

**Worker Participation in OHS: The
Hidden Potential to Change
Intensified Working Arrangements**

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Introduction

- Health and safety committees (HSCs) including worker representation is a key to successful OHS.
- HSCs has been advanced by OHS practitioners and academics as the basis of any effective OHS system.
- They are fundamental right under ILO conventions and a key component under the Robens model of OHS, including the HSE Amendment Act, 2002 (see S2A).
- However, are HSCs effective in resolving intractable issues (eg organisation of work & work intensification)?

Introduction

- Using HSCs within the NZ health sector as an example, we will argue that:
- HSCs & worker representatives, (WRs) under the *Health and Safety in Employment Amendment Act, 2003* are often under-utilised.
- HSCs are effective conduits between management and workers in the decisions and implementation of staffing levels together with other OHS issues.
- The ILO's resolute promotion of tripartite dialogue between the key players is contingent upon the rights of workers to participate in the decisions concerning their safety and health – including broader issues.

Research on Successful HSCs & WRs

Key factors for effective worker participation are:

- The influence of a broader cooperative approach to employment relations,
- Longstanding social partnerships, including effective channels of communication
- It should be a statutory requirement, with attached penalties for breaches.
- Adequate resources, time & training programs for managers and workers, but mandatory TU training for health and safety representatives

(Weil 1999, Walters 2006, Peppard 2007; Markey et al. 2008)

Varied Success of HSCs & WRs

Success of HSCs & WRs is varied for a number of reasons:

- Growing trend in precarious employment is rarely conducive to worker participation arrangements
- TUs have experienced dwindling membership, thus impacting on recruiting worker representatives.
- Getting employees interested in becoming WRs has become a major problem both in NZ and overseas.
- There are differences of opinion between the employers and employees as to the function of HSCs and WRs

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- (see Johnstone, et al, 2005; Rasmussen et al., 2006; Gunningham, 2008; Hovden 2008; Trägårdh 2008)

ILO Response

- **Universal Declaration on Human Rights (UN, 1948):**
 - Everyone has the right to life, to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment ”.
- **C155 Occupational Safety and Health Convention, 1981:**
 - Article 19 representatives of workers in the undertaking, co-operate with the employer in the field of occupational safety and health
- **The 3 basic rights:**
 - The right to know about the workplace hazards
 - The right to refuse to work in hazardous conditions
 - The right to participate in the decisions concerning health and safety

Case Study - Health Sector: Background

- Healthcare reforms of the 1990's resulted in nursing numbers being reduced by 36%
- In 2008 there were 45,691 registered practicing nurses, compared to 50,693 nurses in 2003
- Average length of patient stay in the hospital was reduced by 20% = work instensification;
- Determining staffing ratios was changed under the 2004 collective bargaining agreement
 - a “bottom up” approach instead of the traditional top down approach

Case Study: Health Sector

The key independent variables of this new system are:

- Patient projected numbers
- HR factors: staff leave, training, ward culture, the physical environment, technology, equipment and work design;
- Supply and demand issues (ie staffing shortages).

Case Study: Staffing Issues

Issues around the this approach:

- Decisions can be subjective and inconsistent with relation to nursing requirements
- The ward-specific nature of the decisions make it difficult to make comparisons across wards or organisations
- The changing role of nurses presents a challenge, with increasing specialisation within the profession thus making decisions concerning allocation of duties and staffing difficult
- Budgets and the availability of nurses can influence staff planning – staffing levels reflect the available budget.

Case Study: HSCs & WRs

- Currently DHBs and NZNO operate consultative committees that were **established in late 1980s**:
- Trade union delegates are often directly involved in H&S committees in DHBs.
- HSCs & WRs are being used to:
 - Direct input and help form with the decisions around staffing issues
 - Provide an avenue for TUs to be regularly involved in the decision making processes
 - Balance the role of senior management
 - Provide a voice for workers
 - Provide an opportunity for trade union training
 - Opportunity to work consensually around important issues.

Summary

- While there have been a number of extensive studies on the topic (see Walters, Frick, Nichols, Quinlan, Weil, etc), the research and use of HSCs in NZ are underutilised – why?
- NZ was late compared to other countries in adopting a participatory framework as prescribed in the Robens model.
- The gains made in the 1980s came to a halt with the ECA, 1990; & it still casts a long shadow
- Strong unionised, stable workforce in industries, such as health, transport, manufacturing, etc, is no longer a reality.

Summary

- Constant reforms divert attention to the immediate concerns such as job security and pay rather than “altruistic” health and safety of their fellow workers.
- However, both TUs and nursing staff managers have begun to realise that HSCs and WRs can be useful when tackling difficult resource based issues.
- This view is not only grounded in research but is also compatible ILO founding principles and conventions.

THANK YOU