related illness and 4.1 million due to workplace injury in 2014-15 with an estimated cost of injuries and ill health from current working conditions was £14.3 billion (2013 prices).[11]

1.2 million people who worked during the last year were suffering from an illness they believed was caused or made worse by their work, of which 500,000 were new conditions that started during the year. A further 0.8 million former workers (who last worked over 12 months ago) were suffering from an illness which was caused or made worse by their past work.[11] For example, around 13,000 people die each year from occupational lung disease and cancer as a consequence of past workplace exposures, primarily to chemicals and dusts.[11]

## Best practice

The World Health Organization (WHO) and the International Labour Organization (ILO) stipulate the fundamental right of each worker to the highest attainable standard of health. To achieve this objective, the WHO Global Strategy on Occupational Health for All endorsed by the World Health Assembly in 1996 states that access to OHS should be ensured for all workers of the world irrespective of age, sex, nationality, occupation, type of employment, or size or location of the workplace.[12] In 2007, the World Health Assembly endorsed the WHO Global Plan of Action on Workers' Health and urged member states to improve the performance of and access to OHS and to: work toward full coverage of all workers to basic OHS for the primary prevention of occupational disease and injury.[13]

In 2008 Dame Carol Black's review of the health of Britain's working age population noted that OHS should be available to all, whether they are entering work, seeking to stay in work, or trying to return to work without delay in the wake of illness or injury; and that OHS should be rolled out across Britain so that access to work-related health support becomes available to all employees – no longer the preserve of the few.[14]

## Legal position

Apart from the UK and Ireland, in most European countries employers are obliged by law to establish or use an OHS.[15]

In other European countries OHS are either incorporated into national health and social services for all working people or are statutorily required through risk based insurance levies on employers, who are obliged to purchase comprehensive occupational health, rehabilitation, and compensation services from independent providers. Examples of where provision of OHS is compulsory include Belgium, Finland, France, Germany and the Netherlands. In Spain it is required for those employing over 1,000 workers and in specific industries in Austria and Denmark.[16]

In the UK the Health and Safety at Work Act 1974 places a wide-ranging duty on employers to protect the safety, health and welfare of employees. The Management of Health and Safety at Work Regulations 1999 require employers to appoint competent people to fulfil their statutory responsibilities. However, there is no further guidance for employers to help them to decide their occupational health support needs.

## The distinctive competencies of the specialist occupational physician

Specialist occupational physicians possess a unique combination of skills that neither other doctors nor other occupational health professionals possess. The distinctive knowledge and skills of specialist occupational physicians are particularly useful in a number of situations – notably, the management of complex occupational hazards and of complex health impacts on fitness for work, provision of occupational health care for doctors and other health professionals, management of environmental hazards associated with industrial activities, leadership of occupational health services, development of policy relating to work and health, occupational health research, and training of occupational health staff.[17]

## Occupational medical workforce in European countries

Worker access to OHS ranges from 15-96% and depends on the country of residence and the type of operation; SMEs being particularly hard to reach.[16] In Finland and the Netherlands access exceeds 90%.[18,19] In the UK, 38% of the total UK workforce access OHS, but this varies by company size; ranging 10% for small enterprises (up to 50 employees) to 52% of employees for large organizations (500+ employees).[1]

Estimates of the ratio of occupational physicians to workers vary widely between and within European countries. Benchmarking is difficult as there are no readily obtainable comparable data e.g. with regard to full-time/part-time status, practising/retired members and level of qualification/training.[16] However, available data is summarised in the table below.

| ***Country*** | **No. of occupational physicians** | **Total labour force (millions)** | **Occupational physician:worker ratio** |
|---|---|---|---|
| *Finland*[18] | 2369 | 2.67 | 1 / 1,127 |
| *Germany*[20] | ~4,200 | 41.73 | 1 / 9,935 |
| *Netherlands*[19] | ~1,900 | 7.98 | 1 / 4,200 |
| *Norway*[21] | 340 | 2.59 | 1 / 7,617 |
| *UK* | 1,320 (total)[4]<br>466 (specialists only)[5] | 31.7 | 1 / 24,015 (all)<br>1 / 68,026 (specialists) |

Inequality in access to occupational physicians in the UK is unrivalled compared to any other northern European country.

## Estimated occupational health workforce needed in the UK

31.7 million people work in the UK[22], more than at any other time, including 1.2 million workers aged over 65 and 3.7 million more workers aged 50-74 compared to 20 years ago. Yet the numbers of occupational physicians is falling. In 2008, the report *'Working for a healthier tomorrow'* found that the proportion of the workforce with access to occupational physicians varied from 1% in agriculture, forestry and fishing to 43% in health and social services.[14] The NHS 'Five Year Forward View'[23], placed a renewed emphasis

on prevention, as did HSE's 2016 Helping Great Britain Work Well Strategy.[24] A key element of this is primary prevention, which is more cost-effective and efficacious from a health perspective than trying to intervene when a person is suffering from more serious ill health. This involves a greater focus on health issues at work.[24]

A recent *Council for Work and Health* report highlighted the critical state of occupational health in the UK, the ageing occupational health workforce, and the lack of training opportunities.[25] It noted that employers of OHS already report difficulty in recruiting suitably qualified practitioners and that the shortfall must be addressed urgently. The *Faculty of Occupational Medicine* stated that 37 new trainees will be required each year over the next 5–10 years to maintain current numbers of specialists, replace those retiring and to address additional staff needs due to changes in funding by employing organisations.[17] Currently less than half that figure are recruited annually.

The *Council for Work and Health* and the *Faculty of Occupational Medicine* recommend that the UK requires one FTE specialist occupational physician for every 25,000 workers, which equates to 1,200 FTE in total (versus 466 currently).[17, 25] Workplaces with more risks or complexity should provide better access e.g. for the National Health Service it has been recommended that there is one full time FTE specialist occupational physician for every 8,000 workers and students at risk.[26]

## The costs of improving access to occupational physicians

Overall there is no cost increase from the estimated occupational health workforce needed in the UK because this restores numbers to what they were. However, how the resource is funded will be different because of the changes in the UK employment market. One of the great challenges is to overcome the view that OHS are a cost and do not contribute to the bottom-line. However, OHS should be highly cost-effective provided that there is an effective skills mix; people work to their distinctive competencies and perform work that add value.

Measuring benefits from an OHS is inherently difficult. An economic model which assumes that the benefits of an OHS are to maximize employee health and morale; performance and productivity; minimize medico-legal costs; enhance workplace safety; and reduce sickness absence indicates that OHS will at least pay for themselves.[27] After identifying key programme costs and perceived or realised benefits, PWC identified a nominal return of £4.17 for every £1 employers spent on workplace wellbeing programmes.[28]

## The costs of doing nothing

Occupational physicians focus on enhancing and maintaining the health of people at work and the organizational effectiveness of enterprises by providing expert advice to management. The cost of ill health in the workplace is already high (over £14 billion annually)[11] and is an issue that neither employers nor government can afford to ignore.

The attrition of occupational physician numbers over the last 25 years and the imminent exodus of ageing specialists and lack of replacements can not be endured without wide impact. It is likely that:

- more workers will suffer from preventable occupational ill health and have their diseases detected at later stages when there may be less chance to achieve a successful outcome
- there will an increased burden on the NHS due to increased cases of occupational ill health and more established disease
- employers will suffer increased costs through increased sickness absence and presenteeism and lost productivity
- the UK economy will suffer as business struggle to remain competitive.

It is arguable that business and the UK economy can not afford to run such risk at a time of economic uncertainty caused by the outcome of the EU referendum; and at a time when there are more older people in work than ever before.

## Undergraduate education

In the report *working for a Healthier Tomorrow*, Dame Carol Black reported that occupational health has a declining academic base.[14] Since 1975 we have witnessed the loss of occupational medicine academic based groups in Aberdeen, Dundee, Edinburgh, Newcastle and Birmingham. This impacts primarily on the evidence base underpinning occupational health practice, but also on the prominence of occupational health departments and capability available to support undergraduate teaching. This, together with competing with other specialities for topics to be included on the undergraduate curriculum, has contributed to the near disappearance of occupational medicine teaching to medical students.

Occupational medicine has a low profile among medical undergraduates and junior doctors. Despite the increasing recognition of the impact and value of

work on health and the growing evidence base to support work as a means of enhancing health, medical schools fall far short of a comprehensive programme of teaching in this important speciality. Dedicated undergraduate teaching of occupational medicine in UK medical schools has declined. 60% of schools undertook formal instruction in 1974, 78% in 1989, 53% in 2000 and 48% in 2009.[29] Whilst schools indicate that core areas were covered in more integrated teaching; 24 % of schools still did not cover occupational skin disease, 19% did not cover occupational respiratory disease, and 24% did not cover occupational stress. The findings are surprising given the frequencies of asbestos-related disease and occupational stress. In 1989, 40% of medical schools provided workplace visits, but it appears that among 21/32 schools which responded to a survey no workplace visits have been offered since 2000.[29] Most medical schools appear to have a way to go if they are to provide qualifying doctors education on the topics they will frequently encounter in their working lives, notably sickness certification, disability and work and vocational rehabilitation.[29]

## Conclusion and recommendations

Good occupational health services are central to the effective management of workplace health.

They:

- Help ensure healthy workplaces and good work;
- Protect and promote the health and well-being of workers;
- Provide early intervention to help prevent people being absent for health-related reasons and improve opportunities for people to recover from illness while at work.

It is clear that while few UK workers have access to multi-disciplinary occupational health services; even fewer have access to a doctor who is specialised in occupational medicine.

Action must be taken to address the overall inequality. The situation with regard to doctors is particularly perilous given the numbers of specialists who are set to retire within the next ten years and with recruitment of trainees running at half the long run average.

Unless there is urgent action the future of the speciality is in doubt, which could adversely impact UK plc performance at a time of economic uncertainty; and at a time when there are more over 50s in employment than ever before and the employment rate of older people is on the increase.

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**A report by the All-Party Parliamentary Group on Occupational Safety and Health.**

**Supported by:**
**Association of Local Authority Medical Advisers**
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