

REGULATING THE OHS SUPPORT ROLE

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ABSTRACT

This presentation examines regulatory strategies for ensuring that workplace decision makers have access to sufficient occupational health and safety (OHS) knowledge, capability and specialised services to be able to fulfil their legal responsibilities, and effectively protect OHS. The presentation discusses the role of providers of ‘OHS support’, as well as the organisation and funding, professional competence, quality and effectiveness of this support.

OVERVIEW OF SYSTEMS AND MODELS FOR OHS SUPPORT

Some form of OHS ‘department’, ‘unit’ or ‘service’, staffed by OHS professionals, is a feature of many larger organisations in Australia. Alternatively, this support may be engaged through OHS consultants or corporate health services. However, access to OHS support that involves active and ongoing engagement with qualified and experienced OHS professionals, who help to lead and resource improvement of OHS performance, is rarely accessible for smaller firms or the self-employed in this country.

This presentation discusses existing Australian legislative provisions in this area,¹ and compares and contrasts them with arrangements in seven other countries: Finland, Norway, The Netherlands, Denmark, Germany, Sweden and the United Kingdom (UK). Of the seven countries reviewed, five have a legal requirement to provide or use OHS support, which has been in place for some years. The other two provide useful examples of how tripartite support for OHS services can foster the development of and access to services.

An additional benchmark for comparison is the model for *Basic Occupational Health Services* (BOHS) developed collaboratively by the International Labor Organisation (ILO), the World Health Organisation (WHO) and the International Commission on Occupational Health (ICOH).² The ILO/WHO model advocates a wide ranging advisory and support role, embracing occupational health as well as safety, prevention as well as treatment and rehabilitation, and addressing specific hazards as well as supporting organisational change to improve OHS. The activities proposed in the BOHS model include: (1) *work environment surveillance* to comprehensively identify hazardous exposures and existing control systems; (2) *health surveillance* for pre-employment, periodic, return to work and end of service assessment; (3) *risk assessment and recommendations for preventive action* in consultation with management, workers and their representatives; (4) *information and education* for

managers, workers, OHS representatives and committee members about risks and preventive measures; (5) arranging *first aid and emergency preparedness* and training; (6) *recording* of activities, exposures, risk assessments, recommendations, and ill-health and injury data; and (7) *evaluation* of activities to determine their effectiveness. The functions may also include *general health care*, such as immunisations and health promotion activities, and the treatment and rehabilitation of work-related injuries and ill-health.

Existing national arrangements for OHS support and services are more or less ambitious in the range of functions undertaken, and those most commonly provided are: hazard identification, assessment, and determining prevention and control measures; providing advice and training; and vocational rehabilitation for work-related injuries and ill-health. Sometimes undertaken are: health surveillance; making arrangements for first aid and emergency response; and evaluating the quality and impact of the OH service.^{3,4,5,6,7,8,9,10,11,12,13}

The OH services are typically multidisciplinary which may be achieved by involving different types of OHS professionals within a particular service, by providing multidisciplinary training staff, or by generalist OHS practitioners enlisting specialists through referrals to independent providers. The most common specialties are medicine, safety engineering or safety science, occupational hygiene, psychosocial or psychology expertise, ergonomics or physiotherapy, and occupational health nursing.^{14,15,16,17,18,19,20} In some countries, a multidisciplinary staffing profile is required to achieve certification of an OH service.

The more common forms organising OH services and support are in-house units (in larger organisations), and group services for employers in a particular industry or geographical location. Private providers offering services on the open market are also part of the system in a number of countries.^{21,22,23,24,25,26,27,28} Likewise there are various options for funding these services including purely employer funded arrangements, insurance funding of services, public funding of publicly run services, and subsidisation or reimbursement to employers of fees.^{29,30,31,32,33}

Whatever the form of organisation and funding of OH services and support, there may be a role for OHS regulators to oversee the competency of providers, their ongoing professional development and the effectiveness of their activities. This may involve specific education and training for professionals providing OH services. There may also be some form of evaluation or certification of OH services against defined standards.^{34,35,36,37,38,39,40,41,42}

Even in countries with well-developed OH services, there are particular challenges in providing support to small firms, the self-employed and workers in non-standard or precarious employment. The problem is both one of payment for services, as well as competing priorities of users, and accessibility of providers. There are various approaches to improving use and access, including providing services free of charge or some other form of financial support;^{43,44,45,46,47} and integrating OH services with vocational or workplace training, workers' health clinics, services for specific sectors, and providing different and flexible access points for users.^{48,49,50,51,52,53}

CHALLENGES FOR AUSTRALIA

Overseas' experience provides some foundations for challenging whether the provision of OHS support in Australia should continue to be largely voluntary and market driven, or whether there is a role for OHS regulation to assist in enhancing access to high quality OHS support. This presentation raises some crucial questions for debate:

1. Is there a case to regulate the use of OHS support since a combination of mandatory requirements to use OH services and/or strong support for OH services by national OHS authorities can yield higher coverage of the workforce?
2. Is there merit in defining the range of OHS support functions provided, and considering how these functions might be provided?
3. Notwithstanding the role that OHS professional bodies and OHS educators play in promoting professional competencies, is there a need to reinforce these current arrangements with requirements that certain qualifications or competencies are pre-conditions for practicing OHS?
4. Is there a case to consider how different forms of organisation of OHS support might be fostered, in the interests of making multidisciplinary OHS support more widely available (including industry, group and regional based services)?
5. Is there merit in pursuing options to make the use of OHS support more affordable to a wider range of employers and the self-employed, through forms of government, insurance or industry subsidy or reimbursement?
6. Is there a need for formal evaluation and accreditation of providers of OHS support? And should funding be contingent on using an accredited provider?

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