

## An Overview of India's Occupational Health Research

Bazmi Elham\*

College of Nursing, Scientific and Educational Research Center of Legal Medicine Organization, Egypt

### Letter

Occupational morbidity in India has changed dramatically as a result of recent industrialization and globalisation. Traditionally labour-oriented markets have been shifting toward greater automation and mechanisation, although general knowledge of workplace safety, occupational and environmental dangers has not diffused throughout society [1]. This study will give an overview of the existing evidence from community-based epidemiological studies and will answer India's growing demand for evidence-based occupational health research. Review of all outcomes that have been published. In India, occupational research is considered as a more complex issue, with child labour, weak industrial legislation, a large informal sector, a lack of attention to industrial hygiene, and insufficient surveillance data throughout the country. While India is undergoing economic transformation, occupational research should strike a balance between understanding current industrial exposures and the health concerns associated with traditional industries such as agriculture and plantations. To deal with the situation, strategies such as current occupational health legislation, enforcement machinery at the sub-district level, health professional training, the necessity for epidemiological evidence, and international cooperation were addressed.

Working patients' health is crucial to UK GPs since about 32 million people work in the UK, and roughly half of a GP's patients work [2]. Recent government publications have highlighted a lack of practical support to help people who are off sick stay connected to and return to work, as well as the fact that people in work should have easier and earlier access to health care, with GPs recognising when early referral might prevent someone from leaving work permanently.

If employers do not 'get it right,' there is a considerable health burden and cost. Accidents and work-related sickness caused by hazardous or pathogenic materials, stress, and ergonomic issues provide a health-care and economic concern [3]. In Great Britain alone, an estimated 25.9 million working days were lost due to work-related illness and 4.5 million owing to occupational injuries in 2015–2016, costing £14.1 billion per year.

In fact, 1.3 million people who worked in the previous year self-reported a work-related ailment, with 500 000 new disorders appearing over that time period. Another 0.8 million people who worked for more than a year have reported a work-related sickness, including societal, individual, and family-related consequences. Around a quarter of the cost is borne by the state, in the form of benefits paid and taxes lost (80%), as well as NHS treatment (20%) [4].

Multidisciplinary occupational health services (OHS) staffed by specially trained professionals with unique and complementary skills, such as occupational physicians (OPs), occupational health nurses, physiotherapists, counsellors, and occupational health technicians, are needed to reduce the incidence of work-related illness. Occupational psychologists, occupational therapists, and liaison psychiatrists may be available through NHS OHS. Typically, OHS does not provide treatment or specialist referrals (unless in an emergency) [5]. According to surveys, 13 percent of British firms provide some type of OHS, but only 3% provide a comprehensive OHS. Because only a

small percentage of the workforce has access to OHS, working people may seek help from their GPs and other healthcare providers for work-related ailments.

The forces that form work it, social evolution, changing modes of production, shifting economic powers, and demographic changes in the workforce have shaped workplace dangers and occupational medicine throughout history. This research underlines the long-term and unavoidable relationship between social structure and worker health, lest we imagine these changes are unique to the present period. Hippocrates highlighted the link between environment (air and water) and health, while he says little about non-military work environments, possibly due to Greece's denigration of physical labour. The Edwin Smith Surgical Papyrus, written around 1700 BC, examines the influence of employment on health. Galen was a physician to Roman gladiators, making him one of the early occupational physicians. Early personal protective equipment included finger and wrist guards worn by Bronze Age archers. Classical writers discuss the diseases and dangers that miners face, and Pliny (1st century AD) discusses face veils. Rhazes' case studies in the Middle East included occupation (9th century). In the 15th century, the personalities Paracelsus and Agricola were well-known for their work on mining and health [6]. Ramazzini's (c1700) work was widely translated during the next few decades and is now well-known to everyone, but its influence between 1800 and 1940 is clear. The birth of a public health movement in the mid-nineteenth century focused attention on the appalling conditions of many factories, as well as the living conditions, poor nutrition, high stress, poverty, and ill health of the new factory working class, while ignoring specific workplace hazards.

Occupational disease recognition in the United States has frequently trailed a generation behind that of the same diseases in Europe. We are currently in the midst of a second industrial revolution, fuelled by multinational corporations and information technology, with production facilities and jobs spreading around the world in search of cheap labour in the poorest countries [7]. The new issues brought by this transition must be recognised by occupational medicine.

### Acknowledgement

None

\*Corresponding author: Bazmi Elham, College of Nursing, Scientific and Educational Research Center of Legal Medicine Organization, Egypt, E-mail: bazmi@gmail.com

Received: 5-Apr-2022, Manuscript No: omha-22-61137; Editor assigned: 7-Apr-2022, Pre-QC No: omha-22-61137 (PQ); Reviewed: 22-Apr-2022, QC No: omha-22-61137; Revised: 24-Apr-2022, Manuscript No: omha-22-61137 (R); Published: 30-Apr-2022, DOI: 10.4172/2329-6879.1000404

Citation: Elham B (2022) An Overview of India's Occupational Health Research. Occup Med Health 10: 404.

Copyright: © 2022 Elham B. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

## Conflict of Interest

None

## References

1. Groneberg DA, Nowak D, Wussow A, Fischer A (2005) Chronic cough due to occupational factors. *J Occup Med Toxicol* 1:3.
2. Wagner U, Staats P, Fehmann HC, Fischer A, Groneberg DA (2005) Functional airway secretion in a rat model of sulfur dioxide induced chronic obstructive pulmonary disease (COPD). *J Occup Med Toxicol* 1:5.
3. Ghosh SK, Parikh JR, Gokani VN, Kashyap SK, Chatterjee SK (1979) Studies on occupational health problems during agricultural operation of Indian tobacco workers: A preliminary survey report. *J Occup Med* 21:45-47.
4. Haldiya KR, Sachdev R, Mathur ML, Saiyed HN (2005) Knowledge, attitude and practices related to occupational health problems among salt workers working in the desert of Rajasthan, India. *J Occup Health* 47:85-8.
5. Kumar S (2004) Victims of gas leak in Bhopal seek redress on compensation. *BMJ* 329:366.
6. Mathews R, Reis C, Iacopino V (2003) Child labor. A matter of health and human rights. *J Ambul Care Manage* 26:181-182.
7. Shukla A, Kumar S, Ory FG (1991) Occupational health and the environment in an urban slum in India. *Soc Sci Med* 33:597-603.