

WHAT SHOULD THE OPTIMAL STRUCTURE AND CONTENT OF A MODEL OHS ACT BE?

SPECIFIC COMMENTS

We offer comment on a few points below, with the common thread being the two broad themes that we feel are of fundamental importance to improving the effectiveness of OH&S legislation and regulation: the relative emphases on occupational health versus safety (i.e., disease versus injury), and reliance on OH&S data/evidence versus insurance data (workers' compensation claims) to guide prevention and control activities.

Legislative Approach:

Q5: We believe that the Act should articulate principles of OHS in a way that is consistent with general public health principles, and readily translatable to action. We would recommend language of the hierarchy of controls, systems or systematic approach, or the precautionary principle. We recently published a concise articulation of a systems approach to job stress [1], and recommend Kriebel and Grandjean as sources on the precautionary principle in OHS [2-4]. Clear articulation of the principles and goals of the Act would set the stage for articulation of appropriate measures of performance, as discussed under 'Accountability' below.

Scope, Application & Definitions:

Duties of Care – Who owes them and to whom?:

'Reasonably Practicable' & Risk Management:

Consultation, Participation and Representation:

Regulator Functions, Powers & Accountability:

Q79: We write with a particular concern about accountability around the performance of the proposed authority, specifically with respect to occupational illness and disease. We believe the Act should specify that the OHS prevention and control (regulatory) authority should be accountable *primarily* to occupational health and safety measures as key performance indicators. This concern is borne out of our published research and experience indicating that there is currently an overreliance on insurance or claims data and that this results in under-recognition of both occupational injury and illness, and in particular an under-recognition of multi-factorial (i.e., caused by a number of work and non-work related factors) chronic diseases, such as depression, anxiety, and cardiovascular disease.

To illustrate, we published an epidemiologic study recently in which we estimated the burden of job strain-related depression in a sample of working Victorians based on exposure data from a population survey combined with estimates of job stress-related increased risk in depression derived from the best available international studies [5, Open Access published on the web]. Job strain is the combination of high job demands in the face of low autonomy or job control. That yielded an estimate of roughly 15% of depression in working Victorians being attributable to job strain. We then applied that percentage to figures derived from the National Mental Health Survey to estimate the number of job strain-attributable cases of depression among working Victorians in 2003 (21,347). Finally we compared that number of cases (21,347) to the number of compensated “mental stress” claims in Victoria in 2003 attributable to chronic work pressures (696), and found that claims statistics underestimate job strain-attributable depression by at least 30-fold. This highlights the need for OHS data to complement claims perspectives in order to realise the goal of the proposed OHS Act “to protect the health & safety of persons undertaking or affected by work” (quoted from page 2, *Issues Paper*).


OH&S measures include measures of exposure or hazard, and measures of work-related injury, illness, and disease. Measures of exposure or hazard include physical measurements (e.g., decibels of noise, ppm of solvents in a worker’s breathing zone, fibres per cc of asbestos), worker surveys (e.g., reports of not being able to hear another worker talking nearby, responses to questions about job demands and autonomy), and other indicators (e.g., use of carcinogen or allergic sensitizer in a manufacturing process). Measures of work-related and occupational illness and disease include doctor-diagnosed conditions, symptoms checklists, biological measurements, and registry data (e.g., traumatic injuries, cancers).

The dominance of insurance over OHS performance metrics is a particular problem with respect occupational illness and disease. The best estimates—both Australian and international—indicate that there are on the order of 10 deaths related to occupational disease for every 1 death related to occupational injury [6-8]. Yet, it is widely recognized that a far smaller proportion of occupational disease cases are compensated by comparison to the proportion of occupational injuries compensated.

Overreliance on claims data also underestimates the burden of occupational injury. Studies comparing injury rates to injury claims rates have shown widely varying degrees of coverage, from as low as roughly 25% of occupational injuries registered in hospital emergency departments for a poor predominantly African-American inner-city Philadelphia population [9] to as high as of 90% coverage for serious injuries requiring hospitalisation in a cohort of highly unionised Canadian sawmill workers [10]. Studies of most work-related chronic disease outcomes, however, are complicated by long latency periods, lack of recognition of relatedness to work, multiple contributing causes—both work and non-work-related, and other factors.

Thus where exposure-disease relationships are established, the use of population-level exposure patterns offers an alternative means of guiding and evaluating policy and practice for work-related contributions to common chronic diseases such as cancers, depression, and cardiovascular disease [11].

History has shown that policy interventions that raise awareness of the potential work-relatedness of a given illness or disease may result in an increase in claims (e.g., this is likely a key contributor to the recent rise in stress-related claims). This can be the case even at the



same time that policy intervention-related decreases in the relevant hazards or exposures begin. Rather than such an instance being judged to be an insurance business failure, it should be viewed as the beginning of an OHS success. The system needs to be able to accommodate the possibility of increasing claims as an appropriate outcome for society (i.e., as an indicator of the Authority's success). Linking a regulator's performance indicators directly to its mission would help to address the inherent conflict between the public health protection function of an OHS authority and its corresponding Workers' Compensation system.

Compliance & Enforcement:

Here we reiterate our point from above (on 'accountability') about the need for outreach, compliance, and enforcement efforts to be based *primarily* on OH&S measures, and for this to be articulated in the Act.

Prosecutions:

Other Issues:

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GENERAL COMMENTS


Please list any general comments you would like to make on any other matters not already highlighted in the Issues Paper. Ensure your general comments fall within the Terms of Reference of the National Review into Model OHS Laws (refer to Appendix A of the Issues Paper).

General Comments:

For the Panel's information on how to qualify these comments, we are occupational health and health promotion researchers and practitioners whose main interest is in translating the benefits of such research into improved working conditions, and in turn decreased work-related morbidity and mortality (AD LaMontagne & T Keegel).

LITERATURE CITED

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