

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

SPECIFIC COMMENTS

Legislative Approach:

Scope, Application & Definitions:

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

‘Reasonably Practicable’ & Risk Management:

Consultation, Participation and Representation:

Regulator Functions, Powers & Accountability:

Compliance & Enforcement:

Prosecutions:

Other Issues:

We would like to comment on section 9.3 Notification of Incidents and Reporting’ in addressing our comments to the Model OHS Law National Review:

From the “National OHS Review Issues Paper” May 2008 (pages 40-41)

9.3 NOTIFICATION OF INCIDENTS AND REPORTING

Notification of incidents and reporting requirements enable OHS authorities to target their compliance and enforcement efforts and to collect, interpret, analyse and report information and statistics relating to health and safety.

Current data sets all have limitations which negatively affect the capacity of governments and industry to appropriately identify and address OHS issues.

All Australian OHS regimes include incident notification requirements. The compliance burden is added to where the requirements vary from jurisdiction to jurisdiction.

Q145. How should an effective reporting system be provided for in the model OHS Act without an unnecessary compliance burden?

The Model OHS Law National Review needs to be cognizant of the inadequacy of workers' compensation claims statistics for the informing of occupational disease prevention programs. Notification of incidents and reporting requirements are not enough, in that occupational diseases in particular are not readily identified in the current system. Insurance claim statistics datasets are not proxy occupational disease registers, particularly for diseases which are caused by a number of factors or have long latency periods. We recommend that OHS disease prevention efforts should be driven by systematic public health surveillance systems, which unfortunately are currently inadequate. Such surveillance systems are vital for the appropriate collection of information about occupational disease and injury as well as for recognised occupational hazards and exposures. Without this type of comprehensive data, intervention efforts around occupational disease prevention will be uninformed and the OHS authorities will be ill equipped to deal with the challenges of providing a safe and disease free workplace for Australians. The current close link between compensation and prevention is inappropriate, in that claims data are unsuitable as indicators for an occupational disease prevention strategy.

The remainder of our comments will consider occupational contact dermatitis as an example of an occupational disease. Despite the relative ease of detecting an occupational causation for occupational contact dermatitis, the condition is still grossly underestimated in WorkCover datasets. Overseas studies with regard to the rate of occupational contact dermatitis generally provide estimates in the order of 80-100 per 100,000 workers, particularly in countries such as Germany¹ where these diseases must be notified.

In a study conducted by the Occupational Dermatology Research and Education Centre, The Skin and Cancer Foundation, Melbourne, we characterised occupational contact dermatitis clinical presentations within a defined geographic area². For a twelve month period from September 2002-September 2003 we reported a prevalence rate of 34.5 per 100,000 and an incidence rate of 20.5 per 100,000. Information supplied to our organisation from WorkCover Victoria for claims from July 2001 to June 2002 using the codes 741 contact dermatitis and 742 other and unspecified dermatitis and eczema, gives a rate of 4 per 100,000 for the state of Victoria. (Denominators for both rates are from Australian Bureau of Statistics rates for numbers of workers). Incidence and prevalence classification was not collected for the WorkCover data, and details regarding criteria for disease diagnoses are unavailable. On this data alone, the incidence rate of occupational contact dermatitis is underestimated by a factor of three and the prevalence rate is underestimated by a factor of seven (Please see attached publication).

There are a number of factors contributing to the inadequacy of information derived solely from Australian workers' compensation datasets with respect to occupational contact dermatitis:

- In occupations such as hairdressing, food handling, nursing and construction, occupational contact dermatitis is accepted as 'part of the job'. Many workers in these high-risk occupations develop chronic dermatitis without seeking advice from a

clinician. By not seeking medical assistance there is no public record of the disease, and the occupational contact dermatitis experienced by these workers is therefore not detected by the workers' compensation system.

- People with occupational contact dermatitis often have their condition managed by general practitioners. Unless a general practitioner specifically enquires about an individual's occupational exposures, this association may not be detected and a worker's compensation claim will not be submitted.
- Employer liability in Victoria is presently the first \$480 of medical expenses and/or the first 10 days of lost time. Any claims within this liability are deemed 'minor'. Many dermatitis claims fall into this category. In Victoria the workers' compensation system is primarily funded by employer-paid premiums. An individual employer's premium is based on major claim costs, the number of accidents in the workplace and the workplace industry rate. Often the employer reimburses these expenses without being submitting the claims to workers' compensation insurers, so as not to affect insurance premiums.
- Many people who have dermatitis, which has been clinically diagnosed as significantly work related, are reluctant to submit a claim. The employer and the workers' compensation system do not take up the financial burden of disease. Instead, treatment and associated costs are borne by the Pharmaceutical Benefits Scheme (PBS), Medicare and by the affected worker. Without an insurance claim, there is no record of disease occurrence from claims derived statistics.

Thank you for this opportunity to contribute to the review process. We invite the Review team to contact us if further information or clarification regarding these issues is required.

Publications referred to in this submission

1. Dickel H, Kuss O, Blesius CR, Schmidt A, Diepgen TL. Occupational skin diseases in Northern Bavaria between 1990 and 1999: a population-based study. *British Journal of Dermatology* 2001;145(3):453-462.
2. Keegel T, Cahill J, Noonan A, Dharmage S, Saunders H, Frowen K, et al. Incidence and prevalence rates for occupational contact dermatitis in an Australian suburban area. *Contact Dermatitis* 2005;52(5):254-9.