



Occupational Health Action Plan to 2013

WORKPLACE HEALTH AND SAFETY STRATEGY FOR
NEW ZEALAND TO 2015



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→ 1. Background and Context

Occupational diseases can and should be prevented. In many cases, knowledge exists to prevent occupational disease (or its recurrence). However, long latency periods following exposure and difficulties attributing the contribution of occupational causes of disease means that it is often more complex to understand than occupational injury. It is likely that this is part of the reason why compensation from ACC for occupational illness and disease is much less common than for occupational injury. As a result, workplace exposure to identified health hazards often ends up as a 'poor cousin' to injury prevention and management of safety hazards. This needs to change.

Under the Health and Safety in Employment Act 1992 (HSE Act), employers have the primary responsibility for taking all practicable steps to ensure the health and safety of employees and others at the workplace. Within the context of occupational health, this is done by managing workplace health hazards to reduce the likelihood of harm. For action to be effective, employers, managers and employees and their representatives must:

- › have easily accessible information on the nature of a health hazard and how it can be controlled and monitored. This information must be updated as knowledge on new health hazards become known and new techniques for managing them are developed
- › have the necessary capability – both through access to equipment and technology, and the managerial skills to ensure that good systems are in place, and
- › be motivated to take action to control exposures to health hazards and reduce risk.

Employers and industry groups, together with trade unions and occupational health experts, must work together to ensure that information, capability and motivation are kept current. Innovation and leadership in health and safety management is a process that can only be led by industry and experts themselves to be effective. Exposures in workplaces are often complex, and may reflect production processes that differ between industries and require specialist technical knowledge. In addition, industry leaders are more likely to be aware of new technologies and processes that may either decrease the risk of exposure or result in newly identified health hazards.

The Department of Labour works closely with both clinical and industry specialists through the Notifiable Occupational Disease System (NODS). Notifications are made through NODS when harm (or suspected harm) has resulted from exposure to workplace health hazards. Through this system an average of 270 notifications are received each year¹, and investigated by multi-disciplinary teams. Specialist panels comprising medical and non-medical specialists from the private and public sectors review individual cases investigated by Inspectors and national patterns in notifications and make recommendations².

The seriousness of some harms and the impact on individuals and their families and communities means that legislated intervention is justified in the public good. These are made under either the HSE Act, or the Hazardous Substances and New Organisms Act 1996 (HSNO), and include:

- › general regulations issued under the HSE Act that prescribe limits on noise exposure and place controls on the hazards presented by particular substances or processes; and
- › Approved Codes of Practice that relate to a range of hazards associated with occupational disease, including isocyanates, noise, hazardous substances and the manufacture of paint, printing and resins.

Best Practice Guidelines and other types of information such as factsheets are also published by the Department of Labour for a range of hazards, including chemicals (e.g. benzene, glutaraldehyde, lead, organophosphates and solvents), asbestos, shiftwork, violence and bullying, hazardous goods and substances, and biological hazards (such as leptospirosis). Although these publications are not made under an Act, they are a valuable source of industry knowledge about appropriate means of control and have evidential value in the event of a prosecution.



In addition, the Environmental Protection Authority (EPA)³ places controls on some hazardous substances under the HSNO Act to manage the adverse effects of these on people and communities. The Department of Labour ensures that the HSNO Act is complied with in workplaces and works in collaboration with the EPA to establish Workplace Exposure Standards. These standards are used by occupational health practitioners to monitor exposure to health hazards in the workplace. Under the HSE Act, employers are required to monitor employees' exposure to a hazard (and its impact on their health) where identified workplace health hazards cannot be eliminated or isolated.

1.1. GIVING OCCUPATIONAL HEALTH ISSUES MORE PRIORITY

This Action Plan has been prepared in response to the 2009 review of the *Workplace Health and Safety Strategy for New Zealand to 2015 (WHSS)*. The review identified the need for a stronger focus on occupational health as a priority issue.

The WHSS National Action Agenda 2010-2013, released in March 2011, has set a new direction for action over the next three years and further highlights the need to:

- › reduce workers' exposures to health hazards
- › raise awareness of occupational health issues, and
- › improve surveillance of occupational disease.⁴

This Occupational Health Action Plan covers the time period from now until December 2013. However, it is also intended to make a longer-term contribution by:

- › giving effect to the Government's goal of 'healthy people in safe and productive workplaces'⁵, and
- › contributing to the goal of a more effective labour market by ensuring that workplaces become healthier and safer⁶.

This Action Plan complements the Action Plans developed for the five priority sectors (agriculture, construction, fishing, forestry, and manufacturing), some of which also include sector-specific occupational health focus areas. For example, the Agriculture Sector Action Plan focuses on animal handling (which encompasses zoonoses such as leptospirosis) and the physical and mental health/wellbeing of workers among other high hazard areas.⁷

1.2. WHAT IS OCCUPATIONAL HEALTH?

The World Health Organisation and the International Labour Organisation have jointly agreed on a definition of occupational health. They say that occupational health should aim at:

"the promotion and maintenance of the highest degree of physical, mental and social well-being of workers in all occupations; the prevention amongst workers of departures from health caused by their working conditions; the protection of workers in their employment from risks resulting from factors adverse to health; the placing and maintenance of the worker in an occupational environment adapted to their physiological and psychological capabilities; and, to summarise, the adaptation of work to a person and of each person to their job."

1.3. THE INCIDENCE AND COST OF OCCUPATIONAL DISEASE IN NEW ZEALAND

Work has been completed in recent years to identify the incidence, prevalence and social and economic costs of occupational ill-health in New Zealand. According to Health Outcomes International (2005)⁸, occupational



disease in New Zealand accounts for greater mortality and morbidity than occupational injuries. It has been estimated that:

- › about 700–1,000 deaths occur every year in New Zealand from occupational disease: particularly cancer, respiratory disease and ischaemic heart disease (such as coronary artery disease)⁹
- › 2–4% of deaths of all people over the age of 20 are due to occupational disease and 3–6% of all cancer deaths in people aged 30 or older are due to occupational cancer
- › there are about 17,000–20,000 new cases of work-related disease every year.

Based on available data, common occupational diseases arising from workplace exposures include:

- › infectious diseases such as tuberculosis, pneumococcal disease and leptospirosis
- › cancers as a result of workplace exposure to carcinogens
- › anxiety, depression and psychological disorders
- › diseases of the nervous system as a result of exposure to neurotoxins, such as toxic encephalopathy from chronic exposure to solvents
- › vascular and musculoskeletal disorders
- › respiratory disease, particularly asthma caused or exacerbated by work, and chronic obstructive pulmonary disease and pneumoconioses as a result of exposure to wood, coal and other dusts, minerals such as silica, fertilisers, chemicals and solvents
- › skin conditions such as dermatitis as a result of exposure to chemicals (especially cutting fluids and solvents) and wet work such as in food handling and preparation; and
- › noise-induced hearing loss as a result of persistent exposure to excessive noise.

Reducing workplace exposure to the hazards that lead to these conditions is critical for improving occupational health.

Occupational disease has social and economic costs for individuals and for the country as a whole through lost productivity. Direct financial costs include the value of lost production, lower incomes for the workers concerned, health and rehabilitation costs, and administrative and transfer costs¹⁰. The costs for cancer, in particular, are exceptionally high. In addition, there are further costs due to pain and suffering for individuals and their families and communities.



→ 2. Priority areas of focus

The previous section indicates that there is much to be done to improve occupational health in this country - there are a wide range of complex issues to be addressed. Bearing in mind the finite resources of both government and industry, it is imperative that we start by focusing our attention on areas that will have the biggest impact over the long term and build a foundation for future action.

This section outlines three areas that have been prioritised over the course of this Action Plan:

- › **reducing exposure** to five occupational health hazards
- › **developing New Zealand's capability** to address occupational health issues; and
- › building relationships between government, industry, and occupational health researchers and practitioners to **work in partnership** to improve occupational health.

2.1. REDUCING EXPOSURE TO HEALTH HAZARDS

The main focus of this Action Plan is preventing occupational disease by reducing exposure to known occupational health hazards.

There are a wide range of workplace exposures and resultant conditions in need of attention, and many of the hazards that have an impact on occupational health are multi-causal in nature. It is important to identify and rank current and emerging risks and/or health hazards for immediate action.

The Department of Labour asked a panel of expert occupational health and safety researchers and practitioners to identify the issues which contribute most to the burden of injury and disease in New Zealand. Health hazards identified as a result of this process were considered alongside other relevant research and information (such as NOHSAC reports), and the following five were selected:

- › cancer-causing agents in the workplace
- › respiratory hazards
- › noise
- › skin irritants, and
- › psycho-social hazards.

There are aggregated benefits for improving health and safety as a result of the fact that the hazards identified above are common problems across the five priority sectors. A profile of each of the five health hazards in New Zealand follows.

2.1.1 Cancer-causing agents in the workplace



International research has found that a wide range of workplace hazards are associated with an increased risk of cancer for specific occupational groups or industries. Within the European Union, it has been estimated that 13.8% of cancers in men and 2.1% of cancers in women can be attributed to work.

New Zealand studies have shown an increased risk of cancer for workers in a diverse range of occupations and industries, including foundries and heavy engineering, athletes, cooks, waiters and bartenders, hairdressers and beauticians, fishermen, hunters and general labourers. Risk factors include exposure to a wide range of chemicals and dusts, in industries as diverse as pulp and paper, forestry, health care, textiles and agriculture.



It has been estimated that there are 237–425 work-related deaths in New Zealand from occupational cancer each year¹¹. These are caused by:

- › lung cancer due to exposure to asbestos, arsenic, beryllium, cadmium, chromium, diesel fumes, nickel, silica and environmental tobacco smoke
- › mesothelioma due to asbestos exposure
- › leukaemia from benzene exposure, and
- › bladder cancer from exposure to textile dyes, paints, pigments, leather, rubber, solvents and poly-cyclic aromatic hydrocarbons.

The most effective strategy to reduce occupational cancer is reducing the use of carcinogenic substances and processes at the workplace - replacing them wherever possible with less dangerous ones. If replacement of carcinogens is not possible, then it is necessary to take measures to avoid or reduce the exposure of workers to carcinogenic hazards. This is usually achieved by isolation, particularly the use of closed processes in which carcinogens are not released into the working environment.

To effectively decrease occupational exposure to carcinogens in the workplace, detailed information on current exposure and the effectiveness of control measures is essential.

2.1.2 Respiratory hazards



An estimated 200–205 deaths each year in New Zealand are thought to have been caused by chronic obstructive pulmonary disease (due to exposure to organic dust, microbial dust, endotoxins, welding fumes and environmental tobacco smoke), occupational asthma and asbestosis.

Occupational asthma is probably the most common work-related respiratory disorder in industrialised countries. It is associated with a wide range of agents, including some inorganic and organic dusts, biological hazards (such as grains, flour, insects and animal parts) and chemicals (including chlorofluorocarbons, isocyanates, metals and welding fumes). Occupational groups where studies have found an increased risk of asthma include sawmill and plywood mill workers, food processors, welders and farm workers.

To effectively decrease occupational exposure to allergens, detailed information on exposure determinants and effectiveness of control measures is essential. Research is currently underway in New Zealand to obtain real-time measurements for peak exposure to asthmagens in relation to work processes in sawmills. This will provide important information on tasks and activities related to peak exposure, identify control measures and other exposure determinants, and assess the potential impact of controls on reducing exposure.

2.1.3 Noise



The fact that noise (unwelcome and excess sound) leads to hearing loss has long been recognised. Noise-induced hearing loss (NIHL) is common in work environments in which excessive noise is prevalent, such as manufacturing and construction. Excessive noise is also associated with other health conditions such as hypertension, sleep disturbance, anxiety, headaches and nausea. Noise-induced hearing loss is most commonly a degenerative condition that has a long latency, with symptoms worsening as a result of cumulative exposure. However, physical damage to the eardrum following a single peak exposure can also result in permanent hearing loss. It is a well-established occupational issue, and remains a major cause of disability and compensation in New Zealand. Recent research from the University of Auckland has estimated that more than 42,000 New Zealand workers suffer from NIHL (based on 2006 data).



The HSE Regulations 1995 require that no employee is exposed to noise greater than:

- › 85 decibels averaged over an 8 hour period, or
- › a peak level of 140 decibels.

Employers are required by the HSE Act to monitor noise exposure and ensure that they comply with exposure standards.

The most common way of managing noise exposure in New Zealand workplaces is the use of protective hearing equipment. More work is needed to eliminate the sources of noise through design processes.

In addition to noise levels, some chemicals have the ability to damage hearing. These are known as ototoxic substances and include some pharmaceuticals, solvents, asphyxiants and heavy metals.

2.1.4 Skin irritants



Skin irritants are common in many occupations and may result in dermatitis. Contact dermatitis occurs when an irritant is applied in a high enough concentration, or over time and frequently. Allergic dermatitis may occur when an allergic response develops to the irritant.

Dermatitis is commonly a result of “wet work”, particularly where that work involves exposure to chemicals such as cutting fluids and solvents. Occupations at high risk of dermatitis include professional cleaning, hairdressing, food handling and preparation (bakers, caterers, cooks and confectioners), health workers (especially nurses), construction industry workers, leather and shoe manufacturers, florists, gardeners and metal workers. ACC accepted 6124 claims for occupational contact dermatitis between 2005 and 2010.

Control of skin irritation that may lead to dermatitis can be achieved through preventing contact, using non-rubber gloves and using less irritating chemicals.

2.1.5 Psycho-social hazards



The International Labour Organisation (ILO) has recognised since 2010 that work-related psycho-social risk factors can result in ill health.

Psycho-social harm is an often hidden problem in the workplace but undoubtedly affects a significant number of workers. The recent review of the WHSS recommended more awareness and understanding of the psycho-social hazards that can have a serious effect on the health and wellbeing of workers. These effects can be exhibited as chronic fatigue, stress-related disorders (such as anxiety and depression), alcohol and drug abuse, heart disease, musculoskeletal disorders and suicide.

The 2002 amendment to the HSE Act recognised that harm may be caused by work-related stress and that workplace hazards can include a situation where a person’s behaviour may be a source of harm. A range of workplace factors may contribute to psycho-social harm - excessive workload, low job control, poor support, and aggression or violence at work among others⁴².

International estimates suggest that work-related stress, depression and anxiety account for an estimated 13.8 million reported lost working days per year in Britain, and that 50–60% of all lost workdays in the European Union are due to stress-related disorders.

Until recently, very little data has been available in New Zealand on the incidence of psycho-social hazards and their impact on individual workers. A survey of more than 2,000 New Zealand workers was conducted for the first time in 2010, commissioned by the Department of Labour. The survey



gathered information on a range of dimensions such as work demands, job satisfaction, burnout and stress. Further information can be found under action 3.7 in the following section. The findings can be used alongside those from research conducted in 2009 on the prevalence of bullying in the health, education, travel and hospitality sectors to identify target populations and interventions.

2.2. DEVELOPING CAPABILITY



Managing occupational health issues can be difficult for workplaces. Knowledge about exposure to health hazards at work often requires specialist health and scientific knowledge, and workplace managers and health and safety representatives do not always have easy access to this information (particularly in smaller businesses). The situation is made worse by the fact that:

- › health care providers may not always consider occupational causes as a factor when dealing with the patient's presenting symptoms
- › not all Health and Safety practitioners and consultants are subject to professional registration, meaning it can be difficult for businesses to be assured that the people advising them on workplace health problems have sufficient expertise to do this competently. However, the *Health Practitioners Competence Assurance Act 2003* does require that occupational health professionals (such as Occupational Health Nurses, Occupational Physicians, Occupational Physiotherapists and Occupational Therapists) are registered with and monitored by a professional body to maintain their specific health competencies¹³, and
- › information and data is not freely available to employers or those seeking occupational health expertise about the people working in the occupational health field, what their qualifications are, or the locations in which they work.

Developing our capability for dealing with occupational health issues requires long-term commitment. It involves three separate components:

- › developing the knowledge and capability of workplace managers and health and safety representatives on the occupational health hazards present in their own workplaces
- › improving the knowledge and skills of health care providers to recognise and refer those people presenting with symptoms suspected as being caused by a workplace exposure; and
- › workforce development to continuously improve the expertise of the occupational health workforce, particularly as new toxicological or industrial hygiene information comes to hand, and new technologies for eliminating or reducing exposures are developed.

The *National Action Agenda 2010-2013* also works towards this third aspect, outlining an action relating to the establishment of a Health and Safety Professional Alliance (HaSPA) in New Zealand in 2012.

2.3. WORKING IN PARTNERSHIP



Improving occupational health requires concerted action from all parties:

- › occupational health and safety practitioners, whether working directly in workplaces or providing external advice
- › occupational health professions and professional groups (such as Occupational Health Nurses and Occupational Physicians, Occupational Hygienists and Ergonomists, Medical Officers of Health, Departmental Medical Practitioners)
- › occupational and public health researchers
- › medical professionals
- › employers and industry groups



- › trade unions, and
- › government agencies (particularly the Department of Labour, ACC and the Environmental Protection Authority).

Success in reducing the toll of occupational illness and disease will only happen if all these groups work together. It involves information sharing between experts with scientific and technical knowledge, and those with a practical operational focus. Research about the effectiveness of interventions to reduce exposure also needs to inform policy and decision-making processes.

The development and implementation of this Action Plan aims to foster common platforms for discussion, debate and consensus about occupational health, including the most effective use of resources.

Some partnerships for occupational health already exist. At a national level, the tripartite Workplace Health and Safety Council has oversight of the implementation of the Workplace Health and Safety Strategy, and provides advice and leadership on the strategic priorities.

The Occupational Health and Safety Industry Group (OHSIG) also acts as an industry forum and includes eleven professional associations all working in the occupational health and safety area from different disciplinary perspectives.



→ 3. Occupational Health Initiatives for 2011-2013

This section outlines actions (current and planned) that will be taken by industry stakeholders and Government to address the priority areas of focus outlined in the previous section.

Icons have been used to show how each action relates to the priority areas, and also to the remaining three action areas of the *National Action Agenda 2010-2013*. The fourth action area, developing capability, is already noted as a priority area of focus for this Plan.



growing occupational health **leadership**



cancer-causing agents in the workplace



building **knowledge**



respiratory hazards



supporting a robust health and safety system (**infrastructure**)¹⁴



noise



developing **capability**



skin irritants



working in **partnership**



psycho-social hazards

3.1. BUILDING EFFECTIVE OCCUPATIONAL HEALTH LEADERSHIP



3.1.1 Consideration will be given to ensuring that the **Workplace Health and Safety Council** membership includes occupational health expertise. In addition, the **Department of Labour** will work with the Council to decide how the Council can most appropriately support the Plan's implementation, which may include the formation of an occupational health steering or reference group.



3.1.2 OHSIG will work with its member organisations, and other stakeholders as appropriate, to develop and publish a position statement about Occupational Health in New Zealand **by the end of 2012**.

3.1.3 Massey University's **Centre for Public Health Research (CPHR)** will host a symposium on *Health and the environment at work – the need for solutions* in **April 2012**. The two-day event will involve international keynote speakers and workshops, with a view to becoming a regular (2 yearly) occurrence supporting professional development and knowledge exchange within the Occupational Health sector.

3.2. PROMOTING THE PARTNERS IN ACTION PLEDGE



The **Department of Labour** will encourage **Occupational Health stakeholders** to become Partners in Action with them in achieving the aims of this Action Plan.

3.3. WORKING IN PARTNERSHIP



The **Department of Labour** will actively foster its relationship with OHSIG and, through them, with professional groups and networks working in occupational health.

In turn, **OHSIG** will engage with the Institute of Professional Engineers New Zealand (**IPENZ**), particularly with their technical group the **Maintenance Engineering Society**, to work on progressing issues such as prevention by design and control of noise at source.

3.4. MAKING OCCUPATIONAL HEALTH INFORMATION MORE ACCESSIBLE



The **Department of Labour** will work with stakeholders to develop its existing Occupational Health Tools resource into a form that will meet the needs of Small and Medium Enterprises (SMEs), and health and safety representatives.

The purpose of this initiative is to provide easily understandable information to workers and managers to empower them to comprehend the risks associated with exposure, the mechanisms available to manage the risks, and the remedies available to them in the event of potential harm. Resources will focus on the five priority health hazards in the first instance.

3.5. PROFESSIONALISING THE OCCUPATIONAL HYGIENE SECTOR



Occupational hygienists play an important role in providing advice on preventing exposure to biological, chemical, physical, ergonomic and psycho-social hazards, based on known science. The **NZ Occupational Hygiene Society (NZOHS)** is working on a strategy for increasing the capability of the profession, assisted by the **Department of Labour**. Potential workstreams include the development of competency standards for occupational hygienists, and reviewing the content of occupational hygiene courses with relevant academic institutions. This work will be done in line with internationally recognised standards for occupational hygiene.



3.6. DEVELOPING A NATIONAL OCCUPATIONAL DISEASE SURVEILLANCE FRAMEWORK



Reducing exposure to health hazards in the working population requires better surveillance of occupational disease or risks. The **Department of Labour** is funding a National Surveillance Framework, which will be developed by Massey University's **Centre for Public Health Research (CPHR)** in **late 2011** and monitored from then on by the **Department of Labour** on the basis of the research noted in 3.7 below. The framework initially focuses on identifying information that can be gathered from existing data bases to establish estimates of occupational prevalence. In the first year, it will focus on establishing the baseline prevalence of work-related cancers, asthma and dermatitis. The information will be developed further in order to be able to measure trends in the prevalence of occupational disease and to assess the effectiveness of interventions.

3.7. BUILDING THE KNOWLEDGE BASE ABOUT SPECIFIC HEALTH HAZARDS AND EXPOSURE



3.7.1 The **Health Research Council** and the **Department of Labour** are jointly funding a number of research projects designed to increase our knowledge associated with specific health hazards.

Over the course of **2011 until mid 2012**, these research projects will be completed and findings published.

They include the following:

- › Incidence and Prevalence of Noise-Induced Hearing Loss
- › Preventing Noise-Induced Hearing Loss
- › Exposure to Carcinogens
- › Occupational Dermatitis in New Zealand Cleaners
- › Asthma in Sawmill Workers, and
- › Workplace interventions to reduce wood dust exposures in joinery and furniture workers.

3.7.2 Massey University's **Centre for Public Health Research (CPHR)** is conducting a multi-year programme of research called *Building Occupational Health Research in New Zealand (BROHNZ)*. In addition to undertaking some of the projects already outlined in 3.7.1, they are also exploring:

- › Occupational exposures and occupational health in Maori
- › Neurotoxic effects of solvent exposure
- › Cancer in meat workers: Identifying the causal exposures
- › Occupational asthma in New Zealand cleaners
- › Occupational exposures and occupational health in workers exposed to fumigants
- › Occupational and Environmental risk factors for Motor Neuron Disease, and
- › Parental Occupational and Environmental exposures as risk factors for Congenital Malformations.

CPHR are also using Video Exposure Monitoring (VEM) technology to assess peak exposures to a range of different workplace hazards in farmers and port workers in Australia and joiners and furniture workers in New Zealand. The technology allows for wireless real-time monitoring of an individual worker's exposure to chemical, biological, radiological and/or physical hazards¹⁵.



3.7.3 ACC will work with the **Department of Labour**, the **Construction Safety Council** and **CPHR** to consider the results of a small pilot project conducted in 2011 that looked at the exposure to silica-containing dust of construction workers cutting fibre-cement weatherboards. Options for further research will be explored, as well as promoting information to industry about the best ways to manage the hazard.



3.7.4 A psycho-social workstream will ensure that findings from the recently completed psycho-social survey of New Zealand workers (the 'Copenhagen study') are published, along with a comparison against other relevant research in the field **by mid-2012**. The **Department of Labour** will also make the study's dataset available to other researchers to inform their work as needed.

3.8. REDUCING HARM TO WORKERS FROM EXPOSURE TO OCCUPATIONAL HEALTH HAZARDS



Workplaces have an obligation to monitor workplace hazards, including exposure to health hazards that cause occupational disease.



Over the course of 2012–2013, the **Department of Labour** will develop and implement a harm reduction project that focuses on reducing workers' exposure to a priority health hazard. Resource will be directed towards priority sectors.

3.9. EXPANDING THE HEALTHLINE SERVICE TO INCLUDE OCCUPATIONAL HEALTH ISSUES



Healthline is an existing telephone support service funded by the Ministry of Health. It is staffed by registered nurses who assess health needs and offer support and advice to callers. The **Department of Labour** and the **Ministry of Health** will assess whether Healthline can provide support and advice on occupational health issues for workers and employers. A feasibility study will be completed **by the end of 2012**.



3.10. DEVELOPING A HSNO ENFORCEMENT STATEMENT



The **Department of Labour** is developing a formal statement outlining its approach to enforcing the Hazardous Substances and New Organisms Act 1996 (HSNO). The document will complement the Department's statement on HSE Act enforcement, *Keeping Work Safe*. The Department intends to finalise the HSNO enforcement statement **by early 2012**, following a brief period of public consultation.





3.11. TARGETING NOISE INDUCED HEARING LOSS (NIHL) AT THE SOURCE



ACC will continue to fund research and work with industry to develop and promote solutions for 'noise at source' problems that can lead to noise induced hearing loss.

Attention will be focused on high risk sectors and associated plant or processes, such as agriculture (quad bikes, milking pumps, shearing sheds and equipment), manufacturing and others.

ACC will work directly with industry, associations and other stakeholders to implement the recommendations arising from this work.

3.12. MONITORING DUST EXPOSURE DURING THE CHRISTCHURCH REBUILD PROCESS



The **Department of Labour** is launching a dust monitoring initiative in Christchurch. Significant amounts of dust are being generated from demolition sites as a result of the Canterbury earthquake recovery phase. Consequently, the general public, demolition crews and other contractors have the potential to be exposed to respirable dusts, nuisance particulates, asbestos fibres and free crystalline silica, resulting in long latency harm.

The initiative has two main aims:

- › monitoring of dust particulates generated from demolition sites and the level of dust exposure to workers and other people in the vicinity; and
- › determining what practicable steps companies should be taking to protect excavator operators inside their cabs, and the wider public, from harmful dusts.

Work began in September 2011 and will continue through **until mid 2012**.

3.13. EDUCATING THE NEXT GENERATION OF WORKERS ABOUT EXCESSIVE NOISE



The Pindrop Foundation,¹⁶ supported by **ACC**, is working to ensure that primary school children are informed early about noise induced hearing loss and how to prevent it. The 'Listen Up' programme is targeted at 8-12 year olds. During a fun and highly interactive 45 minute session, students learn how to reduce their exposure to excessive noise. The lesson incorporates physics, anatomy, general science and valuable health lessons. Up to 75,000 children will receive this programme in **2012**.

3.14. REVIEWING HAZARDOUS SUBSTANCE GROUP STANDARDS



Group standard approvals of industrial chemicals manage the risks associated with particular groups of substances with a single set of conditions.

The **Environmental Protection Authority (EPA)** is reviewing its Hazardous Substance Group Standards framework to identify how they might be improved for ease of compliance with the conditions.



3.15. IMPROVING THE SAFE HANDLING OF CHEMICALS AT WORK



The **Environmental Protection Authority (EPA)** has established a programme of work focused on improving the accessibility of chemical safety information for small and medium enterprises (SMEs).



This programme involves the development of a toolkit of simple, concise information about how people can manage their chemicals safely and comply with the hazardous substances legislation (HSNO). The toolkit will include a simple calculator tool that will help small and medium enterprises work out the key controls for compliance, including obtaining test certificates under HSNO.

The EPA will engage with influencers (groups who frequently interact with SMEs) to distribute the toolkit once it is completed. This is a multi-year programme with key elements of the toolkit to be completed by **30 June 2012**. The EPA is also aiming to establish contact and develop relationships with key influencers in the same timeframe.

3.16. REVIEWING THE DEPARTMENT'S NOTIFIABLE OCCUPATIONAL DISEASE SYSTEM (NODS)



The **Department of Labour** will lead a review of the current NODs system by **2013**.

3.17. SHARING INFORMATION TO IMPROVE OCCUPATIONAL HEALTH SURVEILLANCE



The **Ministry of Health** maintains a Hazardous Substances Surveillance System (HSSS) through a contract with **CPHR**. The HSSS collates existing data sources about instances of injury caused by hazardous substances to describe:



- › where injuries or illness are occurring
- › how frequent they are
- › whether they are increasing or decreasing; and
- › whether prevention efforts have been effective.



Non-identifying data captured by this system relating to occupational exposures will be shared with the **Department of Labour** to improve surveillance of occupational health.

The **Department of Labour** and **Ministry of Health** will also share information and work together on noise-related issues that cross the boundaries between occupational and environmental noise exposures, including during the development of standards and guidelines.

3.18. SUPPORTING MEATWORKERS TO MANAGE PSYCHO-SOCIAL STRESSORS



The **New Zealand Meatworkers Union** is working with the **Mens Health Centre** to develop a "Looking out for your mates" strategy that focuses on issues affecting men (both at work and outside of work) that can have a negative effect on their workplace safety and wellbeing. The work has arisen from the need to manage the additional stresses for meatworkers brought on by the Canterbury earthquakes, and will cover a range of issues such as family violence, counselling, addiction, and family law/child access. A pilot will be developed and trialled in the Canterbury region in 2012 and a National roll-out will be considered on the basis of the pilot.



3.19. ADVANCING THE KNOWLEDGE, PRACTICE AND STANDING OF OCCUPATIONAL MEDICINE



The **Australian and New Zealand Society of Occupational Medicine (ANZSOM)** is a professional organisation which provides a focal point for the advancement of knowledge for those registered medical practitioners who are actively involved in or who are interested in Occupational Medicine. ANZSOM plan to work over the next two years to:

- › form a sub-committee to look at ways to ensure under-graduate medical training in the area of Occupational Medicine can be strengthened and co-ordinated. This will involve looking at the curricula and developing a presentation that can be used in discussions with the country's training providers
- › develop a series of case studies for distribution to primary care doctors that highlight the clinical pathways in the detection of occupational disease (particularly relating to the five priority health hazards of this plan); and
- › develop a set of competency criteria for its members.

3.20. STRENGTHENING THE OCCUPATIONAL HEALTH COMPONENT OF GP VOCATIONAL TRAINING



In New Zealand the training involved in gaining vocational (specialist) registration as a General Practitioner takes a minimum of three years, provided through the **Royal New Zealand College of General Practitioners (RNZCGP)**. **RNZCGP** are currently further strengthening and expanding educational aspects of their curriculum related to Occupational Health with the assistance of Occupational Physicians.

3.21. INCREASING OUR UNDERSTANDING OF PSYCHO-SOCIAL WORK FACTORS IN NEW ZEALAND



The **Healthy Work Group at Massey University** will continue to conduct a bi-annual Workplace Violence study, and promote the findings to industry. In 2011, 96 organisations responded, and a full report has been posted on the Healthy Work Group website.¹⁷ Further research is concerned with control measures for workplace violence in the health sector.

In addition, **Massey University** are proposing to undertake qualitative research to identify leadership qualities that may be protective factors against workplace bullying and promote healthy work.



→ 4. The next ten years

Occupational diseases frequently have a long latency period, meaning it can take many years before evidence of health issues emerge. For this reason, we need to think beyond the timeframe of this Action Plan about ways of improving occupational health over the longer term.

4.1. BUILDING AWARENESS OF OCCUPATIONAL HEALTH ISSUES

Occupational health issues have a much lower profile in the public view than safety ones. There is a need to raise the profile of these issues in the minds of workers and their families, managers, and health professionals. This should include being conscious of health hazards at work and the importance of taking active steps to reduce exposure because of the long latency period of many occupational diseases. While many of the actions in this Plan will make a good start (see 3.4 for example), a longer term view will be needed over the next ten years to improve general awareness amongst New Zealanders.

4.2. SAFE DESIGN

The design of workplaces, jobs, plant, and equipment (including personal protective equipment 'PPE') is an important focus for the future. An essential element of good design is matching the workplace layout and design to the physical attributes of the worker. For example, attention at design stage to reducing machine noise will have a greater impact on reducing hearing loss than the use of PPE.

In addition, designs for plant and technology that are based on anthropometric data¹⁸ that is not relevant to the target population may lead to occupational disease, injury or death. For example, safety equipment that is based on "average" body size for men may expose women working in non-traditional occupations to an increased health and safety risk. Accurate anthropometric data for the New Zealand population is important for ensuring that designers, architects and suppliers of plant, technology, safety clothing and equipment can play their part in ensuring the highest possible standards of health and safety.

Although progress in this area is a long term proposition, the groundwork can and should start now. See action 3.3 in the previous section as an example.

4.3. WORK, HEALTH AND PRODUCTIVITY

Maintaining employee health and wellbeing is seen as critical for reducing the lost productivity as a result of absence from work and facilitating the continued labour market participation of skilled workers. Health issues are the most common reasons for early and unplanned exit from the labour force.

In the face of an ageing population and international labour shortages, maintaining personal health will become increasingly important for retaining a skilled ageing workforce.

Over recent years, a strong evidence base has been built that demonstrates close links between working and the physical and mental health of employees. In the UK, Dame Carole Black's *Working for a Healthier Tomorrow* provided a comprehensive review of this evidence and has been influential in shaping debate and public policy. It is clear that unemployment and absence from work for long periods of time - as a result of illness or disability - cause further harm to health and wellbeing. A number of studies have demonstrated that working can reverse the negative health effects of unemployment, and can also assist in the process of rehabilitation from ongoing illness and injury.



In 2011, the New Zealand Government signed up to the Consensus Statement of the Royal Australasian College of Physicians and the Australasian Faculty of Occupational and Environmental Medicine entitled *Realising the Health Benefits of Work*. This statement contains a number of recommendations for government, employers and health professionals. There is now a need to consider how to give effect to these recommendations in a way that contributes to the development of evidence-based policy and treatment approaches.

5. Monitoring

The Department of Labour will continue to work closely with the Workplace Health and Safety Council, industry, researchers and practitioners to monitor progress in achieving the Occupational Health Action Plan, particularly in respect of a whole sector approach to reducing exposure to workplace health hazards.

The Department will work with others to ensure access to better quality information on the state of occupational health and safety in New Zealand for interested stakeholders. This will include developing a broad framework for both activity and outcome monitoring which includes:

- › immediate measures of response to activity
- › intermediate measures of changed awareness and/or practice in workplaces, and
- › intermediate measures to record improvements in statistics.

The Department will report on progress against high-level indicators for occupational health in an annual State of Workplace Health and Safety report.

Each of the organisations/agencies that have contributed actions to this plan will monitor progress of their own activity against the stated indicators and measures of success. The Department will take a supporting and co-ordinating role, collating the information annually for inclusion in a progress report for the National Action Agenda and all the Action Plans.

This Occupational Health Action Plan will be reviewed and updated in 2014.



→ Endnotes

1. Based on combined data from 2005/6 to 2010/11
2. Current NODS panels are: Asbestos and Occupational Respiratory Disease; Chemical and Solvent; Musculoskeletal; Physical Hazards; and Psychosocial.
3. Previously known as the Environmental Risk Management Authority (ERMA).
4. Occupational disease is defined as disease/illness that is either *caused* by, or *made worse* by exposure to hazards at work.
5. Workplace Health and Safety Strategy for New Zealand to 2015
6. Department of Labour Statement of Intent 2011-2014 *New Zealand thriving through people and work*
7. For further information about the Sector Action Plans, go to <http://www.dol.govt.nz/whss/sector-plans/index.asp>
8. Health Outcomes International Pty Ltd. *Methods and Systems Used to Measure and Monitor Occupational Disease and Injury in New Zealand: NOHSAC Technical Report 2: Wellington, 2005.*
9. Driscoll T, Mannetje A, Dryson E, Feyer A-M, Gander P, McCracken S, Pearce N, Wagstaffe M. *The burden of occupational disease and injury in New Zealand: Technical Report.* NOHSAC: Wellington, 2004
10. Access Economics. *The economic and social costs of occupational disease and injury in New Zealand: NOHSAC Technical Report 4: Wellington, 2006.*
11. Driscoll T, Mannetje A, Dryson E, Feyer A-M, Gander P, McCracken S, Pearce N, Wagstaffe M. *The burden of occupational disease and injury in New Zealand: Technical Report.* NOHSAC: Wellington, 2004
12. For further information, go to: <http://www.osh.govt.nz/publications/stress/index.asp> or <http://www.hse.gov.uk/msd/mac/psychosocial.htm>
13. For a full list of the health professionals covered by the Health Practitioners Competence Assurance Act 2003, go to: <http://www.moh.govt.nz/moh.nsf/indexmh/hpca-responsibleauthorities>
14. Further explanatory information about these general action areas and their contribution to improving health and safety performance can be found in the *National Action Agenda 2010-2013.*
15. CPHR welcomes the opportunity to work directly with businesses/industry organisations that want to use VEM as a monitoring tool in their workplace/sector to help understand how best to manage workers' occupational exposures. For more information, contact CPHR@massey.ac.nz
16. For more information about this organisation and the 'Listen up' programme, see: <http://www.pindrop.org.nz/site>
17. <http://www.massey.ac.nz/massey/learning/departments/school-of-management/research/healthy-work-group.cfm>
18. Anthropometric data includes information on height, weight, body part dimensions, strength, flexibility, endurance and psychological skills and capacities.



