IS HEALTH A GOVERNANCE ISSUE?

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In the financial services sector corporate governance standards focus on how firms and groups are organised. How are functions allocated, how are the interests of customers safeguarded? Are independent non-executive directors able to function? Are directors and senior management fit, trained, competent and honest? Fitness, of course, implies health but health is rarely focused on as a governance issue in its own right.

This contrasts with the approach to governance in the healthcare sector. The Boorman review recommends that, with a view to optimising patient care, “the NHS operating framework should clearly establish the requirement for staff health and well-being to be included in national and local governance frameworks to ensure proper board accountability for its implementation”. The Boorman report echoes the wider recommendations of the Black Review of the health of Britain's working age population:

> “Improving the health of the working age population is critically important for everyone, in order to secure both higher economic growth and increased social justice.”

Poor health in the working population can affect performance and compliance with objectives identified in a regulatory regime such as that run by the Financial Services Authority. This applies particularly to mental illness and alcohol and drug misuse. The London Code of Conduct for Principals and Broking Firms in the Wholesale Markets addressed the issue. It said:

> “Management should take all reasonable steps to educate themselves and their staff about possible signs and effects of the use of drugs and other abused substances. The judgement of any member of staff using such substances is likely to be impaired; dependence upon drugs etc makes them more likely to be vulnerable to outside inducement to conduct business not necessarily in the best interests of the firm or the market generally and could seriously diminish their ability to function satisfactorily.”

This guidance was abandoned when the Financial Services and Markets Act 2000 came into force in 2001. Two recent FSA enforcement cases, however, suggest this may have been a mistake.

In the first the FSA made a prohibition order against a trader for short selling involving amounts in excess of US$10 million. It noted:

> “He drank alcohol over lunch and it appears that this affected his behaviour on his return to the office, although he was not visibly drunk. Between 17.04 and 19.37 on 6 February 2008, Mr Redmond sold 24,868 lots and bought 19,493 lots of WTI Futures on the ICE web-based trading platform, WebICE. His

> trading represented over 30% of the total lots of WTI Futures traded on ICE on 6 February 2008. His short position reached 8,900 lots at 18.36. By 19.37, Mr Redmond had a substantial net short position of 5,395 lots."

Earlier this year the FSA also made a prohibition order against a Mr. Perkins whose trading in Brent crude futures "secured the price of Brent at an abnormal and artificial level. The trading records show that Mr Perkins' trading had the direct effect of increasing the price of Brent. Mr Perkins lied to his employer in placing the trades on 29 June and then initially attempted to cover up his unauthorised trading on 30 June."

The final notice records:

> "Mr Perkins' explanation for his trading on 29 and 30 June is that he was drunk. He says that he drank heavily throughout the weekend and continued drinking from around mid-day on Monday 29 June. He claims to have limited recollection of events on Monday and claims to have been in an alcohol induced blackout at the time he traded in the early hours of 30 June. Mr Perkins' explanation for his behaviour is supported by medical evidence."

Evidence from scientific literature shows that heavy drinking may lead to inappropriate risk taking in, for instance, sexual activity and driving of motor vehicles. There seems no reason in principle why this should not extend to, for instance, financial trading, investment management, corporate finance, insurance underwriting and lending on sub-prime mortgages. The decline and fall of Mr. Robert Maxwell could be regarded as an illustration. The question has not, however, been researched in peer-reviewed scientific literature, mainly because the financial sector is uninterested in sponsoring this kind of research.

People tend to assume that rules on alcohol and drugs should be focused on junior employees and low status professions and on the managed rather than the managers and least of all those at the top. An occupational health nurse whom I met on a course at the Institute of Psychiatry told me that when she was interviewed for a job in a leading firm of solicitors she was told that health initiatives were aimed at admin staff and that lawyers were above such matters. Where, however, research has been carried out into the problem in high status professions such as doctors, lawyers and airline pilots, serious problems have been identified, often combined with a failure to address those problems until the individual concerned has developed a high level of dependence requiring intensive medical treatment. Alcohol and drug misuse in lawyers often leads to financial crime, such as theft of client money and involvement in moneylaundering transactions.

In the UK, of the liberal professions doctors have been most proactive in identifying colleagues suffering from addiction and/or mental illness. This is done through the Sick Doctors Trust and the Doctor's Support Network. Within the National Health Service a Practitioner Health Programme (PHP) also addresses the special health needs of doctors in the Greater London area. It draws on treatment resources in the private as well as the public sector. Within the NHS, where resources for alcohol and drug treatment are often inadequate, the needs of doctors are prioritised.

Some financial firms and groups have pro-active alcohol and drug policies, often within wider health policies. These can sometimes achieve the same outcome as the PHP. Not all of the largest firms, however, have followed this course. Some outsource health issues to employment assistance programmes (EAPs) and have no policy on alcohol and drug use.

The firms also often provide private medical insurance as an employee benefit. It usually (although not invariably) excludes treatment for alcohol and drug dependence, although there is evidence that the availability of treatment through insurance encourages help seeking.

The alcohol policy of insurer RSA was featured as an example of best practice in the Labour Government's original Alcohol Strategy for England in 2004. It may have been adopted partly with a view to encouraging policyholders to follow the lead so as to reduce insurance claims. The human resources department of RSA, however, did not respond to my request for an update on progress. This is perhaps not surprising given the sensitivity of the subject.

Within the NHS the health of the workforce is critical to the safety and recovery of patients. It is unlikely that it will ever be as significant a business priority in the financial sector, but it perhaps deserves to move a little up the list of priorities and pick up some visibility within policy development as well as enforcement. The FSA and the trade associations could perhaps make a start by encouraging firms to overcome their sensitivities, share their experiences and start supporting peer-reviewed research into the extent of the problem and the success of measures applied to reduce it.