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The challenge to workplace health and safety and the changing nature of work and the working environment

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**Chapter objectives**

This chapter will enable readers to understand the:
- links between employment insecurity and occupational health and safety (OHS)
- relationship between employment insecurity and poor health outcomes
- connection between the design and management of work and psychological or physical harm
- importance of employee voice in bringing about improved psycho-social well-being at work
- growing challenges to worker involvement in OHS despite its efficacy in reducing occupational illness and injury.
Introduction

Changes in the work environment present significant challenges to workers' health and safety. The pursuit of labour flexibility, intense competitive pressures and the shift towards decollectivism and deregulated labour markets have produced new workplace risks to occupational health and safety (OHS), while eroding the capacity of workers to respond to such risks. Foremost is the challenge posed by the changing nature of employment, specifically the growth of precarious forms of employment, as well as greater job insecurity experienced by permanent employees. The second risk is the surge in psycho-social distress associated with increasingly demanding employment conditions, and third is the decline in occupational health and safety worker representation and consultation, contributing to a void in mechanisms for identifying, monitoring and controlling risks at work. These risks are not inevitable, but reflect choices made by organisations and governments about the priority given to worker health and safety vis-à-vis other economic and political objectives.

Changes in the nature of employment: precariousness and job insecurity

In Chapter 2, we considered the Australian employment model and especially the causes of growing workforce insecurity, and in Chapter 10 we examined the multiple sources of labour force disadvantage. In this section, we return to discuss the issue of 'precariousness' because of its important implications for workplace health and safety.

The nature of employment has changed substantially in recent decades. As firms have pursued greater labour flexibility, an increasing share of the workforce has faced precarious employment, which is characterised by increased job insecurity, more volatile incomes and a reduced capacity to voice workplace concerns. In Australia, the growth in labour flexibility is most readily evidenced through the expansion of casual employment. Around 16 per cent of those in the workforce were employed on a casual basis in 1983; the proportion peaked at 26 per cent in 1998 before stabilising at about 24 per cent in 2010 (ABS 2011a). Initially concentrated in service industries with peaks and troughs in customer demand, such as hospitality and retail, casual employment is now dispersed across a range of industries, including manufacturing, construction, warehousing and health care (ABS 2011g). Most casuals (70 per cent) are employed part-time and, reflecting the expansion of casual employment into industries that formerly were the domain of full-time male workers, an increasing number of casual workers are men, with this category now making up 16 per cent of the male workforce (ABS 2011g).

Temporary agency work (also known as labour hire) is another form of precarious employment that has experienced rapid growth since the late 1980s. Agency workers are hired by an agency and placed with a host employer while continuing to be employed and paid by the agency. Although agency workers make up only 3–4 per cent of the Australian workforce, as in other developed economies, agency workers are disproportionately employed in low-skilled and often hazardous occupations and industries, and
their employment creates downward pressures on wages and employment conditions, safety and union membership (Arrowsmith 2006). They are often paid lower wages than those received by their co-workers who are direct employees and are reluctant to join or become active in unions for fear of job loss. They too are hired predominantly on a casual basis (80 per cent of agency workers are estimated to be casuals), paid only for the time placed with a host. While some are placed with one host for an extended period, others ‘churn’ through multiple host workplaces at very short notice. Indeed, a common problem encountered by agency workers is the ‘uncertainty of living by the mobile phone’, waiting to be told when and where their next placement will be (Underhill & Quinlan 2011). While temporary agency work originated with white-collar office ‘temping’, like casual employment more generally, it has since expanded into a diverse range of industries from manufacturing, maintenance work, food processing and warehousing, through to hospitals and call centres.

A third form of precarious employment is independent contracting, whereby workers supply a service but are not employees. While some independent contractors operate genuine businesses, others are more accurately described as ‘dependent contractors’ because they are typically reliant on a single employer for work and exercise little discretion in the manner of its performance – they resemble employees but are not entitled to employment-based protections, such as a minimum wage or other employment conditions. Independent contractors make up about 9 per cent of the workforce, a share that has remained relatively stable in recent decades, notwithstanding anecdotal evidence to the contrary. An audit of cleaning-service employers in 2011, for example, found that 22 per cent of employers had misclassified employees as independent contractors) (Fair Work Ombudsman 2011). The extent to which these self-employed workers are dependent rather than independent contractors has not been estimated but is likely to vary by industry and function.

Together, these three types of precarious workers make up just under one-third of the Australian workforce; after allowing for those on fixed-term contracts and other business operators, only 62 per cent of the workforce comprises permanent employees, and 18 per cent of them are part-time (ABS 2011g). Similar developments in the growth of precarious employment have occurred in other advanced economies, although the form differs by local institutional arrangements. Hence, while 13.5 per cent of workers in the European Union were employed on temporary contracts in 2010 (Eurofound 2011), only 9 per cent of German workers were employed in fixed-term jobs (although 20 per cent were employed in low paid ‘marginal’ employment) (Siefert 2011); one-quarter of British workers were employed part-time and another 6 per cent were in temporary jobs in 2010 (Slater 2011-); and around 32 per cent of Spanish workers have been employed in temporary jobs since at least the turn of the century (Malo 2011). This shift in the nature of employment is widespread, and its implications for workers’ well-being are increasingly the focus of research and government inquiries in many countries.

Alongside the growth of less-secure forms of employment has been the expansion of outsourcing, privatisation and repeated rounds of downsizing and restructuring since the 1990s in Australia. Each has contributed to permanent employment
becoming less stable, resulting in increasing numbers of workers in precarious employment. One of the most significant developments had been that both Labor and non-Labor governments at the state and federal levels have undertaken privatisation and outsourcing, resulting in a marked shift in employment away from in the formerly stable, unionised public sector to the private sector. By 2010, only 20 per cent of employees worked in the public sector compared with 32 per cent in the mid-1980s (ABS 1985, 2011a). Among private sector employers, a common response to global pressures has been ‘offshoring’, or other forms of extreme cost-cutting. As we saw in Chapters 1 and 2, employment in manufacturing – another former mainstay of secure employment and unionisation – has fallen steadily over recent decades. In contrast, employment in the service sectors expanded from around 66 per cent of the workforce in 1984 to 78 per cent in 2010 (ABS 1985, 2011a). These shifts in the industry distribution of employment have brought considerable job uncertainty during periods of change, and resulted in a greater proportion of the workforce facing ‘softer’ health and safety risks (such as psycho-social risks), including concerns about work intensification and declining quality of jobs.

Although these changes began in the 1980s, they were hastened by changes to workplace relations laws implemented by both Labor and Liberal-National Coalition governments, as discussed in previous chapters (see especially Chapter 5). Prohibitions on collective agreements that contain clauses restricting the use of agency and casual workers in effect provided an incentive to utilise insecure forms of employment, while prohibitions on including basic conditions – such as rest breaks and minimum breaks between shifts (raising concerns about issues such as fatigue) – both increased workplace health and safety risks during the years of the Howard Liberal-National Coalition government. Prohibitions on paid union training (including OHS training) and restrictions on the right of entry to union officials also eroded the capacity of unions to respond to OHS issues. Further, the elimination of unfair-dismissal protections for many workers undermined their confidence in raising health and safety concerns. Removing protection from unfair dismissal was regarded as a impediment to enforcement of OHS laws by government inspectors because it was more difficult to shield complainants from employers, particularly in small workplaces (Quinlan, Bohle & Lamm 2010). Although many of these collective rights have been reinstated since 2010, union membership remains at historically low levels, leaving gaps in OHS worker representation. Also, despite the reinstatement of many of these rights, there are few signs of employer reliance on precarious forms of employment being reversed. Consequently, as we shall see below, health and safety concerns arising from precarious and insecure employment have continued.

**Precarious employment and health and safety at work**

Evidence that the changing nature of employment was detrimental to worker health and safety began to emerge in the 1990s, and was consolidated in a study by Quinlan,
Mayhew and Bohle (2001). Their review of more than 100 studies of job insecurity and downsizing reported that more than 80 per cent of studies found that OHS had been adversely affected by this development and only part-time employees experienced ambiguous effects. A further review of international research on outsourcing and subcontracting found poorer OHS outcomes in 23 out of 25 studies, while the exceptions (one in subcontracting and the other in home-based work) yielded ‘mixed’ results (Quinlan & Bohle 2009). Narrower reviews of research into temporary employment (e.g. Virtanen et al. 2005) have also revealed a clear preponderance of studies identifying a negative association between OHS outcomes and precarious forms of work.

Drawing upon the commonalities revealed across studies, Quinlan and Bohle (2004) developed the Economic and Reward Pressure, Disorganisation and Regulatory Failure (PDR) model to explain why precarious employment impacted negatively on workplace health and safety. The model groups explanatory factors into three categories. The first, economic and reward pressures, includes elements of economic pressure and power that are both immediate to the job – such as piecework payment systems – and part of the broader labour market – for example, irregular income streams of precarious workers and lack of income support following injury. It encompasses sources of income insecurity that influence safe work practices, such as low job and income security and intense competition for work, which can contribute to a range of hazardous practices, including work intensification, ‘cutting corners’, accepting hazardous tasks, working when injured and multiple job-holding (Quinlan & Bohle 2004). An OHS inspector, for example, described his experience with subcontractors in the following terms:

Every site we go on they have subcontractors there and . . . it certainly creates problems because if they don’t get the job done they don’t get paid so they’ll work longer hours, they’ll try and take that shortcut unfortunately because they’ll get the job done quicker . . . (cited in Quinlan, Johnstone & McNamara 2009: 564)

The second factor, disorganisation, encompasses characteristics that tend to emerge in organisations that lack a commitment to a stable workforce. It includes the exacerbation of complex, ambiguous rules and procedures, and changes to work rules and practices, which become lost among the myriad ‘visitors’ to the workplace. In these circumstances, OHS knowledge and management systems become fractured, while inter-worker communication, task coordination and lines of management control are weakened. Under-qualified, under-trained and inexperienced workers who lack familiarity with the workplace become more commonplace. In this setting, precarious workers are less able to collectively organise or to be ‘heard’ at the workplace. Importantly, disorganisation should not be seen simply as an outcome of oversight, but rather as a characteristic feature of the relationship between contingent workers and their employers. The use of temporary workers affects employer attitudes to induction, training, participation in workplace committees and other activities, with implications for safety (Quinlan & Bohle 2004: 93).
The third category, *regulatory failure*, refers to the extent to which OHS and employment regulation are weakened through the complexity of precarious employment and inter-organisational contracting arrangements. Gaps in coverage emerge in employment protection and minimum entitlements; compliance is weakened as employee knowledge of entitlements declines or is undermined by their labour market vulnerability; and enforcement processes encounter hurdles, such as identifying those with legal responsibility and the opportunistic liquidation of business entities to avoid prosecution. Another element of regulatory failure is inconsistent or discriminatory aspects of both the form and implementation of regulation practices that bear most heavily on those in precarious employment (including foreign and undocumented workers). Quinlan and colleagues' (2009) study of OHS inspectors' perceptions of the problems associated with changing employment arrangements also highlights how these complexities stretch already limited inspectoral resources, because of the need to continually explain obligations to multiple parties at single worksites and to undertake follow-up visits to the multiple office locations associated with those parties. Table 11.1 summaries the key risk factors associated with the three components of the PDR model.

Underhill and Quinlan’s (2011) analysis of the injury experience of temporary agency workers in Australia demonstrates how PDR factors contributed to a higher risk of injury and more severe injuries for agency workers compared with traditional, directly hired workers. The agency workers were predominantly employed as casuals, and many were injured early in a placement; 18 per cent were injured during the first week of their placement and 35 per cent within the first month. By contrast, only 5 per cent of comparable directly hired workers were injured during their first month of employment. The irregular work and income of temporary workers resulted in economic pressures to accept any placement available, to work intensely to ensure another placement would be offered, and not to report injuries for fear of job loss (contributing to relatively minor injuries becoming more severe). Some agency workers were placed to perform tasks for which they were neither qualified nor experienced (including, in one case, a youth who was fatally injured), and such training as was provided by the agency employer or the host was often inadequate. Three-way communication between workers, agencies and hosts in relation to workplace risks

<table>
<thead>
<tr>
<th>Economic and reward pressures</th>
<th>Disorganisation</th>
<th>Regulatory failure</th>
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</thead>
<tbody>
<tr>
<td>Insecure jobs (fear of losing job)</td>
<td>Short tenure, inexperience</td>
<td>Poor knowledge of legal rights, obligations</td>
</tr>
<tr>
<td>Contingent, irregular payment</td>
<td>Poor induction, training and supervision</td>
<td>Limited access to OHS, workers’ compensation rights</td>
</tr>
<tr>
<td>Long or irregular work hours</td>
<td>Ineffective procedures and communication</td>
<td>Fractured or disputed legal obligations</td>
</tr>
<tr>
<td>Multiple job-holding (e.g. may work for several temp agencies)</td>
<td>Ineffective OHSMS/inability to organise</td>
<td>Non-compliance and regulator oversight (stretched resources)</td>
</tr>
</tbody>
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*Source: Underhill and Quinlan (2011).*
was often fractured and, when workers raised OHS and workplace concerns, employers and hosts ‘passed the buck’ between one another, with neither resolving the issue. Workers also risked dismissal or being offered a placement too far from home to be practicable, as a consequence of raising concerns or taking time off to recover from minor injuries. Once injured, the majority in this sample were offered no further placements, notwithstanding having recovered from their injuries.

These findings in relation to temporary agency workers are not unique to Australia. Studies undertaken in the United States (e.g. Smith et al. 2010), France (e.g. Francois 1991), Spain (e.g. Benavides et al. 2006) and Finland (e.g. Hintikka 2011) have found that agency workers experience a higher rate of injury than directly hired workers, while studies in Canada (e.g. Lippel et al. 2011) and Sweden (e.g. Aronsson 1999) have identified similar practices contributing to OHS risks for agency and on-call workers.

The risks associated with precarious work also extend to poorer health. A study of poorer health outcomes among precarious workers in Canada (Lewchuck et al. 2003) led to the development of the ‘employment strain’ model, which identifies seven components of employment strain that are common to precarious employees and contribute to poorer health. These are uncertainties arising from lack of control over access to work (employment uncertainty); earnings unpredictability; household precariousness (providing basic needs); scheduling; work location; task; and workload. Not only were precarious workers more likely to report poorer health, they were also more likely to report being tense at work and exhausted after work. These stress-related symptoms were an outcome of the uncertainty or employment strain continually faced by precarious employees. Clarke et al. (2007), in further tests of the model, distinguished between the importance of employment relationship uncertainty, support and effort. Those in unsustainable precarious employment who preferred but were unable nor expected to find permanent employment experienced high employment and income insecurity, poorer health outcomes and the least access to social support at work, both from their household and in the community. As Clarke et al. observe (2007: 325): ‘Their employment situation both creates a need for support but makes it more difficult for workers to access it.’ Only the small proportion of workers who were satisfied with precarious employment reported good health and social support, leading them to consider their work arrangements sustainable in the longer term.

Over the past decade, a number of governments have initiated inquiries specific to OHS and changing employment, or have included changing employment in the terms of reference of broader inquiries into OHS (e.g. Dean 2010; NIOSH 2002; Stewart-Compton, Mayman & Sherrif 2009). The response of the Australian government has been among the more innovative to date. The model national OHS laws, which commenced in 2012, broaden the responsibilities of organisations to ensure that they provide a safe and healthy work environment for all workers, not just the organisation's employees. The laws are intended to overcome the complexities and confusion that flow from multi-employer worksites, such as those that arise when contractors and temporary agency employees are engaged by organisations (Johnstone 2011). However, the risks
confronting precarious workers originate in part from their acute job insecurity, a problem derived from gaps in employment rather than OHS regulation. These risks also flow from a lack of knowledge about their employment rights, including the right to compensation once injured. Injured casual workers, for example, are three times more likely than permanent workers to not apply for workers' compensation, because they either believe they were not covered or are not aware of entitlements (ABS 2011h). Lastly, the continual exposure to organisational restructuring and downsizing noted earlier has produced work environments in which precarious workers increasingly are joined by permanent employees in being exposed to chronic uncertainty and its associated detrimental health impacts.

Organisational change, job insecurity and health

There is now consistent evidence that job insecurity contributes to psychological ill-health, and that the higher the level of insecurity, the more ill-health increases (Ferrie et al. 2008). Importantly, perceived job insecurity – when workers are fearful or continually worried about job loss – shows a stronger direct relationship with poor health than objective insecurity, such as when the nature of the employment contract is insecure (Strazdins et al. 2004). Also, while it might be thought that those with poorer psychological health are more likely to be located in less secure employment, studies that have measured changes in psychological health over the duration of employment from secure to insecure status have confirmed that the direction of causality is from job insecurity to poorer health (Ferrie et al. 2008).

The Whitehall study (also known as the Stress and Health Study) was among the earliest to identify the adverse health consequences of job insecurity. These studies analysed data collected from more than 10 000 British public servants, beginning in 1985 (for further details, see the study website at <http://www.ucl.ac.uk/whitehall>, accessed 20 December 2012). Baseline screening commenced in the mid-1980s, and data-collection continued over a 15-year period, during which there was substantial restructuring and privatisation. Workers who experienced chronic job insecurity reported poorer self-rated health and greater levels of psychiatric morbidity (depression) than those whose jobs remained secure; those whose jobs shifted from secure to insecure also experienced elevated blood pressure. Neither alcohol consumption nor smoking behaviours accounted for these outcomes. Some adverse effects were enduring, with poor psychological health evident for extended periods after job security returned, notwithstanding improvements in self-reported health (Ferrie et al. 2008). Similar outcomes have been found in other industry sectors and countries (e.g. Virtanen et al. 2002). The impacts of job insecurity are not limited to psychological health. Poorer physical health, including fatigue, chronic insomnia, migraines, colds and flu-like symptoms, as well as musculoskeletal disorders, have all been identified (Ferrie et al. 2008).
Employees who remain in downsized organisations – the 'survivors' – have been shown to experience a number of health problems associated with increased job demands, including those flowing from subsequent under-staffing, often accompanied by increased uncertainty about their own future in the organisation. As in the studies reported above, outcomes include anxiety, depression, poorer self-reported health, musculoskeletal problems and heart disease (see Quinlan 2007 for a review of such studies). Increased rates of workplace injury have also been identified in studies of downsizing in the health sector, along with increased violence at work (Ferrie et al. 2008). While many studies of the health effects of downsizing rely on workers' self-reported health status (typically the General Health Questionnaire, an internationally recognised reliable and validated evaluation tool), the small number of studies utilising objective data have found a greater likelihood of the use of anti-depressant prescription drugs, elevated blood-sugar levels (a potential precursor to diabetes), blood pressure and early retirements on medical grounds (see Ferrie et al. 2008 for a review of such studies). A Danish longitudinal study of public sector restructuring found a high level of 'burnout' (physical and psychological fatigue and exhaustion), accompanied by cynicism, detachment from the job and a lack of professional accomplishment among more than 1000 respondents (Anderson et al. 2010). Although consultants had been engaged to assist with communication during restructuring, it was found that a lack of worker involvement in the process contributed to these poor mental health outcomes.

Faced with the uncertainty and pressures associated with employment in organisations undergoing cost-cutting, employees have been found to respond with high levels of presenteeism (attending work while ill), estimated to be more costly to organisations than absenteeism; excessive (and often unpaid) working hours; delaying vacation leave (with an associated risk of burnout); and reluctance to report OHS problems or take part in OHS committees (Quinlan 2007). Organisational change is so pervasive that job insecurity – even for permanent employees – is now considered an ongoing feature of the labour market (Ferrie et al. 2008). The policy implications of such an assessment point to the need for the promotion of reductions in job insecurity across the workforce, not only for precarious workers.

**Growing prevalence of psycho-social hazards and the changing workplace environment**

Alongside job insecurity are a range of other employment characteristics that together make up the psycho-social work environment. Known as psycho-social risks, these hazards involve 'those aspects of the design and management of work, and its social and organisational contexts, that have the potential for causing psychological or physical harm' (Leka & Cox 2010: 125). While the poorer health outcomes associated with job insecurity and organisational change include psycho-social outcomes (especially to the extent that these outcomes are associated with distress), the most commonly recognised health outcome of psycho-social risks is occupational or job stress.
Workers experiencing occupational stress face considerable difficulty in accessing workers' compensation, including a greater likelihood that the claim will be investigated and rejected, and a reluctance of doctors to support such claims. It is perhaps unsurprising that recent Australian data on workplace injuries show that those with job stress were least likely to receive workers' compensation (78 per cent of those who claimed to have job stress did not receive workers' compensation), yet were most likely to require five or more days of leave in order to recover (compared with all other injury types) (ABS 2011h). This survey also found that 4.9 per cent of the workforce have self-reported work related stress or another mental condition (ABS 2011h). Other surveys suggest that this phenomenon may be more prevalent and have significant costs. LaMontagne and colleagues (2008) estimate that in 2003, 13.2 per cent of male workers and 17.2 per cent of female workers in the state of Victoria were likely to suffer depression attributable to job strain. Between 2006/07 and 2010/11, it was reported that there had been a 54 per cent increase in workers' compensation claims for stress (notwithstanding a relative restrictive definition of the disease), and that such claims accounted for one in five serious claims (requiring one or more weeks off work) (Comcare 2011). The cost of depression across the Australian workforce was estimated to be $12.6 billion per year in 2007, based upon an estimated 1.54 million workers (14.7 per cent of the workforce) suffering depression. This included $3.4 billion attributed to lost productive time and $8.9 billion attributed to job turnover or employee replacement costs (LaMontagne, Sanderson & Cocker 2010). Under the circumstances, it is not surprising that workers' compensation claims for occupational stress are regarded as just the 'tip of the iceberg'.

Surveys in the European Union also report high levels of work-related stress, with between 20 and 30 per cent of workers reporting that their health was at risk because of work-related stress in 2007 (Leka et al. 2011). The cost of work-related stress, depression and anxiety was estimated to be more than £530 million in the United Kingdom, and between €830 million and €1656 million in France, in 2009 (Eurofound 2009). Importantly, from the perspective of worker entitlements to compensation for work-related injuries, the International Labour Organization (ILO) recognised occupational stress as an occupational disease (where a direct link is established between exposure to risk factors and a mental disorder) in 2010 (Leka et al. 2011). Such recognition represents an important step in terms of employers bearing responsibility for minimising exposure to known risks.

Of the explanations for occupational stress, Karasek's (1979) model is the most widely accepted and tested. His job demands/job control model identifies a significant interactive relationship between levels of job demands, job control and mental strain. Put simply, 'job strain increases with the relative excess of demands over decision latitude' (1979: 5). 'Job demands' were defined to include variables such as working fast, working very hard, excessive workloads, and whether the job was hectic or sufficient time was allowed to complete tasks. 'Job control' included factors such as the degree of discretion over task organisation, the repetitive nature of tasks and participation in decision-making. The combination of high demand and low job control produced 'job strain', which in turn is measured by exhaustion and depression.
indicators. Further, increased exposure to high-strain jobs contributed to unresolved strain and was manifested in poor mental health. It was found that social support can mitigate only some of this risk.

More recent studies have estimated that job strain doubles the risk of depression (LaMontagne et al. 2008). Further, an Australian study of managers and professionals found that the combination of job strain and job insecurity markedly increased the odds of suffering both mental and physical health problems (Strazzdins et al. 2004). Belying the accepted view that work is always good for you, Broom and colleagues (2006) analysed a sample of almost 2500 Australians aged 40–44 years, and found that those who reported job strain, job insecurity and low levels of ability to find a new job if their current employment ended were more likely to report that they suffered depression than those who were unemployed.

There are two other models worthy of brief consideration. The first is the effort/reward imbalance model (Siegrist 1996), which emphasises the imbalance between efforts expended by employees and the rewards provided by employers, including non-tangible recognition. Additional variables of low social support, including support from co-workers and supervisors, have also been joined with this model when identifying higher-risk practices (Bultmann et al. 2002). This model has been expanded to include the level of job security as a reward, offering a potential explanation for the poor outcomes associated with job insecurity noted above (Silla, Gracia & Peiro 2005). The second model is the organisational justice model, which posits that a lack of procedural and relational justice within organisations contributes to occupational stress (Kivimäki et al. 2007). In this study, organisational injustice was found to be associated with poorer health, with the highest level of risk occurring when injustice was combined with a high effort-to-reward imbalance.

Interventions to reduce the risk of job stress take three forms. The first of these are primary organisational level interventions, which focus upon the cause of stress—such as job design, work pace or the operation of a joint-workplace OHS committee. The second are secondary individual-level interventions, which focus upon modifying individual responses to stress to facilitate better responses to stressful situations, such as stress or time management programs. Finally, there are tertiary interventions, which involve treating those exhibiting symptoms of stress. LaMontagne and Keegel (2010) point out that primary interventions offer the maximum benefit to individuals and organisations because of their focus upon causal factors. They also affirm the importance of meaningful participation of those targeted by such interventions:

Participation is a particularly important principle in job stress intervention because it is integral to the prevention and control of job stress itself. Participation is a concrete enactment of job control, demonstrates organisational fairness and justice, and builds upon mutual support among workers and between workers and supervisors. (LaMontagne & Keegel 2010: 8)

Egan and colleagues’ (2007) review of 18 studies examined health outcomes following interventions that increased employee involvement in decision-making. It concluded that most interventions led to improved health. This outcome was reinforced
by a review of 19 studies of task restructuring (Bambra et al. 2007), which found that only those interventions that reduced job demands resulted in improved health, and that increased job demands tended to affect health adversely.

However, both the reality of employee involvement and the robustness of research findings on employee health have been questioned, particularly in those cases in which employee participation was direct rather than representative, and where psycho-social risks were conceptualised in individual rather than collective terms. As Walters (2011: 604) points out, 'many of the factors which have contributed to this declining influence [of trade union representation in OHS] are the same ones that contribute to the rise in psycho-social risks and their effects at work'. From the various findings on the link between employee well-being and employee participation, we see the importance of research on employee voice — an issue that is considered further in Chapter 7.

The potential for effective employee involvement in mechanisms to reduce psycho-social risks, however, is also central to proposals emanating from the European Union. A major project piloting an integrated risk-management approach to psycho-social risks was undertaken and a 'European Framework for Psycho-social Risk Management' developed that endorses the participatory approach and promotes 'ownership' by all stakeholders (managers, workers and their representatives) as a key component of psycho-social risk assessment (Leka & Cox 2010). The effectiveness of this approach is yet to be evaluated fully. Nor has such an approach been well supported in Australia, where a revival in the popularity of behaviour-based approaches to health and safety (such as the promotion of employee resilience) has shifted attention back to individualised responses, rather than a focus upon organisational-level sourced problems. As Shaw and Blewett (2000: 465) observe, the:

resurgence of worker behavior as a sufficient explanation for occupational ill-health and as the most effective target for interventions to improve OHS ... [is depriving] workers of the power to act on their environment, only on their behaviour.

Worker involvement is also diminishing as a result of a number of other changes occurring in the working environment, considered in the next section.

The demise of worker involvement in workplace health and safety

The scope for and importance of worker involvement in occupational health and safety has been touched upon throughout this discussion — for example, the absence of precarious workers' involvement at the most rudimentary level of raising individual concerns heightens their risk of injury, while interventions that enhance workers' involvement in decision-making have been linked to improved health outcomes. Here we turn to the role of formal involvement in OHS workplace processes, namely worker OHS representatives and worker participation in joint OHS workplace committees, and the scope for precarious workers being represented in OHS matters at work.
Workplace health and safety is often partitioned off by management from other collective concerns at the workplace. It is regarded as an area requiring expertise or, particularly in the case of small businesses, a problem created by reckless workers—otherwise known as ‘the careless worker’ syndrome—and therefore requiring behavioural change rather than corrections and improvements in production and work processes. Yet research has found consistently that collective worker involvement is essential to the development of a safe and healthy workplace; that effective OHS is not the domain of experts (although their input is necessary); and that a safe workplace is an outcome of deliberate actions by both management and workers.

Since the 1980s, most Australian states have enacted OHS legislation supporting (to varying degrees) worker health and safety representatives and joint OHS committees, and this approach is also embodied in the new, national model for OHS laws (which has so far been enacted at the federal level and in the Australian Capital Territory, Northern Territory, New South Wales and Queensland). Worker health and safety representatives generally are involved in day-to-day activities such as risk assessments, monitoring practices and investigating problems when they arise, as well as making representations to management. Joint OHS committees are composed of management and worker representatives, and are intended to have higher-level policy-orientated functions. Quinlan, Bohle and Lamm (2010: 344) distinguish these functions as monitoring and enforcement by worker representatives and problem-solving by OHS committees. Some states mandate that workers make up at least 50 per cent of the members of an OHS committee to ensure that these bodies are not dominated by management’s interests.

Statutory endorsement of formalised worker representation in OHS is well supported by research on the impact of such involvement, particularly when unions are part of the process. In the United States, deaths from hydrogen sulphide were less frequent in unionised than non-unionised workplaces, and fewer illnesses and injuries were recorded in the public sector when workers were involved through an OHS committee. In Canada, a reduction in lost-time injuries was associated with health and safety committees, while worker empowerment was consistently associated with lower injury rates (Johnstone, Quinlan & Walters 2005). In the European Union, active union representation and participatory management have been associated with improved sickness absence rates in Norway, and interaction between works councils and unions (including a willingness by unions to mobilise union power) contributed to increased employer compliance with statutory obligations to involve workers in OHS in the Netherlands (Popma 2008). In the United Kingdom, analysis of the Workplace Industrial Relations Survey data identified both higher injury rates in workplaces where management did not consult over OHS, and lower rates when joint consultative arrangements were in place (Walters & Nichols 2007). Other studies have found a positive relationship between worker representation and improved OHS practices, such as tackling OHS issues and getting things done (Walters & Nichols 2007); paying closer attention to risks embedded in company processes, such as psycho-social workloads; and raising awareness of OHS issues and improving compliance with OHS statutory requirements (Popma 2008). No such
studies have been conducted in Australia in recent times, although Biggins and Holland's (1995) findings are consistent with the international studies. A feature of these international studies is that effective worker involvement also involves trade unions, and direct employee participation has not been shown to have an equivalent impact (Walters & Nichols 2007).

A three-step process is thought to explain why unionised workplaces with active worker involvement result in lower injury rates and more effective preventative approaches to OHS (Walters & Frick 2000). First, workers draw on union resources for expertise and training, enabling an informed, independent voice that can be exercised without fear of discrimination. Both the quality and quantity of such training have been shown to be crucial to worker representatives developing and being integrated into workplace health and safety in European studies. Second, the independent voice provided by unions, when coupled with additional work activities such as hazard identification (made possible because of the knowledge and expertise gained from the union), helps shape the OHS management system, including its responsiveness to OHS problems. Third, the nature of the OHS management system will in turn determine the extent to which hazards are identified and either removed or controlled (Walters & Frick 2000). Other explanations for the direct link between reduced injuries and union-supported worker representation emphasise the greater knowledge of the work environment and the associated risks that are held by workers compared with their managers. Also, worker representatives can act as 'watchdogs' on managers to ensure that the health and safety interests of their constituents are not compromised by a management focus on maximising production and profit – which may be prioritised above optimal OHS management’ (Loudoun & Walters 2009: 181).

Walters and Nichols (2007) caution that there are preconditions to effective worker representation and consultation. These include legislative support for the role of OHS representatives; demonstrable senior management commitment to both OHS and participative approaches, as well as the capacity to support participative approaches; competent identification, evaluation and control of risks by management and workers; trained and informed autonomous representatives supported by external unions; and consultation and communication between the OHS representatives and those they represent. The discussion below focuses on the first of these preconditions.

In Australia, there is no systematic collection of data on the number or location of workplace OHS representatives or joint OHS committees; however, the limited evidence suggests that OHS representatives are only found in unionised workplaces, and that the numbers have diminished substantially since the mid-1980s (Quinlan, Bohle & Lamm 2010; ABS 2011a). The weakening of trade unions has meant that the institutional infrastructure – including access to independent expertise, training and support in disputes over OHS – has slowly eroded in Australia, thereby undermining participative processes (Johnstone, Quinlan & Walters 2005). Limited overseas evidence suggests that a similar pattern of decline is occurring – for example, in the United Kingdom, the WIRS points to a fall in the number of workplaces undertaking consultation over OHS matters between 1998 and 2004.
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(Walters 2011). In Sweden, where legislation has supported worker OHS representation for almost a century, the number of workplace representatives has remained relatively stable, but they have reported greater levels of harassment and lower levels of resources under the less favourable political and labour market environment that has emerged over the past decade (Frick 2011).

Legislative support for OHS worker representation is thus insufficient when other institutional and political settings are hostile to unionisation and worker involvement. A Victorian survey of more than 800 OHS representatives, for example, reported that 32 per cent had been intimidated or bullied by their employer and/or manager for raising OHS issues (Victorian Trades Hall Council 2004: 11). Similarly, a survey of 41 584 workers (mostly union members) undertaken by the ACTU reported that 27 per cent of respondents agreed with the statement that 'employees who speak out about issue as safety are frowned upon'. A parallel public survey of 1000 workers found that 26 per cent agreed with the same statement (ACTU 2011). A smaller, national survey of 762 managers (54 per cent) and non-managers (46 per cent) conducted by Safe Work Australia drew more positive results: 90 per cent of respondents agreed that they were 'not afraid to challenge unsafe situations or unsafe work practices' and a similar proportion (89 per cent) agreed that 'employees are encouraged to raise health and safety concerns in your workplace' (Job & Smith 2011).

To overcome the perception of disadvantage that flows from voicing OHS concerns, the Victorian Occupational Health and Safety Act 2004 was amended in 2009 to strengthen the protection against organisations that discriminated against workers who raised OHS issues. A large stevedoring company was the first to be prosecuted under this provision; it was fined A$180 000 in 2011 for having suspended and threatened to dismiss a worker (who was also an OHS representative) who had refused to use a new method for unloading steel from vessels, because the OHS committee had not been consulted before its introduction (a legal requirement), and he and other workers were not familiar with the new process (OHS Alert 2011). The Fair Work Act 2009 also protects workers who are adversely affected for raising OHS issues, as we noted in Chapter 5. This protection was demonstrated by a recent Federal Court decision granting an injunction preventing a large manufacturer from giving a final warning on dismissal to a health and safety representative following disagreement over unsafe practices (Automotive, Food, Metals Engineering, Printing and Kindred Industries Union v Visy Packaging Pty Ltd (No. 2). These two examples illustrate the need for demonstrable enforcement of the employment rights of OHS representatives to support their OHS activities. Without such support, workers will continue to be reluctant to voice concerns or become OHS representatives.

We now move to consider the second major barrier to worker involvement in improving OHS: the capacity for employees to be represented on these issues in view of the changing nature of employment and the low incidence of OHS representatives across Australian workplaces. The growth in precarious employment, along with greater job insecurity experienced by permanent employees, has produced an environment in which an increasing proportion of the workforce are either excluded from OHS participatory processes or are prevented from participating due to fear of job
loss. For example, Keegel and colleagues (2010) found that casual employees were least likely to participate directly in OHS issues – for example, through conversations with management – as well as through representative mechanisms. Union members were also found to be two-and-a-half times more likely to be involved in direct forms of participation than non-union members, suggesting that even direct participation may be contingent upon unionisation. Underhill’s (2008) survey of temporary agency workers in Victoria found that a substantial minority – around one in four – reported being either dismissed for raising OHS concerns, or did not voice their concern for fear of dismissal; a similar proportion found their concerns were ignored when raised. Host employees – often resentful about the presence of agency workers, whom they perceived as a threat to their own employment – were also reluctant to incorporate them into OHS committees or represent them in relation to host OHS issues. Consultation over OHS within temporary agency firms has also been found to be problematic, with downward communication rather than consultation being most common (ACREW 2007). Other practical impediments to the involvement of precarious workers in workplace OHS issues also exist. Part-time workers (including part-time casuals) are less likely to be engaged in workplace issues, less likely to have received appropriate training and, in the case of workplaces where worker involvement was discouraged, less likely to risk their employment or discrimination by becoming involved in representative processes (Johnstone, Quinlan & Walters 2005).

The growth in outsourcing and the resulting presence of multiple employers in a single workplace complicate the issue of establishing employee representation in OHS, as well as which employer should respond to the concerns raised. As Johnstone, Quinlan and Walters (2005: 95) observe, worker OHS representation and joint OHS committees presume an identifiable and relatively stable group of employees located together or in very regular contact, and working for a single employer...new work patterns break this nexus or on OHS weaken it to the point where it would be extremely difficult for these mechanisms to be used effectively.

The model national OHS laws are intended to overcome these complexities; however, they presuppose the presence of workplace OHS representatives. As we have demonstrated, this has been undermined by declining unionisation. While worker involvement in OHS has consistently been shown to improve workplace health and safety, the assumption that workers can exercise their voice regarding OHS issues without fear of discrimination and without union support is not well founded.

### Conclusion

The focus of this chapter has been on occupational health and safety outcomes in a changing work environment; however, it is clear that underpinning many of these issues are changes in the workplace relations environment and legislation. Over recent decades, the political economy of many developed countries has shifted markedly to
neo-liberal policies, which have promoted deregulation of the labour market and discouraged unionism — either directly through regulatory constraints on collective bargaining, or indirectly through encouraging employers to adopt more anti-union approaches. These changes have weakened workers' capacity and ability to respond to OHS issues, and have limited their access to legislated benefits and protections once they are injured. Precarious workers are more likely to be injured; workers with job insecurity are more likely to experience poorer health outcomes; and the changes in the nature of organisations and jobs have been accompanied by increased levels of job stress. The capacity of workers to respond to these issues through workplace consultative processes has diminished.

The regulatory settings for OHS in Australia have been relatively stable since the mid-1980s. The increased risks that have emerged have resulted mostly from the deregulation of the labour market and the subsequent increased power of employers to determine employment conditions without sufficient regard to OHS considerations. These changes in employment regulation arguably have undermined the intent of OHS regulation — such as employee involvement — while also creating new risks such as psycho-social hazards. In addition, these changes have created an environment where the risk and the associated costs of workplace injuries, which were intended to be borne by employers through workers' compensation systems, increasingly are borne by injured workers and the public health system. As we explained in Chapter 1, this is one of the consequences of the advance of neo-liberal ideas. In this way, the social inequalities in health experienced elsewhere are likely to become more pervasive in Australia, notwithstanding a universal health system to support workers once they are injured.

There are nevertheless indications that other developed economies have started to address some of these concerns. The European Parliament passed a non-legislative resolution on mental health in 2009, which included a call to employers to 'promote a healthy working climate, paying attention to work-related stress, the underlying causes of mental disorder in the workplace, and tackling those causes' (Leka et al. 2011: 1051). It also called on the European Commission to 'require businesses and public bodies to publish annually a report on their policy and work for the mental health of their employees on the same basis as they report on physical health and safety at work' (Leka et al. 2011: 1051). In Belgium, for example, employers are now required to regularly screen their organisation and collect data on antecedents of stress and well-being. But these developments are taking place in a socio-political environment with a tradition of social dialogue.

In Australia, where re-regulation of the labour market has been strongly resisted, even under a Labor government, the prospect of such an approach being adopted seems remote. Safe work practices and a healthy environment benefit employers, workers and society, yet OHS often remains a contested issue — or, in the case of both precarious workers and those subject to job stress, is simply overlooked. There is a need to reconsider the economic and social benefit of 'workplace flexibility' when the health effects are so pervasive.
Discussion questions

11.1 What are the three forms of precarious employment? How does their increasing prevalence potentially impact on workplace health and safety?

11.2 Discuss the implications of the rise of neo-liberal policies for the development of workplace health and safety.

11.3 Explain and evaluate the Economic and Reward Pressures, Disorganisation and Regulatory Failure (PDR) model as it applies in Australia.

11.4 'The consequences of the increasing precariousness of employment for workers' physical and mental health are not confined to the direct consequences of their employment insecurity.' Evaluate this statement.

11.5 How is employee voice linked to improving workplace health and safety, and worker health and well-being?

11.6 'Declining union density and the rise of precarious employment together threaten the cornerstone of the Australian approach to regulating workplace health and safety.' Discuss.