



# Strategic Review of the Workplace Health and Safety System

## Submission template

This template can be used to make a submission to the Independent Taskforce on Workplace Health and Safety. The template does not limit the length of your answers, and you can attach documents to supplement your answers if you wish. Alternatively, you can use the on-line questionnaire to make a submission, which can be found at [www.hstaskforce.govt.nz](http://www.hstaskforce.govt.nz). The on-line questionnaire restricts the length of your answers to about 300 words per question.

Please refer to the taskforce's consultation document, *Safer Workplaces* before completing this template. The consultation document can be found at [www.hstaskforce.govt.nz](http://www.hstaskforce.govt.nz)

### About you

\* Indicates mandatory questions

#### 1. \*Your full name:

David McBride

#### 2. \*Is this submission on behalf of an individual or an organisation?

☒ Individual ☐ Organisation

Name of organisation:

#### 3. \*Region

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Northland   | <input type="checkbox"/> Whangarei     | <input type="checkbox"/> Auckland           |
| <input type="checkbox"/> Waikato     | <input type="checkbox"/> Bay of Plenty | <input type="checkbox"/> Gisborne           |
| <input type="checkbox"/> Hawke's Bay | <input type="checkbox"/> Taranaki      | <input type="checkbox"/> Manawatu-Whanganui |
| <input type="checkbox"/> Wellington  | <input type="checkbox"/> Marlborough   | <input type="checkbox"/> Nelson             |
| <input type="checkbox"/> West Coast  | <input type="checkbox"/> Canterbury    | <input checked="" type="checkbox"/> Otago   |
| <input type="checkbox"/> Southland   | <input type="checkbox"/> Overseas      |   |

#### 4. \*Respondent category

- |  |  |
|--|--|
| <input type="checkbox"/> Employer                | <input type="checkbox"/> Not in paid employment                    |
| <input type="checkbox"/> Manager                 | <input type="checkbox"/> Occupational health nurse                 |
| <input type="checkbox"/> Employee                | <input checked="" type="checkbox"/> Health and safety practitioner |
| <input type="checkbox"/> Self-employed           | <input type="checkbox"/> Other:                                    |
| <input type="checkbox"/> Employee representative |  |

#### 5. \*Which type of industry do you manage, own a business in, or work in?

- ☐ Agriculture
- ☐ Forestry
- ☐ Fishing
- ☐ Mining
- ☐ Manufacturing
- ☐ Electricity, Gas, Water and Waste Services
- ☐ Construction
- ☐ Wholesale Trade
- ☐ Retail Trade
- ☐ Accommodation and Food Services
- ☐ Transport, Postal and Warehousing
- ☐ Information Media and Telecommunications
- ☐ Financial and Insurance Services
- ☐ Rental, Hiring and Real Estate Services
- ☐ Professional, Scientific and Technical Services
- ☐ Administrative and Support Services
- ☐ Public Administration and Safety
- ☒ Education and Training
- ☐ Health Care and Social Assistance
- ☐ Arts and Recreation Services
- ☐ Other Services

#### 6. \*Size of business that you own / manage or work for?

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Self employed | <input type="checkbox"/> 20-49 employees |
| <input type="checkbox"/> 1-5 employees            | <input type="checkbox"/> 50-99 employees |
| <input type="checkbox"/> 6-9 employees            | <input type="checkbox"/> 100+ employees  |
| <input type="checkbox"/> 10-19 employees          |  |

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## 7. Gender

☒ Male ☐ Female ☐ Other

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## 8. Age

- |                                |   |
|--------------------------------|---|
| <input type="checkbox"/> 15–24 | <input type="checkbox"/> 45–54            |
| <input type="checkbox"/> 25–34 | <input checked="" type="checkbox"/> 55–64 |
| <input type="checkbox"/> 35–44 | <input type="checkbox"/> 65+              |

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## 9. Ethnicity

- |   |  |
|---|--|
| <input type="checkbox"/> NZ Maori       | <input type="checkbox"/> Asian                                 |
| <input type="checkbox"/> European       | <input type="checkbox"/> Middle Eastern/Latin American/African |
| <input type="checkbox"/> Pacific Island | <input type="checkbox"/> Other ethnic group                    |
| <input type="checkbox"/> Other European | <input checked="" type="checkbox"/> Do not wish to indicate    |

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## 10. Your contact details

Phone number(s)

Email address:

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### Please tick the boxes below as appropriate

☒ I consent to my submission being placed on the Independent Taskforce on Workplace Health and Safety website

☐ I would like my name withheld from publication (submissions from individuals only)

Please note that your name and contact information, including any personal information, is being collected so that the Independent Taskforce on Workplace Health and Safety can publish the names of people and organisations who or that made submissions, follow up with a respondent if any submission needs clarification, and for the general purposes of the Strategic Review of the Workplace Health and Safety System. The Independent Taskforce on Workplace Health and Safety is the intended recipient and holder of the information and can be contacted at PO Box 3705, Wellington, New Zealand. In accordance with Privacy Principle 7, you have the right to access and correct any personal information you provide.

## **Submission of Dr David McBride**

Associate Professor in Occupational Health

University of Otago

Dunedin School of Medicine

david.mcbride@otago.ac.nz

### **1. What do you think is driving the differences in health and safety outcomes for different demographic groups?**

This is a complex issue. The highest rates of injury are found in Agriculture Forestry and Fishing, followed by Construction. These are male occupations. Rates are highest for the younger (on farms, farm children) as well as the older. In my belief the factors in the young are experience, and in the older 'ageing factors' including declining cognitive function. The inter-relationships are however highly complex, for example there are likely to be less male-female differences once confounders (primarily industry and age) are taken into account.

### **2. What changes are needed to the workplace health and safety framework to improve outcomes for demographic groups with higher than average rates of injury and illness?**

Those industries with the highest rates are inherently hazardous. The effects of flexible labour (temporary labour) and unskilled labour in some industries, are to fragment employment, and specific health and safety induction may not be taking place at an adequate level.

#### **Suggestions:**

**There should be a formal requirement for *specific to workplace* health and safety induction courses. Not just a 'site safe' system.**

**Education is needed as part of an intervention programme, but must be followed up with regulatory action in terms of enforcement, see 2 below.**

### **3. What do you think the challenges are with the current health and safety regulatory framework?**

The Robens model is 'enabling' with employers taking the lead in the control of health and safety issues. In my experience there are three types of employer:

1. Those that regard occupational health and safety (OH&S) as an integral part of their operations; have the expertise and resources to formulate a good OH&S management plan and comply with the provisions of the HSE Act. (Active)
2. Those who would like to do more about occupational health and safety but do not have the expertise and resources. (Wishful)



3. Those who do not want to know about OH&S and may indeed avoid compliance. (Avoidant).

Enabling legislation does not influence the latter, group 3, employers. See the following section.

## **2. How do you think the health and safety regulatory framework could be improved?**

The problem lies in operationalisation of some aspects of the HSE Act. We are becoming more aware that single interventions in prevention of occupational injury and disease are not likely to be effective, but that **multi faceted interventions, do have an effect**. See for example

Ref 1 (p 49)

<http://ipru3.otago.ac.nz/ipru/ReportsPDFs/OR075.pdf>

Ref 2

<http://www.sciencedirect.com/science/article/pii/S0925753506000701>

As regards the legal framework, Inspectors do have power. Infringement notices were introduced by changes to the HSE Act in 2003. These can cost up to \$3,000. The average is however much less, in the order of hundreds of dollars. When they were first proposed they were intended to be like other forms of fine, instantaneous and difficult to get out of. Unfortunately there were changes betwixt proposal and implementation: the infringer must have been warned for the same, or a similar matter, within the past 2 years. The 2 years is in fact an MBIE operationalisation. If inspectors had the power to issue instant fines it would, in my view, make a big difference. As it is, there have only been 239 notices issued since the change in the Act. That is about 30 per year I think.

The other modes of enforcement is through prosecution. Since the introduction of the Act, according the statistics are as follows. There were 2,591 total charges convicted, \$19,689,893.25 of total fines and \$9,297,633.53 of total reparations. That is, on average, a fine of \$7599 and reparation of \$3,588. There have been 484 successful prosecutions in the last five years, an average of 96 per year. The average up to 1995 must have been 175 per year.

Most prosecutions under the Act are taken under section 6, failure to provide a safe place of work. Success in Court is more certain if an employee is killed or seriously injured. Examples come from Safeguard Magazine, recent examples of which are the issue of January-February 2012. Delta Utility Services (Alexandra District Court) were fined \$75,000 for the death of a Linesman killed when a power pole he was working on collapsed. It should have been marked as unsafe to climb. An employee of George Grant Engineering was trapped under a collapsed crane and sustained an ankle fracture \$25,000 and reparation \$17,500. Ancient Kauri Wood Products \$30,000 fine and \$20,000 reparation: left hand



amputation (machinery guards not functional). Tumu Timbers \$30,000 and \$12,000: amputation of three fingers. The maximum penalties (2003 H&S Amendment Act) are 2 years in jail or a fine of \$250,000. As Trevor Mallard said (personal communication, 2008)

<https://occenvmed.wikispaces.com/file/view/Untitled.pdf>

□Thank you for your email of 29 May 2008 regarding penalties for workplace fatalities. A 2003 amendment to the HSE Act 1992 quintupled the maximum penalty from \$50,000 to \$250,000 and even to half a million dollars in some cases. The amendment also doubled the maximum term of imprisonment. These changes have not been immediately reflected by the courts. Courts typically determine the amount of a fine in relation to previous, similar cases. To change this pattern, the Department of Labour adopted a new approach to sentencing submissions. Instead of providing the courts with comparative tables of previous fines, the Department advised them to assess fines based upon first principles. The level of a fine, as a percentage of the maximum fine, should be proportionate to the level of culpability. The Department is currently appealing several cases in the High Court where they considered the fines to be too low. The previous highest fine (\$55,000) has been exceeded three times this year already.□

Note also that reparations can be insured against, fines cannot

#### **Suggestions:**

**Instant fines which are instant.**

**Fines which are punitive and reparation which is realistic.**

**The legal profession needs more training in the interpretation of the HSE Act.**

**Judges should be given □first principles□sentencing guidelines for occupational deaths, injuries and disease.**

#### **5. How effective are the regulators in influencing workplace health and safety outcomes?**

Apart from administering and enforcing the HSE and HASNO Acts it is very difficult to comprehend how MBIE interprets the regulatory roles and responsibilities. It is therefore very difficult to assess effectiveness. As things are currently static as regard to fatal and non-fatal injuries:

Ref 3:

<http://www.dol.govt.nz/whss/state-of-workplace/index.asp>

and compare poorly internationally the answer is □not effective at all□

## **6. How could the regulators' roles and responsibilities be changed to improve their effectiveness in influencing workplace health and safety outcomes?**

I write with 17 years of experience as a Departmental Medical Practitioner (DMP). The problem has been one of constant restructuring: OSH, DoL Workplace Group and now MBIE.

Some of this was because of poor perception of "OSH". No one will change that, an awful lot of people do not want to be told what to do (see 7 below). The changes in management have seen changes in leadership priorities, policies and approach. An example from the recent past was that Inspectors were discouraged from "cold calling" companies.

In my view the Health and Safety Council is ineffective. There have been numerous attempts to influence the H&S climate. The Royal Society held two one day workshops in 1998 to "articulate a vision for the environmental and occupational health sector". The latest attempt is the "National Action Agenda 2010-2013".

The problem is that, between these two reports, nothing has actually happened apart from the consistent and ongoing changes to "OSH".

Some of the gradual changes (erosion) go right back to devolvement of the workplace H&S from the Ministry of Health, where there was a significant "health" component.

Ref 4

<http://journal.nzma.org.nz/journal/124-1328/4513/>

OSH at least did have, up to the mid 2000s, two "Senior" DMPs who helped to develop health policy advice. Each OSH Branch had, in the 1990s, at least one "health" inspector, usually a nurse and also a DMP. This expertise is now sadly depleted. A significant improvement, the creation of a full time Chief Medical Advisor post in 2008 was followed by disestablishment. The rationale was, apparently that "the provision of expert advice, practice leadership, and services is proposed to become part of the core accountabilities of the new National Services and Support Division". The reality was a need to cut 18.8% from the budget. The job profile of this position can be found at:

[https://occenvmed.wikispaces.com/file/detail/20110323\\_GM+National+Services+and+Support+FINAL+1.docx](https://occenvmed.wikispaces.com/file/detail/20110323_GM+National+Services+and+Support+FINAL+1.docx)

I cannot find a medical role in it.

DMPs are now leaderless and, being Regionally based, have no capacity to influence the regulatory framework. The power of DMPs within the regulatory framework is also somewhat limited in comparison with Medical Officers of Health who have powers, for example, during disease outbreaks. There is room for synergy here and a definite role during natural and other disasters, for example in ensuring the health and safety of rescue workers.

Funding is also a problem (indeed one of the root causes of it, as above), as (within the MBIE group) the funding *intended* for H&S, for example from MfE under HSNO *will not* be dedicated. It needs to be. This will ensure that the regulator can have a presence *in the workplace* and that the playing field for employers will be level.

ACC should stay as the "no fault insurer" and act like an insurer. They should not have a role in regulation, but support injury prevention initiatives and be required to improve their statistics and reporting.

**Thus the following suggestions.**

- 1. MBIE workplace group absolutely must be unbundled and put back into an Occupational Health and Safety stand alone organisation.**
- 2. There should be adequate funding to undertake the role- i.e. HASNO funding should go towards the inspection function.**
- 3. The leadership should actually know something about H&S, and there should be a medical advisor.**
- 4. There should be a statutory role for health professionals.**

## **7. Impacts of changing workforce and work arrangements.**

It has been suggested that flexible working arrangements may cause an increase in ill-health. A recent study of musculoskeletal disorders has however provided no evidence that work organisational factors are a significant influence, but that work related psychosocial factors (job satisfaction and job strain) were:

Ref 5

<http://injuryprevention.bmj.com/content/16/2/96.full.html>

In some types of work individual attitudinal factors may however strongly influence safety, for example on farms a significant barrier to safety is: (Lovelock K, Cryer C. Effective Occupational Health Interventions in Agriculture Summary Report)

Ref 6

<http://ipru3.otago.ac.nz/ipru/ReportsPDFs/OR072.pdf>

"Having to rush and being tired and/or fatigued were the most prevalent barriers to safety reported". In addition, twenty five percent (25%) of responders reported a lack of equipment would present a barrier at least some of the time. Similar responses were evident amongst the sample, but they also cited pressure from neighbours, co-workers, or management as affecting their ability to work safely. Economic and time pressures subsume safety concerns on a significant proportion of farms."



## **8. What changes to the health and safety framework, if any, are needed as a result of the changing workforce and work arrangements?**

It is clear that there are significant problems in many sectors. Because of a previous HRC/ACC funded project Agriculture is probably the best documented example that I have, but not by any means the only one. This indicates that there is a cultural pattern of not thinking about the consequences of injury or disease.

Ref 7

[www.hrc.govt.nz/sites/.../Drs%20Lovelock%20&%20McBride\\_0.pdf](http://www.hrc.govt.nz/sites/.../Drs%20Lovelock%20&%20McBride_0.pdf)

The perceptions of farmers, farm workers and family members of government workers were considerably more empathetic than the experiences of many government employees may indicate from their interactions with members of the farming community. However, amongst most there was a resistance to the idea of enforcement or "regulation". For most this was attributed to pragmatic reasons; and for a minority, because it was seen as unnecessary state interference.

Note that this community is not "H\$S averse".

We know that we need to go beyond educational interventions and that these should include a legislative component even though this may meet with resistance. The interventions do however need to be strongly evidence based.

Competitive cost pressures are undoubtedly a major problem, particularly with long working hours. There are ways to deal with long working hours as a hazard (it can be identified assessed and controlled) but there is no way of enforcing such assessment and control *unless* the "Approved Codes of Practice"(ACOPs) are given more legal weight. The ACOP, as best practice, thus fulfils dual roles, as education and as a standard to be complied with. There has been a tendency to issue more "guidelines" than ACOPs and to develop them in association with Industry. The latest "Preparing for a Chemical Emergency Plan" from Responsible Care (New Zealand Chemical Industry) costs \$120 for non members.

### **Suggestions:**

**Start with some of the types of interventions already identified (e.g. ref 3 and 4) and start to apply them!**

**Strengthen the legal status of the ACOP and make them free.**

## **Q9 How effective do you think worker participation is in improving workplace health and safety in New Zealand?**

In my opinion worker participation is strongly associated with the Trades Unions, which as we know have become increasingly side-lined. This is a real problem in SMEs. One area where I agree that more research is needed.

## **What improvements can be made to worker participation in workplace health and safety so as to get better workplace health and safety outcomes?**

The idea of a regional support centre is an excellent one. I would have it based (as I have said elsewhere) based on DHBs.

### **11. To what extent do directors and other senior leaders provide effective leadership and governance of workplace health and safety?**

In my experience, Directors and senior leaders know that H&S is important, but do not necessarily know how to approach the matter and develop a workplace "safety culture". The whole thing stems from the development of personal knowledge and expertise. If they get "advice" from consultants, there may well be problems: the Taskforce Reference Group meetings identified that Health and safety consultants often had insufficient knowledge.

As an occupational and environmental physician, I would argue that the profession of occupational and environmental medicine has the requisite knowledge and leadership skills to help in this. For larger enterprises, at least one Board member should have H&S skills.

Who employed full time occupational physicians within the Public Health Framework. This changed with the HSE Act and the change to DoL. The change meant that occupational physicians fell outside the public (Medical Officer of Health) training scheme, so we lost our funding. I would strongly argue that, once again, we should within the public health system

Leadership also means taking responsibility The Employer "Taskforce reference" group also recognised that "the regulator needs to start at the beginning of chains of influence, with Principals, and hold accountability there. In any project there is always some difficulty in identifying exactly who the principal is, and this is important when calling the principal to account. Starting with large to medium size businesses that person should be senior, at Board level, because the whole modus operandi of any undertaking, for example production imperatives, comes from that senior level: as do H&S resources.

### **12. What improvements can be made to directors' and other leaders' participation in workplace health and safety, so as to get better workplace health and safety outcomes?**

Health and Safety is **not** a key component of Management. Operations, supply chain, accounting, finance, marketing and law all have a far higher profile and "level" within management.

Leaders of organisations should have taken on board the fact that the sustainability of an enterprise or business is strongly influenced by a strong health safety and environmental climate. The NZ "clean and green" image is not actually so. Neither is it safe.

**Suggestions.**

**Ask employers associations and business NZ to showcase how supply chain imperatives (see section 15) have had a top down influence**

**Unfortunately financial imperatives are a strong driver too, so, for the recalcitrant, financial penalties at a senior level may help to provide an incentive.**

**Occupational medicine advice should be available at senior management level.**

**Occupational health skills and experience should be promoted by senior management as being a positive factor in career development.**

### **13. To what extent do firms have the capacity and capability to effectively manage workplace health and safety issues (including through accessing external resources)?**

Most workplaces in New Zealand are small. Previous research carried out in Dunedin small businesses

Ref 8, available at:

<https://occenvmed.wikispaces.com/home>

showed that most knew about the HSE Act, but 45% reported that they had insufficient knowledge and understanding to comply. A minority, 35%, reported having actively sought information. The main source of information was employer groups followed by (at the time) OSH. A substantial minority (41%) of employers did however say that they would be unwilling to approach OSH because ☐ they were afraid they would be required to undertake costly changes, that they would be prosecuted, or that they did not see OSH as helpful and thought it might be difficult to deal with. ☐

Standards among H&S professionals are highly variable. Industry needs guidance on who to trust.

### **14. Options for improvement.**

Employers associations and Business NZ should be, and are, a source of Health and Safety information. Ready access to advice would help, and some do employ H&S advisors.

In my opinion, the Government, as an Employer, should be taking a position of accountability for employees here, vicarious liability notwithstanding. To that end large Government Agencies, the Ministries of Education and Health, should be *required* to provide an adequate Occupational Health and Safety Service.

#### **Suggestions.**

**See section 12, provide a publicly available occupational and environmental health resource.**



**Anyone giving *health* advice should be a member of a professional body who provide standards for registration and re-accreditation.**

### **15. How effective are existing financial and non-financial incentives in improving workplace health and safety outcomes?**

Financial incentives would mainly be the ACC Partnership Programme, Workplace Safety Discounts, and Workplace Safety Management Practices. If you look at the Business NZ website Health and Safety section it is clear how important these factors are. I am not sure how effective these are: the audits were OK, but did not really look at how *effective* the systems were.

Much more important are the 'supply chain' imperatives that require subcontractors to include health, safety and environment in their management plans. These are generally driven from companies at higher levels in the chain who are more likely to have good HSE plans themselves.

### **18. How could incentives be better used to improve workplace health and safety outcomes?**

Business probably does see the advantages that lie in a 'safe and environmentally friendly brand' in promotion of their service or product. Some formal operationalisation of this would help. Business NZ could facilitate development of 'branding', e.g. 'made cleanly and safely in New Zealand'.

#### **Suggestions:**

**Some form of 'sustainability score' that takes into account both safe working practices and environmental performance might be a good assessment (and marketing) tool. I like the smiley face Danish approach, however we are New Zealanders.**

### **17. How successful are government, industry, corporate or other potentially influential bodies in influencing health and safety outcomes beyond their own workplaces (for example through influencing their suppliers, counterparts, and competitors)?**

A low level of leadership has emerged as a key theme from the reference group meetings, as have 'bottom line' considerations in procurement. The Government, on an occupational and environmental level, is as much to blame here as anywhere as it does not have strategic health and safety goals *as an employer*. Teachers, for example, do not have access to a health and safety service through the Ministry of Education, that responsibility is devolved to school boards of trustees, who, understandably, know little about it

A concrete example of Government *non* supply chain imperative would be the purchase by KiwiRail of railway stock from China North Rail. With this sort of hands off approach I do not know how they can influence others. It must start from the very top.

Fair work principles are undoubtedly important, and this will require legislation.

**18. What could be done to get government, industry, corporate or other potentially influential bodies to exert greater influence on improving workplace health and safety outcomes beyond their own workplaces?**

It must start with the Government putting some real resources into occupational health and safety.

**Suggestion:**

*require* District Health Boards to have an adequate occupational health unit which is physician led, forward looking and available to advise other workplaces.

Breaches of H&S Law *should* lead to a breach of contract.

**19. How strong is New Zealand's current approach to regulating major hazards?**

This is undoubtedly a major weakness, with regulations covering a small number of industries.

The approved code of practice: Approved Code of Practice for Safety and Health in Managing Hazards to Prevent Major Industrial Accidents.

Ref 9:

<http://www.osh.dol.govt.nz/order/catalogue/pdf/hazardac.pdf>

is now nearly 30 years old.

**20. What improvements to the regulation of major hazards would lead to better health and safety outcomes?**

**Suggestion:** Write a new ACOP, and strengthen their legal standing. This is a general problem, many ACOPs are out of date

**21. Significant challenges to managing occupational health risks and managing occupational substances.**

The effect of occupational (and occupational exposure) on health is still largely unknown. The most recent paper

Ref 10:

<http://www.nzma.org.nz/journal/124-1328/4507>

says □Mortality rates according to occupation in New Zealand males: 2001□2005 □shows that □there continues to be marked differences in mortality between occupations in New Zealand

and that many of these differences persist following adjustment for socioeconomic deprivation. □ We do not know why,

On the other hand Dame Carol Black strongly argues the need for work to be healthy.

Ref 11:

Black C. Working for a healthier tomorrow. London: The Stationery Office; 2008.

<http://www.dwp.gov.uk/docs/hwwb-working-for-a-healthier-tomorrow.pdf>

One of the key barriers to employers investing in the Health and Safety of employees was a: □ Lack of appropriate information and advice □ □ . This is particularly true for smaller organisations which tend not to have access to an occupational health scheme. □

And:

□ There is insufficient access to support for patients in the early stages of sickness, including those with mental health conditions. GPs have inadequate options for referral and occupational health provision is disproportionately concentrated among a few large employers, leaving the vast majority of small businesses unsupported. □

In the United Kingdom, occupational health had become detached from mainstream healthcare. The professional bodies also recognised that the major barrier to extending the scope of practice was a historical exclusion of occupational medicine from the □ open access □ National Health Service. The need was for □ working-age health □ approached by a multidisciplinary team, to be brought back into the mainstream of health care.

The other challenges identified for occupational health were a limited remit (in terms of helping only those in employment); an uneven provision of services; inconsistent quality; a diminishing workforce; the shrinking academic base; a lack of good quality data and a poor □ Image and perception □ of occupational medicine as an single minded agency focussed on the needs of the employer.

As a Health professional, the HSNO Act is complex and a closed book to me. I have given up trying to understand it. One simple thing that could be done is to *require* the manufacturers and suppliers of hazardous substances and goods to supply an adequate Safety Data Sheet.

## **22. What changes could be made to the existing health and safety framework to reduce the harm caused by occupational disease and ill-health?**

**Suggestion: In light of the above, to have an open access occupational health system based on DHBs available to employers and employees.**

**Require the suppliers of hazardous substances to supply an adequate Safety data Sheet.**



**23. What workplace health and safety challenges are specific to the self-employed and small-to-medium enterprises?**

See 13.

**24. What improvements could be made to the workplace health and safety framework, and its implementation, to ensure that it's effective for self-employed and small-to-medium sized enterprises?**

See 14

**25. To what extent are New Zealand's workplace injury and occupational disease data collection mechanisms conducive to robust monitoring, investigation and comparative analysis?**

The Notifiable Occupational Disease System (NODS) run by DoL has been dysfunctional for years. At present there is no NODS Registrar. ACC data suffers from the lack of specific diagnostic coding, and the NZHIS (or whatever it has changed to now) National Minimum Dataset under records occupation. The NOHSAC report:

Ref 12

<http://ipru3.otago.ac.nz/ipru/ReportsPDFs/OR056.pdf>

Describes the situation fully.

**26. What opportunities are there for improving data collection, integration and reporting?**

The NOHSAC report defines what is necessary.

**Suggestion**

To this I would add occupational disease reporting from Sentinel General Practices.

**27. Do you think New Zealand culture influences our workplace health and safety outcomes?**

The Kiwi she'll be right attitude pervades NZ culture and operates at multiple levels. From The Effective Occupational Health Interventions in Agriculture project. Once again, this is not specific to the agricultural industry it is just a project that we recently carried out. If it had been any other SME the results might largely have been the same.

[http://www.hrc.govt.nz/sites/default/files/Drs%20Lovelock%20&%20McBride\\_0.pdf](http://www.hrc.govt.nz/sites/default/files/Drs%20Lovelock%20&%20McBride_0.pdf)

I highlight the following as regards attitudes:

Stoicism and fatalism towards serious injuries, "when your time's up, it's up"

**Genuine concern about disease risk arising from exposure to chemicals (e.g. cancer) (my highlight)**

Most farmers do not want to read about injury and disease statistics in their sector;

Behavioural change resulted more as a result of personal injury or "near-miss" incident, or injury or death of family member or friend.

General resistance to the idea of health and safety enforcement or regulation

I think that this arises partly from a fast-paced home and working life-style. The general approach is to try to save *our* valuable time by cutting corners, which leads to unsafe working practices. In fact, it does not take much longer to do things properly. *We do* do things that are compulsory in Law and enforceable, or give rise to a "serious" health risk, like cancer. We need a bit more research into perceptions of workplace H&S.

**28. What might we do to improve our culture relating to workplace health and safety?**

**Suggestion:**

**Most of all, it needs a serious, top down, Government first re-think. With adequate resourcing. In other words a publicly available occupational health service.**