Universal health coverage for workers

Side event at the 66th World Health Assembly
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Report
Setting the scene

The links between health, sustainable development and poverty eradication become striking when we look at the world of work. Workers in poor communities are much more likely to be exposed to occupational hazards and to suffer work-related diseases and injuries. The resulting disabilities affect their working capacity and income earning potential. Furthermore, global health threats such as HIV/AIDS, tuberculosis (TB), malaria and the growing burden of non-communicable diseases and mental ill health additionally reduce working capacity and labour force participation.

Access of workers to health protection and preventive services is still limited mostly to workers in large enterprises in the formal sector with decent jobs and social protection benefits. The working poor and informal sector workers do not have social protection and insurance for occupational injuries. The WHO global survey on workers’ health carried out in 2008/2009 among 120 countries found that two thirds of countries still had very low coverage of workers with occupational health services and one fourth of countries did not even know their actual coverage level.

In 2007 with Resolution 60.26 “Workers’ Health: Global Plan of Action” the 60th World Health Assembly of the World Health Organization urged Member States to work towards full coverage of all workers, particularly those in the informal sector, agriculture, small enterprises and migrant workers with essential interventions and basic health services for the prevention and control of occupational and work-related diseases and injuries. Furthermore, the 12th General Programme of Work proposed universal health coverage as one of the five leadership priorities to guide the work of WHO for the period 2014–2019. Universal health coverage combines access to services needed to achieve good health (promotion, prevention, treatment and rehabilitation, including those that address health determinants) with the financial protection that prevents ill health leading to poverty. It provides a powerful unifying concept to guide health and development and to advance health equity in coming years.

In working towards universal health coverage it is important to provide all workers with access to people-centred health services that can respond effectively to their specific health needs and expectations. These include protection against occupational diseases and injuries, maintaining their working capacity, workforce participation and income earning potential, and empowering them to promote their physical and mental health and social wellbeing.

Convention 155 of the International Labour Organization stipulates that occupational safety and health measures shall not involve any expenditure on the part of the workers (article 21). Therefore, the financing of services for protection and promotion of workers’ health needs to be organized and financed in a way that workers do not have to pay for prevention and treatment of occupational diseases and injuries, and that they have social health protection for accessing services needed for maintaining their health and working capacity.

Several developing countries, such as Thailand, Indonesia, Sri Lanka, South Africa, Colombia, Brazil, Philippines, and Tanzania started working toward this objective by integrating interventions for protecting workers’ health into their primary care services particularly for working populations not covered by company occupational health services, social health protection or insurance for occupational diseases and injuries. Industrialized countries, such as Italy, The Netherlands, the United Kingdom and the United States of America are concerned with the impact of the growing burden of chronic diseases and mental ill health on sickness absenteeism, social security and productivity.
The side event

During the 66th session of the World Health Assembly, the delegation of South Africa, in collaboration with WHO Department of Public Health and Environment, convened a side event on universal health coverage for workers. The purpose was to highlight the experience of several countries in addressing the health of workers at the primary care level and to discuss the challenges involved in working towards universal health coverage of workers.

Panelists at the side event (from left to right): M. Zungu, W. Sawasdivorn, I. Heath, Minister P.A. Motsoaledi, B. Kistnasamy, M. Neira, Dame C. Black

The event was co-chaired by Dr. Barry Kistnasamy, Commissioner for Occupational Health at the Ministry of Health of South Africa and Dr. Maria Neira, WHO Director for Public Health and Environment. The panellists were:

- Dr. Pakishe Aaron Motsoaledi, Minister of Health of South Africa
- Professor Dame Carol Black from the Department of Health of England
- Dr. Winai Sawasdivorn, Secretary General of the Thai National Health Security Office
- Dr. Muzimkhulu Zungu, Medical Director of Medical Bureau for Occupational Diseases, South Africa
- Dr. Iona Heath from the World Federation of Family Doctors (WONCA)
- Dr. Maria Neira, WHO Director of Public Health and Environment

The event was attended by delegates of the World Health Assembly – senior public health policy makers and representatives of non-governmental organizations, as well as by experts from WHO and ILO.
Key messages

“Still too many workers get sick or injured by their work – they all need good health care and financial compensation for the harm.”

Dr. Barry Kistnasamy, Commissioner at the Department of Health of South Africa opened the event by emphasizing the heavy toll of occupational diseases and accidents on the world’s working population. Still too many workers who get sick or injured by their work do not have access to preventive, curative and rehabilitative health services and to compensation for the occupational injuries. This event was intended to highlight countries’ experiences in integrating workers’ health into primary health care and to discuss the contribution of health systems to sustainable economic development and poverty eradication through protecting and promoting the health of workers.

Barry Kistnasamy is Compensation Commissioner for Occupational Diseases at the Department of Health. He serves also as Executive Director of the National Institute for Occupational Health and the National Cancer Registry. Prior to that he was Dean of the Nelson Mandela School of Medicine in South Africa.

“Can we move towards universal health coverage without addressing the specific health needs of workers?”

Introductory remarks by Dr. Pakishe Aaron Motsoaledi, Minister of Health of South Africa

In 2007 at the 60th World Health Assembly we endorsed the resolution on the Global Plan of Action on Workers’ Health. We are all committed to working towards full coverage of all workers with essential interventions and basic health services for the prevention of occupational injuries and work-related diseases.

There are effective interventions and occupational health services, both basic and specialized that do this. However, access of workers to health protection and preventive services is limited mostly to workers in large enterprises in the formal sector with decent jobs and social protection
benefits. The working poor and informal sector workers do not have insurance coverage or services for occupational injuries and diseases.

Currently about one billion workers – nearly one in three – live below the poverty line of US$2. Such people often work in hazardous conditions. They suffer work-related diseases, injuries, and disabilities. They lose their capacity to work and to earn their living. In poor communities, when the breadwinner falls sick and cannot work anymore, the whole family suffers and there is no social protection to help. This is the vicious circle of persistent poverty. For example in our country, silicosis, TB and work injuries take a much larger toll in poor communities.

With the current job crisis and the reduction of the employment opportunities in the formal sector and the changing patterns of employment, we see more persons entering the informal sector which has been the norm in many developing countries. Can we move towards universal health coverage without addressing the specific health needs of workers? Their health is an essential prerequisite for sustainable economic development - it is a national capital. But do health systems support this capital?

As with many other countries, we are now reforming our health system in South Africa and we are re-engineering our primary health care system. We want to end the exclusion of poor workers and we want our health services to contribute more efficiently to sustainable economic development. Furthermore, can we address the enormous burden of noncommunicable diseases and mental ill health on sickness absence and social security without linking occupational health services to primary and community care?

The traditional occupational health and safety systems and services are not fit for the new realities! I believe we need new models of organizing primary health care services so that all workers can benefit. We need new ways of financing such services. We need to remove the barriers faced by informal workers and vulnerable workers in the formal sector in accessing social security and the health system.

This is the reason that we wanted to open this discussion at the Assembly this year. We will hear several different perspectives and experiences here. However, we hope that this discussion will continue outside these walls and that it will provide inspiration for others!

Dr. Pakishe Aaron Motsoaledi was appointed Minister of Health of South Africa in 2009. He holds a Bachelor of Medicine and Surgery from the University of Natal.
“Good work is good for health.”

Professor Dame Carol Black from the Department of Health of England highlighted the impact of chronic diseases on workers’ productivity in her country. Good work is considered good for health and for those with chronic conditions; work can promote recovery and rehabilitation. Particular challenges are chronic mental disorders which require coordination between primary care services, occupational health advice and employers. Chronic conditions, such as common mental health problems, musculoskeletal disorders, cardiovascular and respiratory diseases, diabetes and cancer, all require vocational rehabilitation, flexibility and adaptation at the workplace. The keys to success are good primary and secondary clinical care by work-conscious healthcare professionals, well informed patients, and support from charities.

In 2009 the United Kingdom started supporting family doctors to understand workers’ health problems through education, training and information (online, telephone and face-to-face). In 2010 a “fit note” was introduced instead of “sick note” considering partial capacity to work rather than full incapacity. A 2012 survey of general practitioners (GPs) found that 90% of respondents considered helping patients to stay in or return to work as an important part of their role, 68% said that GPs had a responsibility to society to facilitate a return to work, 76% agreed that staying in or returning to work was an important indicator of success in the clinical management of people of working age. However, only 19% indicated that there were good services locally to which they could refer their patients for advice on returning to work. Fewer GPs (10%) reported they had received training in health and work within the past 12 months. (Department for Work and Pensions, Research Report No 835).

In 2014 a special service will start providing specialist work-related assessments and advice to GPs and employers regarding workers’ health. This will be state-funded and will include: (1) assessment by occupational health professionals for employees who are off sick for four weeks or more; (2) initial telephone triage with case management for employees with complex needs who require on-going support to enable return to work; and (3) an online job search service for employees who are able to work, but are unlikely to return to their current employers. Both GPs and employers would be able to refer to this community-based service.

Professor Dame Carol Black is Adviser on Health and Work to the Department of Health of England. She is author of the report “Working for a healthier tomorrow” and she also carried out an independent review for the UK Government of sickness absence in Britain.
Universal health coverage is not only for rich countries.”

Dr. Winai Sawasdivorn, Secretary General of the Thai National Health Security Office spoke about the experience of his country in providing health services to all workers. Thailand introduced a medical welfare scheme for low-income people in 1975 when gross national income (GNI) per capita was only US$390. The community-based health insurance scheme was introduced in 1983 when GNI per capita was US$760 and achieved universal coverage in 2002 with GNI per capita of less than US$2000. The Thai example shows that universal health coverage is not only for rich countries and that reaching it is a real political and financial commitment. By 2012 almost all of population (99.5%) was covered by three schemes – Universal Coverage (75%), Social Health Insurance (15%) and Civil Servants’ Medical Benefit Scheme (10%). Services by all three schemes were free at the point of delivery. The benefit package was comprehensive and covered low cost care such as outpatient services to high cost care such as chemotherapy, haemodialysis and open-heart surgery. All services covered medicines. This results in a minimum level of catastrophic health expenditure and prevents impoverishment from paying medical bills.

Half of the total population are workers (36 million) and nearly two-thirds (24 million) work in the informal economy: farming and fisheries (59%), services (19%) and crafts (7%). About 12% encounter occupational problems: chemical effects (67%), hazards from equipment (20%). The interventions for occupational health and rehabilitation by the primary care units are covered by the universal health coverage scheme. These interventions include: (1) outpatient services such as simple and common occupational disease recognition and case management, maintaining records about work in patient cards, and disease reporting; and (2) outreach services in communities, including farm or workplace survey, participatory data analysis, health screening (e.g. cholinesterase tests for exposure to pesticides) and communication of results to workers for joint problem solving. The challenges are to expand occupational health services nationwide, to strengthen the role of sub-district local governments, to add the interventions for primary prevention in the benefit package, and to develop a system for monitoring and evaluation.
Addressing the health needs of workers requires re-engineering primary health care.

Dr. Muzimkhulu Zungu, Medical Director of the Medical Bureau for Occupational Diseases of South Africa, spoke about the challenges and initiatives on addressing workers’ health in the policies for primary health care in his country. In 2012 the population of South Africa was 53 million of which 65% were of working age (15-64 years). The economically active population was 17.7 million - 13.3 million in the formal sector and 4.4 million in informal economy. In 2009 the top ten diseases related to work were: noise-induced hearing loss, mental health problems, TB, trauma, shock, allergies, skin diseases, asthma, asbestosis, and musculoskeletal disorders. In the mining sector the mortality from silicosis and active TB was increasing. The governance of occupational health was shared between the Departments of Health, Mineral Resources, and Labour.

The Department of Health is in the process of amending its occupational health legislation and a programme is to be developed to expand coverage for all workers, including informal workers in the context of the national initiative for primary health care reengineering – moving to district-based care, which entails working with district-based community outreach teams, health promotion and disease prevention by primary care teams, district specialists teams and school health. Healthcare for workers was transitioning from the traditional occupational health, limited to workplaces mainly in the private sector, focused only on problems directly related to work of permanent employees under employers’ responsibility, to a public health-based care where action goes beyond the workplace to address all health determinants, among all workers (formal and informal) with the involvement of all stakeholders.

The model for workers’ health services included: (1) community level – primary care nurse, environmental health officer and community health workers; (2) district hospital – specialists in family medicine, general practitioners, occupational nurses and hygienist; (3) regional (secondary level) hospital – specialists in occupational medicine; and (4) central hospital – academic and referral units in all disciplines of occupational health.

The next phase of the programme will include an integrated social protection system for workers, developing infrastructure and human resources for workers’ health and ensuring appropriate funding. The challenges are availability of human resources, curative focus of primary care, fragmented service delivery and insufficient quality assurance.

Dr. Muzimkhulu Zungu is a medical doctor specializing in occupational medicine from South Africa. Currently he is Medical Director of the Medical Bureau of Occupational Diseases in South Africa. He also has appointments with the Department of Health and clinical occupational medicine.
Dr. Iona Heath from the World Federation of Family Doctors (WONCA) argued about the importance of people-centred care for workers. She recalled that originally the primary health care movement enshrined in the Alma Ata Declaration from 1978 was based on social justice. The best health systems were based on primary care.

Most health care – including occupational health – could, should, and did happen in primary care. Primary care was especially concerned with knowing the person and context. People did best when primary care and occupational health care professionals worked well together. Primary care professionals should know as much as possible about the workplace and what can be done for work-related diseases and health risks.

The global conference “Connecting Health and Labour” held in The Hague in 2011 provided a road map for integrating occupational health into primary health care. The major barriers for action included the communication between occupational health and primary care experts, the additional time for primary care providers to act on work-related problems, and the complexity of occupational health.

Dr. Iona Heath is a member of the Executive Committee of the World Organisation of Family Doctors (WONCA). She is a general practitioner and until recently was President of the Royal College of General Practitioners.
We need to work together to build the capacities of health systems to deliver these interventions to the largest possible number of workers.”

Dr. Maria Neira, WHO Director of Public Health and Environment reminded the audience that according to the definition adopted by the UN General Assembly in 2012 “universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population…” (UN General Assembly, Resolution on Global Health and Foreign Policy, 2012).

The WHO global survey among 120 countries carried out in 2008/2009 found that two thirds of countries still had very low coverage of workers with occupational health services and one fourth of countries did not even know their actual coverage level. There were three ways of expanding coverage. The first way was by increasing the proportion of costs that are covered; this was to ensure that workers do not have to pay for prevention, diagnosis, treatment and rehabilitation of occupational diseases and injuries. This required expansion of the insurance schemes for occupational diseases and injuries. The second way was by increasing the number of interventions – for example by adding primary prevention of occupational risks and promotion of work capacity to the diagnosis and treatment of occupational diseases and injuries. And the third way was by expanding the groups of workers who have access to basic interventions for workers’ health – there are good examples about covering workers in the informal sector, small enterprises, farmers, and migrant workers.

The interventions for protecting health at the workplace encompass most stages of the life cycle. Unfortunately there are still working children often in hazardous conditions, women in vulnerable work situations, adults in the informal sector participating in dangerous activities, and the elderly, helping the family or trying to make ends meet.

The global conference on connecting health and labour was held in The Hague in 2011 with kind support from the Dutch Ministry of Health. For the first time occupational health and primary health care experts discussed ways of addressing the specific health needs of workers, and identified essential interventions at the primary care level. These interventions included: (1) primary prevention of occupational risks – providing advice for improving working conditions, for example through workplace visits, information materials and training of workers; (2) secondary prevention – early detection of occupational diseases and injuries, their referral, reporting, and eventually treatment and rehabilitation; and (3) tertiary prevention – promoting working capacity, return to work, and reducing sickness absence.

These essential interventions were not expensive - WHO studies in five countries demonstrated that the cost of the interventions per worker served varied between 14 and 83 Purchasing Power Parity Dollars. Currently, WHO is developing methodology for assessing costs to health systems from the delivery of essential occupational health interventions at the primary care level. A special module on workers’ health will be included in the international OneHealth costing tool. This would
allow countries to integrate these interventions in their national health accounts, and to mobilize additional resources, for example through social security or pooling together private funds.

There is a need to work together to build the capacities of health systems to deliver these interventions to the largest possible number of workers, particularly in the informal sector, small scale work settings and migrant workers. Health systems should support individuals in maintaining their working capacity and income earning potential and mitigate or prevent work-related disease or injury.

In the ensuing discussion participants spoke about the challenges to providing health coverage for informal sector workers, about the need to address workers’ health in the global forums on public health and development, and about the potential to involve civil society in the efforts to move towards universal health coverage for workers.

Dr. Maria Neira is director of the WHO Department of Public Health and Environment. She deals with all WHO policies regarding environmental determinants of health, including climate change, chemical safety, water and sanitation, and workers’ health.