

SYMPOSIUM ON OCCUPATIONAL HEALTH IN NEW ZEALAND

**Te Papa, Wellington
17-18 November 2008**



OCCUPATIONAL HEALTH AND THE PRACTITIONER – REVIEW AND RENEWAL

**Where Have We Come From –
Where Are We Going**

Dr Bill Glass

“Our workplace injury rate is higher than many of the countries against which we compare ourselves socially and economically”.

Craig Armitage, 2008

“There are few positive health outcomes related to occupational medical practice. This is variously because: occupational medicine has become generally responsive to the needs of insurers and regulators and hence assessment and not treatment based ...”

Des Gorman, 2008

I am not going to give statistics of the number of sore throats we see, or anything of that sort, but am just going to talk about some aspects of the girl's lives that have a bearing on their health.

Dr Tom Garland, 1935

Most people engaged in industry are aware that the evaluation of sickness rates and the determination of the financial liabilities imposed by sickness upon the State, the Employer and the Employee are tasks of great difficulty and importance.

Dr May Smith, 1936



Jude Knights - Wormalds

“Although not accounted for in the balance-sheet, the **most important asset of any enterprise is the people it employs**. This investment in people as individuals and as a co-ordinated team is difficult to measure in monetary terms. An enterprise cannot function without people and responsible management are well aware of the enormous cost of replacing and training new people. **Thus while the preventive maintenance of plant and machinery is accepted irrespective of cost as being necessary to ensure maximum productivity, management’s prior concern should be care for the people who use this equipment.**



Apart from all other considerations, management have a social responsibility as one human being does to another, to ensure the health, welfare and safety of the people they employ and equally the employees in their own interest, have a responsibility to co-operate with management.:

Concern about welfare is concern about the person as a whole, not just their workplace injury or disease. It is about the state of health they bring into the workplace from outside, and the state of health they take home with them at the end of the work shift.

“Whereas hazardous work conditions can plainly affect the health of the worker, so too can unsatisfactory lifestyle habits affect a person’s ability to work.”

Evan Dryson, 1980s

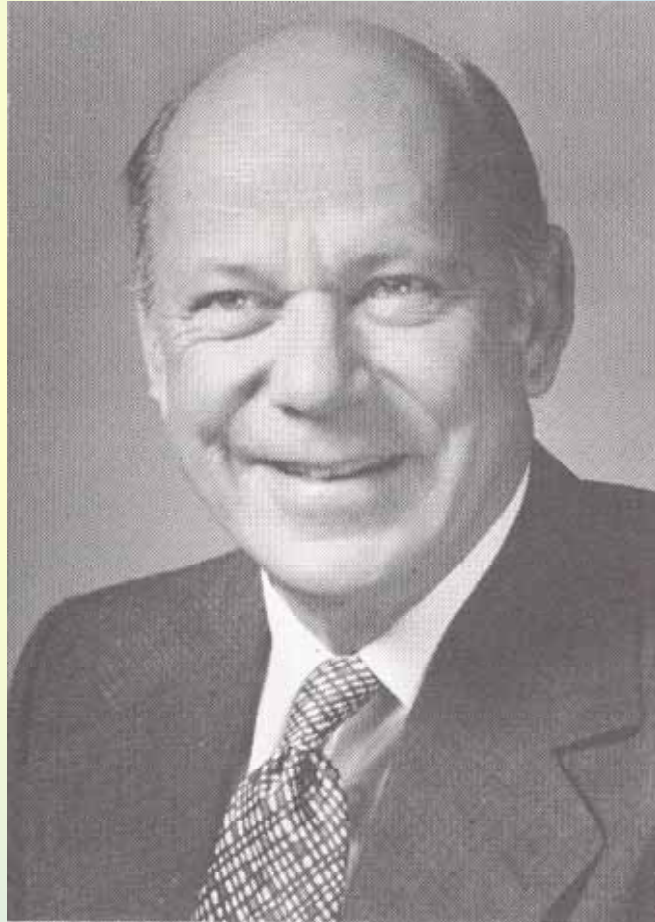
THREE KEY POINTS

1. Employer investment in people
2. Health and well being in the workplace
3. Measuring and reporting on such benefits

Dame Carol Black, 2008

What happens if welfare is neglected, given that it is an integral part of a person's "health"? You all know. There is disaffection, low morale, absenteeism, poor quantity and quality of production, or to use the more dramatic and accurate term used in May Smith's report, in the 1936 publication, "labour wastage".

We either cherish, respect and care for people at work or lose and waste their skills.



Doug Green

“We have had four years of talk, but virtually no action, on simple and easily achievable recommendations such as the recording and coding of occupation on routinely collected data such as death registrations, cancer registrations and hospital admissions”.

Neil Pearce, 2008

“In 1974 New Zealand abandoned its system of compiling and publishing statistics on occupational injuries; and since that date even the simplest information on those killed at work has not been published”.

Walker Report, 1981

- Noise induced hearing loss
- Musculoskeletal damage to the hand/forearm
- Leptospirosis (in the 1960s it was brucellosis)
- Solvent induced neurotoxicity
- Skin reactions to work hazards
- Asbestos (yes, still) and other occupational respiratory diseases such as asthma and COPD
- Stress

Occupational Health will be judged by its practice, by whether it has made a difference – for the better – to the working lives of those who as a result of their physical, mental and emotional labour produce our goods and services and in so doing create our wealth.

The Occupational Health Practitioner is not the agent of change. That is the role “of decision makers in New Zealand boardrooms and shop floors” (Craig Armitage, 2008).

Occupational Health Practitioners can contribute to that change by their skill, knowledge, commitment and practice.

In order to continue to provide the best possible contribution those who practice occupational health must be constantly reviewing, re-evaluating and renewing those skills, that knowledge, commitment and practice.

**WE NEED TO INITIATE AN ONGOING
CULTURAL REVOLUTION
– IN THE BEST SENSE.**

- The need to recognise welfare as a part of health and safety, considering people as both individuals and as part of a group, respecting and cherishing the human resource.
- The need to recognise that there is an environment outside the workplace which is interdependent with the workplace and that that environment includes the home.
- The need to recognise that without systematic measurement we cannot objectively measure either the problems or the solutions.

And finally:

- That unless we as Practitioners understand and focus on these issues we cannot contribute to the change that the decision makers need to make in this county to integrate work, health and productivity.