

# **The British Occupational Hygiene Society response to the Call for Evidence on a Men's Health Strategy**

## ***Why listen to BOHS?***

For over 70 years, BOHS has been the independent scientific voice of preventing ill health in the workplace. The decline in ill-health caused by the workplace in areas such as silicosis, pneumoconiosis and other industrial diseases has not been accidental or merely as the result of changing ways of working.

Research, control measures and professional insights from BOHS have been instrumental in the reduction of the burden of ill health through work in the UK. From legionella, through asbestosis, other cancers, silicosis and musculoskeletal disorders, the research and publications of the Society and the work of its members has saved literally thousands of men's lives in traditionally male-dominated industries.

## ***Is making workplaces part of the solution going to be a cost to business?***

In tandem with this, good occupational hygiene has been a driver of increased productivity, reduced costs and delays and longer and healthier working lives. This is strongly evidenced in some of our most economically successful sectors, such as pharmaceuticals, the chemicals and energy industries. High standards in the prevention of exposure to hazards is not a barrier to business effectiveness, but an enabler of business continuity.

This is because preventing men from being exposed to chemical, biological and physical hazards to health in the workplace is far more effective and cost-effective than trying to identify and treat the consequences of uncontrolled exposure, whether through occupational health interventions or the National Health Service.

Rolls Royce reports in the [Journal of Occupational and Environmental Medicine](#) that it costs them 50m pounds per annum to manage work related musculoskeletal disorders, which principally affect their male workforce. To provide a cost context, this amount of money could fund 25 NHS Integrated Care Board MSK packages in the NHS or over ten NHS WorkWell pilots. Interventions which prevent, rather than treat (or retire) male workers with MSKs, promise tremendous savings for employers, retention of skilled staff and lowered cost for healthcare and benefits.

### ***Workplaces need to be seen as more than early intervention treatment centres***

In the last century, steelworks would include primary care facilities. This was seen as progressive in making early interventions into treatment of accidents and illness caused by work. There are some exceptional examples of early intervention and primary care facilities in UK workplaces, for example the Health Centre at Hinkley Point C. However, we need to follow the lead of Hinkley Health in not just seeing the benefits of using the workplace for diabetes testing and mental health support. Workplaces can and do make people ill and should be recognized as a potential contributor to men's ill health. Treating health in the workplace as seriously as we treat safety, with similarly rigorous standards of design, process management, control and accountability is critical. Recognising high potential exposures that risk serious ill health in the same way as near-misses in potentially fatal accidents can and will make a difference.

The Men's Health Strategy must see the direct and proven links between poor management in the "Health" part of "Health and Safety" as contributing over 800,000 instances of preventable ill health to the UK's men's health burden, with almost 12,000 respiratory disease deaths each year arising from workplace exposures.

### ***The future, not the past***

It is easy to view respiratory illness as a past exposure legacy from heavy industries. However, instances of respiratory illness caused by work are going up, rather than down, despite the decline in smoking and the end of many male-dominated heavy industries. This is because we have taken our eye off the ball. We estimate that over 750,000 workplaces, with predominantly male employees, depend on specially designed Local Exhaust Ventilation to prevent workers from inhaling known carcinogens, asthmagens and respiratory sensitisers.

However, there is no minimum qualification or competency standard for those who test and maintain these systems and the minority have ever been checked to see whether their design will actually remove the hazardous particulates and fumes. The result is HSE discovering time and time again that LEV is not effective in preventing disease.

The cost of respiratory cancers caused by the workplace to the NHS is double the cost of care for all paediatric cancers, yet the controls (designing out dust-generating processes, water suppression, local exhaust ventilation or, at the very least PPE) are relatively easily achieved. These are today's manufacturing problems and need a modern enforcement and regulatory solution to ensure the polluter of the workplace environment pays to keep it clean or carries the full cost in health for failures.

As we contemplate significant shifts in the way in which men work and the challenges of modern working environments, we need to remember that the workplace is the critical economic and practical determinant of the health of our nation. Work generates wealth and can either be a positive or a negative driver of men's health. New ways of working and new industries bring new threats.

While installers of asbestos aren't at risk of mesothelioma, heat pump, insulation and solar panel installers are, as well as plumbers, electricians and others upgrading our building stock. It is these trades that are seeing early cases of cancer from random exposure amongst a generation that believed that because asbestos was banned, the risk disappeared. Practically no apprenticeship standard for a trade at risk from asbestos exposure requires asbestos awareness training. Just in the way that practically no building apprenticeship standard has a suitable and sufficient level of training in managing silica dust exposure.

These are old hazards but will strike down a new generation of predominantly male workers because of ignorance. In the process of working in ignorance, they will inadvertently let loose carcinogens into our general environment, harming us all. While construction dust contributes 40,000 new cases of COPD to the NHS each year, it also contributes 20% of London's air pollution.

***Men's health is not just a question of lifestyle, education and access. Work makes all the difference***

BOHS welcomes the development of men's health strategy, but it will have limited impact and relevance on most men if there is not an appropriate recognition and focus on how the workplace causes ill health. Put simply for working men, most of the preventable hazards which result in premature death arise as a result of the work that they do or cannot do. Many of the factors which promote preventable disability and economic inactivity arise from how they work. Many of the factors that amplify lifestyle health risks have a close association with work, and men's working contexts can significantly influence access to healthcare, health literacy and health awareness.

Health strategies which fail to recognize the central role of preventing hazard exposures in the workplace, risk allowing antagonizing factors which sabotage public health initiatives, while failing to address amplifying factors, which increase health risk.

The Women's Health Strategy for England made this mistake. It viewed the workplace solely as somewhere where women's pre-existing health issues could be managed but paid little or no attention to the workplace as a cause of ill health. We can see how this approach has been deficient, with ill health caused by work increasing year-on-year for women.

Men's Health Strategy cannot afford to repeat this mistake. If it ignores the fact that poor management of hazards to men's health in the workplace makes people ill, it will fail before it starts.

The following provides two examples of major risks for men and how occupational factors are critical drivers for ill health in two industries.

### *EXAMPLE 1: The workplace as a cause of premature death among men: The Example of Heart Disease*

The most common cause of premature death for men over 55 is Ischaemic Heart Disease according to ONS figures. While general population factors and lifestyle factors are undoubtedly critical, a men's health strategy cannot afford to ignore the impact of occupational factors on working men in relation to IHD. ([A systematic review of studies in the contributions of the work environment to ischaemic heart disease development - PMC](#)).

While it may be argued that there are intersectional relationships between race, class, education etc., it seems clear that occupation and occupational status in its own right has a significant relevance to health outcomes for men. ([Health disparities by occupation, modified by education: a cross-sectional population study | BMC Public Health | Full Text](#))

Some occupational factors which contribute to higher IHD risk are very specifically gendered. ([A longitudinal linkage study of occupation and ischaemic heart disease in the general and Māori populations of New Zealand - PMC](#)). While noise has been associated with IHD, it appears to be less of a factor for men working in some industries than for women ([Long-term transportation noise exposure and incidence of ischaemic heart disease and stroke: a cohort study - PubMed](#)). Conversely, comparable elevated (even light) occupational physical activity creates a more pronounced risk factor of IHD for men than for women. ([Prospective relationship between occupational physical activity and risk of ischaemic heart disease: are men and women differently affected? - PubMed](#)). This is particularly significant since men tend to be more closely associated with roles with higher OPA.

When combined with respiratory illness, the importance of IHD in contributing to premature death, including death before retirement age, becomes even more significant ([Ischaemic heart diseases deaths including comorbidities, England and Wales - Office for National Statistics](#)). Regardless of the significant impact of silica on respiratory health (e.g. COPD, lung cancer and silicosis), silica exposure increases the risk of IHD ([Occupational exposure to silica and risk of heart disease: a systematic review with meta-analysis | BMJ Open](#)). Men are far more likely to be in building and related occupations where there are high levels of

silica exposure. This will be doubtlessly related to higher levels of IHD amongst construction workers, in addition to other factors already mentioned and lifestyle factors.

The same applies to occupational exposure to particulate matter diesel exhaust. ([Occupational exposure to particulate air pollution and mortality due to ischaemic heart disease and cerebrovascular disease - PMC](#)). Again, the working population exposed to high levels of DPM are predominantly male. For those in road haulage, there is a high level of exposure to DPM, but other factors are likely to further increase IHD risk. While drivers are not supposed to work more than 56 hours per week, there is a strongly established increased risk of IHD from shifts at or above 55 hours ([The effect of exposure to long working hours on ischaemic heart disease: A systematic review and meta-analysis from the WHO/ILO Joint Estimates of the Work-related Burden of Disease and Injury - ScienceDirect](#)). Long distance drivers typically work to the maximum nine hour driving periods, but there is a strong dose-response relationship for shifts over 8 hours in terms of relative risk ([Shift work and ischaemic heart disease: meta-analysis and dose-response relationship | Occupational Medicine | Oxford Academic](#)). Thus, while it is easy to characterize the risk factors for the predominantly male working population of long-distance drivers as relating to diet and exercise, other factors, including sedentary work, night shifts and length of working time are significant and preventable factors.

At a time of climate change and working environments that have not been adapted to manage hot weather, it is of further importance to consider the largely male population working with extreme heat that increases risk of IHD [A Review of the Links Between Work and Heart Disease in the 21st Century - PMC](#). Heat stress is itself the cause of other health conditions and worthy of focus.

#### *EXAMPLE 2: Men's lifestyle and its negative impact on health: The Example of Musculoskeletal Disorders*

Lack of exercise, poor diet, lack of access to health resources and substance use are all major concerns for a men's health strategy. The results in terms of mental illness, obesity, diabetes, IHD, leading to the extremes of death by overdose and suicide are legitimate causes for concern.

Employers have been prevailed upon to directly intervene in lifestyle behaviours, such as promoting exercise, better diets, access to health benefits etc. This is welcome but should not be at the expense of ignoring the workplace factors which cause these problems.

Musculo-skeletal disorders promote pain, leading to self-medication, moving away from complex food preparation and towards insomnia and mental health problems. For working people, while exercise may be good for them, work itself is most likely to contribute to MSKs.

In the UK, 70% of those inactive because of long-term sickness and with a main health condition that is musculoskeletal, self-report a further musculoskeletal condition ([Rising ill-health and economic inactivity because of long-term sickness, UK - Office for National Statistics](#)). MSKs are also a significant driver of absenteeism ([Musculoskeletal health in the workplace - PubMed](#)) and very strongly associated with mental health problems. Over 540,000 workers report work causing MSKs according to HSE, with more days lost by men because of MSKs than women, by nearly 50% in the over 55 group. In industries such as construction, this is a significant factor in labour and skills loss ([Fuller working lives in construction report \(October 2018\)](#) before retirement age, with a significant proportion of those leaving becoming permanently economically inactive.

The impact of the working environment on MSK risk is considerable. Whether it is office-based working or driving long distances, poor equipment can be a major factor in causing MSKs ([Prevalence of Musculoskeletal Disorders in Heavy Vehicle Drivers and Office Workers: A Comparative Analysis Using a Machine Learning Approach - PMC](#)). Increasing “steps” for drivers may reduce BMI with initiatives such as SHIFT may be of benefit (<https://bmcmmedicine.biomedcentral.com/articles/10.1186/s12916-022-02372-7>), but not if the MSKs are caused by whole body vibrations caused by poor cab design.

Working conditions for the predominantly male workforces in transport and construction, for example, such as on-site construction with casual accommodation, or the absence of accessible healthcare for long-distance drivers, will have direct impacts on lifestyle and health. Long periods of separation from family and friends contribute towards poor mental health, increasing also factors such as the likelihood of acquiring STIs. The absence of food preparation facilities and long hours have a negative impact on diet. Isolation and enforced periods of inactivity promote addictive behaviours.

However, in addition to these factors, pain and fatigue from MSKs impact on the desire to exercise, the ability to prepare food and the likelihood of self-medication by substance use. To disregard these powerful occupational factors in the context of men’s health would be a major oversight.

### *Conclusion*

Across the range of men’s health risks, workplace causes cannot be ignored. The workplace can also be a powerful factor which operates against public health initiatives and is



restrictive of access to health for men. Insufficient attention has been paid to gendered difference in health risk and stereotypes/sociological studies, rather than clinical evidence, have tended to influence assumptions about health and work ([Working conditions of commercial drivers: a scoping review of psychosocial work factors, health outcomes, and interventions | BMC Public Health | Full Text](#)).

While this brief response provides only two examples of areas where men's health is impacted by occupational factors, they illustrate that for the most significant risks to health and the nation's wealth, employers can and must do more about how men work if the strategy is to succeed. We would be delighted to provide further, fuller and more comprehensive evidence to help ensure that this is not another missed opportunity.

**Professor Kevin Bampton,**

**CEO British Occupational Hygiene Society (Deputy Chair, Council for Work and Health)**

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