Primary health care (PHC) and the application of its principles have been reaffirmed to be of central importance to health systems. The PHC approach covers context-specific services that are relevant to the population for whom the services are designed. The notion of Basic Occupational Health Services (BOHS), wherein there is an application of the PHC principles in the occupational health sector, can be viewed as the provision of basic and essential services for the workforce.

However, BOHS provision has low coverage and where available, quality and relevance of the services are questionable. Like with routine health service provision globally, BOHS service provisioning can be assumed to be patchy at best in low and middle-income countries. The challenge in low and middle-income countries is that a majority of the adult population is a part of the informal sector. The number employed in the formal sector is proportionately much smaller. Typically, the size of the informal sector is larger than the formal sector in most developing countries, including India, and only its estimated size is available through estimates generated from representative surveys like the National Service Scheme (NSS) in India. This further impedes targeting of the initiatives, consequently resulting in poorer coverage among the informal sector who may need these services the most. Provisioning BOHS has been a challenge globally. In India, primarily driven by pragmatism and the search for simpler ideas, there is an effort toward innovating for mini occupational health services for unorganized labor markets.

We believe that the BOHS debate and the broader discussion need to consider the newer paradigm that is now evident in the health sector, including India. The global discussion on health care is dominated by discussions towards the idea of universal health coverage (UHC). As defined by the WHO, UHC means that all individuals and communities receive the quality health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Dr. Tedros Adhanom Ghebreyesus, Director-General of the WHO has stated that “UHC, based on strong health systems, is the best way to ensure that people can access the health services they need, without financial hardship.” Indeed, all UN Member States have agreed to try to achieve UHC by 2030, as part of the Sustainable Development Goals. In this context, we see a complete synergy with the activities that underpin BOHS; namely surveillance of work environment and risk assessment, health surveillance and health examinations, advice on preventive and control measures, health education and health promotion, and promotion of workability, maintaining preparedness for first aid and participation in emergency preparedness, diagnosis of occupational diseases, and record keeping.

A review of the UHC and the SDG literature also reveals that not only are UHC related principles well-recognized terminology, but they also have much larger traction among decision-makers and feature in political dialogues globally. Countries have traveled along the UHC path and there are several UHC models advocated by countries. Larger countries have also experimented with within-country models for advancing UHC. We believe that BOHS aligns well with the UHC approach and principally can be subsumed within the UHC principles, where the workforce needs the usual services plus some additional services. This synergy with the larger global movement can give a much-needed fillip to BOHS advancement.

While the former idea is based on a strong principled argument, the current practical changes on the ground in India give us a strong reason to align closely with this movement. We acknowledge that the principal challenge in India is that in spite of a demand for BOHS services, expanding its coverage is challenging. Examining the BOHS problem through the UHC cube; two dimensions: “Who is covered” and “Which services are provided” demand immediate attention. The captive formal sector is easier to target for greater coverage since it is defined, enumerated and essential services and the infrastructure for delivering the services are mandated by law. The informal sector, large and sometimes mobile, is difficult to target as a part of the efforts towards expanding UHC services. The government is also seized on the question of how to provide services to the unreached and expand the basket of services that are being provided. The government has already embarked through laudable efforts such as Ayushman Bharat/PMJAY.

The synergy in principles between UHC and BOHS needs to advance from “principles” to “demonstrated action.” Widening the basket and targeting of the activities towards the informal sector workforce is common ground. The government is increasing the financial outlay for the above-listed schemes and embarking on creating a network of health and wellness centers across the country. The industry has always been a strong advocate for occupational health (OH) and its provisioning. The industry can develop models that will guide informal sector workers to these facilities. The industry also has the opportunity to support the government through sharing its OH
expertise through the new infrastructure, provide support, and assume its responsibility of caring for its workforce.

IAOH has an important role to play here. It can extend a profound thrust through its members, and branches to evolve dynamic and adaptable models that work. These models can be implemented; followed by rigorous evaluation for effectiveness and their applicability. These models will have to be in sync with the government initiatives for greater efficiency and sustainability. The government’s efforts in health care provisioning can be matched by industry efforts for impact. Indian Association of Occupational Health (IAOH) can provide a platform towards demonstrating a workable proposition for catering to the unreached workforce and positively contributing to the lives of 600 million-strong workforce in India. Such a BOHS model that transcends challenges of low and middle-income countries can be a lasting contribution of India’s premier OH association to the world.

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