Primary Health Care and Workers' Health at the ICOH Congress in Seoul (June 2015).

Introduction

More than 85 % of all workers have no access to professional support in health and safety at work. Therefore, new programs have been started in several countries to involve primary or community health care (PHC) in workers' health needs. In a special session organized by Frank van Dijk (LDOH) and Peter Buijs experiences from various countries were presented. *Peter Buijs* clarified that the **history** of connecting primary health care to the health of the workers started already in 1978 in Alma Ata. However, it took until 2014 before the ICOH-WONCA common Statement and Pledge could be launched concluding to address jointly "gaps in services, research, and policies for the health and safety of workers and to better integrate occupational health in the primary care setting, to the benefit of all workers and their families".

South East Asia

Orrapan Untimanon reported about the situation in **Thailand** with 38 million workers, including many informal workers in agriculture. To date more than one third of all Primary Health Care Units in Thailand provide occupational services. A SWOT analysis showed as strengths well-developed multidisciplinary teams and the collaboration with local authorities. Weaknesses are the insufficient number of health personnel and limited knowledge among primary health care staff.
Hanifa Denny informed about the situation in **Indonesia** with 125 million workers. Efforts to provide care to workers are supported by the government, most services are delivered through the primary health care system. PHC centers have Occupational Health Posts (POS UKK) with community participation: two or three occupational health volunteers. A number of centers are supported by Occupational Health referral centers (BKKM). Coverage is increasing but the workers' health program is not a mandatory service and funding is insecure. Evidence is needed on economic and health benefits of the programs to stimulate increase in coverage. *Claudio Colosio* presented challenges for half of all workers, working in **agriculture**. The sector suffers from many work accidents and occupational diseases. Much work is Dangerous, Dirty and Demanding and adequate occupational health surveillance is mostly not available. One of the models is Basic Occupational Health Services (BOHS), a form of collaboration between occupational and primary health care. Essential health packages on local level can be supported by nurses and physicians in rural health centers, also functioning as referral centers. Education and training, custom-made tools and full support from workers, employees and employers are needed. New ICT technologies (smartphones, internet) may increase coverage and quality of care.

Africa, Latin America, Middle East , Europe

Muzimkhulu Zungu described that **South African workers** have limited access to occupational health services. Re-engineering seeks to shift the PHC system from a largely passive, curative and individually oriented system to one with a more proactive, integrated and population-based approach. Ward Based PHC Outreach Teams headed by a nurse will also perform essential health services for workers. Pilot sites are implemented as demonstration sites for workers' health. Strengthening is needed such as by education and training. *Said Arnaout* informed about the **Eastern Mediterranean Region**. Coverage with occupational health services is mostly very low. One innovation was the development of

occupational and environmental health standards for accrediting hospitals and other health care facilities in the Gulf countries. This will strengthen infrastructures, human resources and organizational capacities. At an international consultation in Semnan, Iran (2014) decision makers were sensitized on the issue and successful experiences were shared such as those in Iran

Andrea Maria Silveira representing *Elisabeth Costa Dias* reported that half of the 101 million workers in **Brazil** have informal work with poor or no social protection. Workers' health is under the responsibility of the National Health System (SUS) and Primary Health Care is the system coordinator. PHC coverage increased enormously and progress has been made, but the infrastructure is still poor, PHC work is devaluated and work-related diseases are underreported. More education of PHC staff is needed and technical support by Reference Centers of Workers' Health.

Raymond Agius described how many General Practitioners (family physicians) in **United Kingdom** were educated in Occupational Medicine following a blended Postgraduate course. With a number of these GPs a network was launched reporting more than 6000 work-related ill health cases and associated sickness absence. An electronic resource 'EELAB' was developed assisting GPs in learning occupational medicine using their own cases. Finally a community of GPs was developed, well- trained in occupational medicine, at the same time contributing to pedagogic and epidemiological research.

Preliminary conclusions

The Special Session closed with a number of preliminary conclusions:

1. The presented examples from various countries show the feasibility of primary health care contributing essentially to workers' health, under various conditions.
2. Clearly, progress has being made in the last decade.
3. It is also clear that this is only the start, both in coverage and in quality.
4. To continue progress, Universal Health Coverage should include specified interventions for workers' health to safeguard embedding in the health systems and future funding.
5. National governments are to be held responsible to create favorable conditions for primary health care to perform interventions in favor of the workers' health and safety.
6. One of these conditions is a well-organized support of PHC by OSH experts and the availability of referral options. PHC physicians have to be trained, but also nurses, technical staff, community health workers and volunteers.
7. Therefore a programmatic approach is necessary inclusive provision of financial resources and a support infrastructure with an online helpdesk, information websites, referral options, education for PHC, custom-made practice tools and feasible instruments for evaluation of the care provided.
8. Community participation has to play an essential role.
9. Modern ICT can be used to increase collaboration, quality and coverage.
10. Evaluation studies are needed to support real progress.