Independent Taskforce
on Workplace Health and Safety

SAFER WORKPLACES
Consultation Document

Contents

Chair's Foreword

Businesses, workers, unions, industry organisations and the Government invest significantly in workplace health and safety. There are many people throughout and beyond these organisations committed to workplace health and safety where hazards and risks are managed and people are kept and remain harm free.

But regrettably it is not as widespread as it needs to be. It is my strong belief that, individually and collectively, we owe it to our staff and work mates, our loved ones, and to New Zealand to keep people free from harm and ensure people return home without suffering work related injury or health issues.

So while there are many examples of good workplace health and safety commitment, our national statistics are sobering, unacceptable and ultimately unsustainable:

- over 100 people[1] die from workplaces accidents
- between 700 and 1,000 people die as a result of gradual work-related diseases
- over 6,000 people notify the Ministry of Business, Innovation and Employment of a serious harm incident in their workplace
- around 190,000 people claim medical costs from ACC as a result of being harmed at work — of these:
    - around 23,000 people[2] are injured seriously enough to be off work for more than a week
    - around 370 people are injured seriously enough to require hospital care and be diagnosed with a life threatening condition.
- New Zealand's workplace injury rates are about twice that of Australia and almost six times that of the UK
- as well as the emotional toll on families and communities the economic and social cost of work related injuries to our nation is around $3.5 billion dollars

Put another way the number of people harmed at work is about enough to fill Eden Park four times. This is simply not good enough so an independent taskforce has been set up to review the current health and safety system and make recommendations to government that will help to drastically reduce harm in the workplace.

It is a complex and challenging task and one we cannot do alone. We need your help and your input.

This document has been produced to provide background and information on what the Taskforce sees as some of the key issues combining to impact on health and safety in the workplace. As each issue is outlined questions are posed for you to respond to or use as prompts for your thinking and feedback.

The main thing is that you contribute so that we can make recommendations to government that are practical, implementable and decisively work towards reducing harm in the workplace.

---

1   This is a broader measure of workplace fatalities than those notified to the Ministry of Business, Innovation and Employment, which averages around 50 notifications per annum. Both these numbers also exclude road fatalities connected to work.
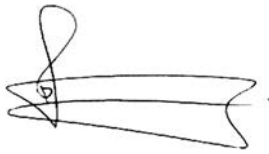
2   This figure differs from the Statistics NZ Work-related Claims figures for weekly compensation. It combines the Statistics NZ payment categories 'loss of earnings compensation' and 'rehabilitation payments' (where rehabilitation claimants are also receiving 'loss of earnings compensation').

Simply put, the Taskforce's recommendations need to change New Zealand's unacceptable and unsustainable workplace health and safety record. Achieving a change will require the combined efforts of government, businesses, workers, unions and society as a whole.

Together we have a fantastic and unique opportunity to make a real and lasting change to one of the most important aspects of everyone's lives — our health and safety. I encourage you to actively and constructively contribute to this process.

While I cannot say that all ideas and suggestions will be incorporated in our recommendations, I can guarantee that all contributions will be appreciated and given due consideration.

My sincere thanks in advance for making the time and effort to be part of this important opportunity.

Rob Jager
Chair
Independent Taskforce on Workplace Health and Safety

Purpose of this Consultation Document

The purpose of this consultation document is to provide you with information to help you to make a submission to the Independent Taskforce on Workplace Health and Safety. The document describes some of the key issues facing New Zealand's workplace health and safety system.

There are two ways you can tell the Taskforce what you think are the most important things that will improve New Zealand's workplace health and safety system:

- Make a written submission
- Attend a public meeting

Information about how you can participate in the consultation process can be found in the back of this document and on the Taskforce's website: www.hstaskforce.govt.nz

Your input is important to us, so please take the time to read this document. By making a submission you will be helping us make New Zealand's workplaces healthier and safer for everyone.

Key Dates

- **Taskforce holds public meetings**
  — early October to early November 2012

- **Submissions to the Taskforce close**
  — 16 November 2012

- **Taskforce reviews submissions and begins writing final report**
  — mid-November 2012 — February 2013

- **Final report presented to the Government**
  — 30 April 2013.

Introduction

1. The Independent Taskforce on Workplace Health and Safety was established by the Government to review whether New Zealand's workplace health and safety system remains fit for purpose. The Taskforce is also charged with recommending a package of practical measures that would be expected to result in at least a 25 per cent reduction in the rate of workplace fatalities and serious injuries by 2020.[3]

2. This consultation document presents:

    *   a framework for thinking about the workplace health and safety system
    *   the Taskforce's initial views about New Zealand's workplace health and safety performance
    *   a high level comparison between New Zealand's workplace health and safety system and outcomes and selected international jurisdictions
    *   a range of issues where the Taskforce is seeking public submissions and the process by which the Taskforce will be consulting on these issues

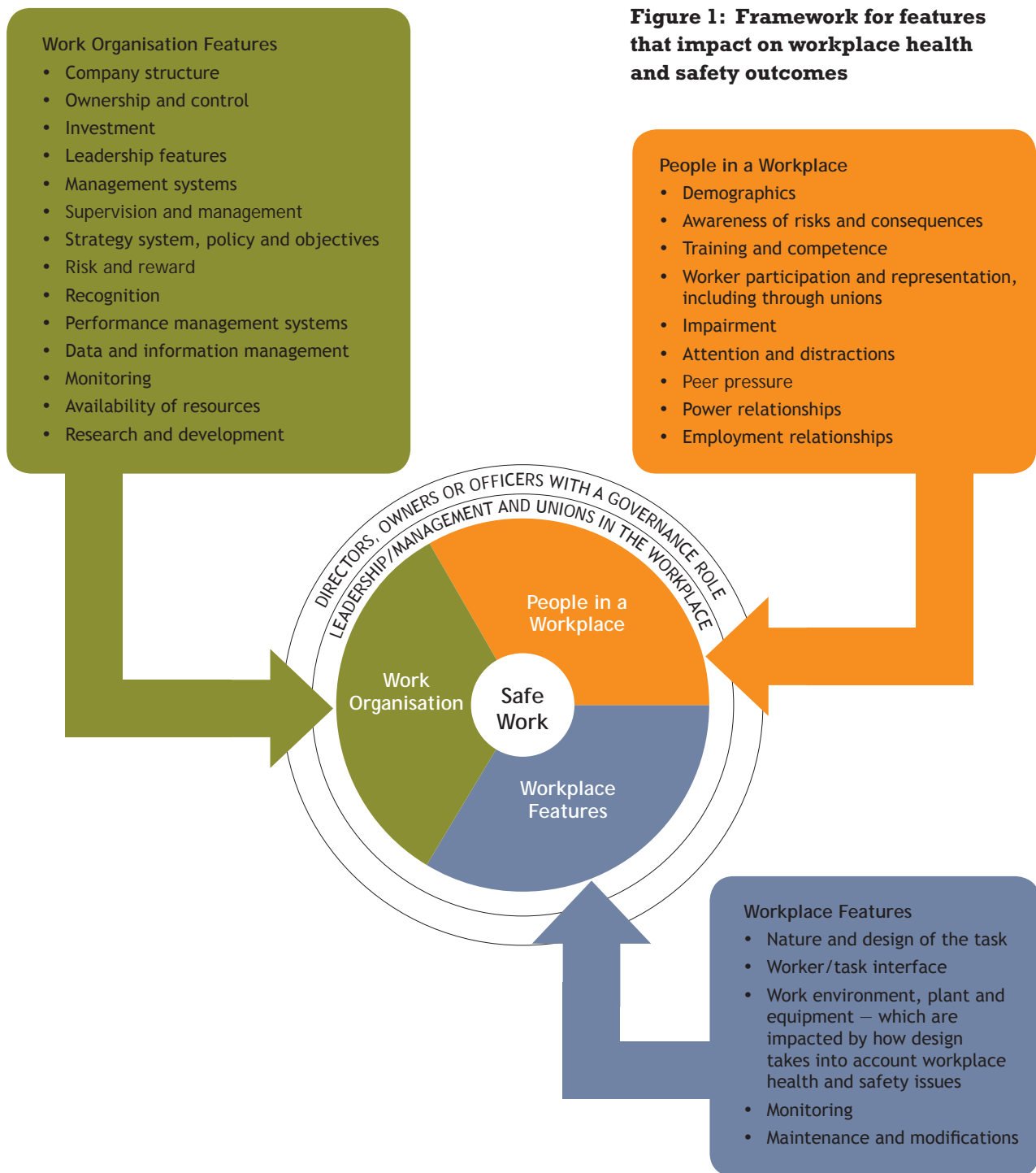## Framework for Workplace Health and Safety System

3. New Zealand's workplace health and safety system has at its heart 2,234,698 workers, employed by over 470,048 employers, of which 324,778 are self-employed, in 505,194 workplaces.[4] These workers, employers and self-employed are the individuals who are directly involved in workplace health and safety.

4. Every workplace needs a system to manage workplace health and safety issues. While the way each workplace operates will be different, a well-functioning system will have allocated collective and individual duties and responsibilities for:

    *   working in a healthy and safe manner
    *   ensuring the right tools, equipment and other resources are being used for the job
    *   organising and designing work in the right way
    *   providing leadership and oversight
    *   identifying, managing and monitoring risks and hazards

The workplace component of the overall workplace health and safety system

5. Figure 1 below presents the central component of the Taskforce's view of the overall workplace health and safety system. It shows a range of features that impact on workplace health and safety outcomes within workplaces. These features relate to:

    *   work organisation
    *   people in a workplace
    *   workplace features

6. These features combine together within a workplace to determine the workplaces' safety culture and collectively impact on the workplace health and safety outcomes for the workplace.

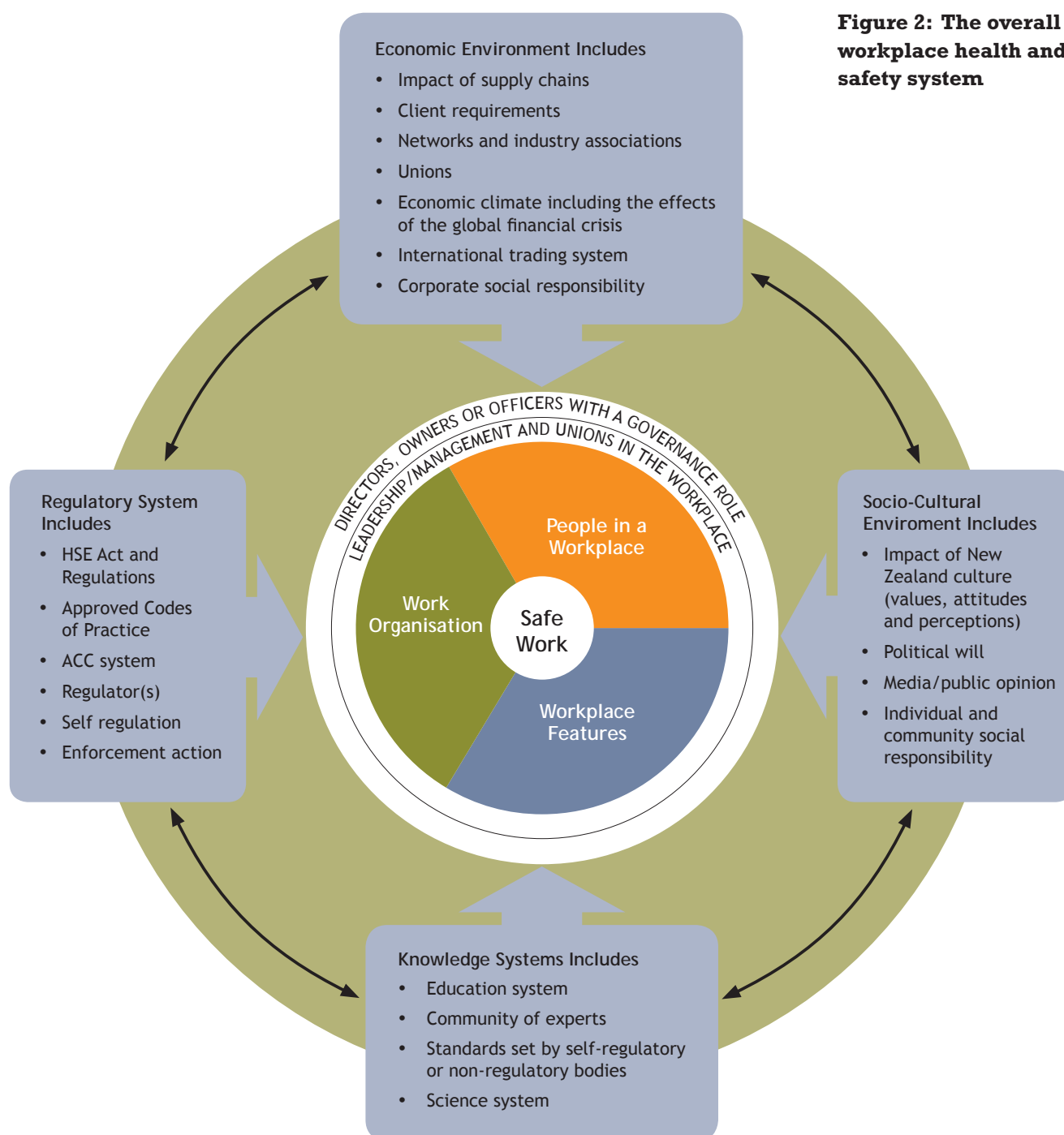3   The Taskforce's terms of reference are provided in Attachment 1.

4   (Statistics New Zealand, February 2011)

Work Organisation Features
- Company structure
- Ownership and control
- Investment
- Leadership features
- Management systems
- Supervision and management
- Strategy system, policy and objectives
- Risk and reward
- Recognition
- Performance management systems
- Data and information management
- Monitoring
- Availability of resources
- Research and development

Figure 1: Framework for features that impact on workplace health and safety outcomes

People in a Workplace
- Demographics
- Awareness of risks and consequences
- Training and competence
- Worker participation and representation, including through unions
- Impairment
- Attention and distractions
- Peer pressure
- Power relationships
- Employment relationships

DIRECTORS, OWNERS OR OFFICERS WITH A GOVERNANCE ROLE

LEADERSHIP/MANAGEMENT AND UNIONS IN THE WORKPLACE

People in a Workplace

Work Organisation

Safe Work

Workplace Features

Workplace Features
- Nature and design of the task
- Worker/task interface
- Work environment, plant and equipment — which are impacted by how design takes into account workplace health and safety issues
- Monitoring
- Maintenance and modifications

The overall workplace health and safety system

7. Individual workers, employers and self-employed in workplaces are influenced by a range of factors that are external to workplaces. Together these factors make up the overall workplace health and safety system within the Taskforce's framework. Figure 2 below shows these external factors, including:

- the economic environment
- the socio-cultural environment
- knowledge systems
- regulatory systems

Figure 2: The overall workplace health and safety system

Economic Environment Includes

- Impact of supply chains
- Client requirements
- Networks and industry associations
- Unions
- Economic climate including the effects of the global financial crisis
- International trading system
- Corporate social responsibility

Regulatory System Includes

- HSE Act and Regulations
- Approved Codes of Practice
- ACC system
- Regulator(s)
- Self regulation
- Enforcement action

Socio-Cultural Enviroment Includes

- Impact of New Zealand culture (values, attitudes and perceptions)
- Political will
- Media/public opinion
- Individual and community social responsibility

Knowledge Systems Includes

- Education system
- Community of experts
- Standards set by self-regulatory or non-regulatory bodies
- Science system

DIRECTORS, OWNERS OR OFFICERS WITH A GOVERNANCE ROLE
LEADERSHIP/MANAGEMENT AND UNIONS IN THE WORKPLACE

People in a Workplace

Work Organisation

Safe Work

Workplace Features

8.   No workplace operates in isolation from the broader economy. As such the economy has an important influence on firms and workers within firms. Workplace health and safety can therefore be influenced by external factors such as from other businesses that a firm supplies or is supplied by, from other organisations that they are a member of or interact with, from interactions with the government, and directly from their customers or end-users.

9.   The regulatory system sets out the roles and responsibilities of all parties in the workplace health and safety system including firms, workers, health and safety representatives and regulators. The regulatory system involves a balance of general

requirements, such as duties to provide a safe working environment and to work safely, with specific restrictions on how work occurs or how hazards and risks are to be managed.

10. The knowledge system is an important source of information and expertise for organisations. Workers can bring general and specific knowledge about workplace health and safety issues with them to their job (for example skills related to hazard identification and management and risk assessment) or can have specialist health and safety qualifications. Many organisations also rely on external health and safety professionals or standards setting bodies for workplace health and safety information, guidance or advice.

11. Finally, the socio-cultural environment is an important influence on firms, as they all need to reflect New Zealand's cultural expectations of workplace health and safety and are potentially subject to scrutiny through public fora if they do not meet society's expectations. Workplaces are a key part of any community and need to operate in a manner that reflects the broader communities' expectations.

12. These features are connected and in an effective workplace health and safety system will seamlessly reinforce each other, as well as directly impacting on the workplace. For example, the regulatory system sets expectations for workplaces, workers, employers and self-employed, and the relationships between these parties. The regulatory system can also set standards for health and safety professionals or for self-regulatory bodies, who in turn directly influence workplaces, workers, employers and self-employed. The regulatory system also sets some of the rules that impact on the economic environment and can influence the design of products, plant and equipment by setting requirements which will flow through into the form of new technologies that are used in workplaces.

13. New Zealand's national culture will impact on workplaces directly through the values attitudes and perceptions that individual workers, employers and self-employed bring with them to their workplaces from their community. The socio-cultural environment will also reflect this culture, often through the media, and create expectations about workplace health and safety that are placed on the government, regulators, the business community generally and the education system.

14. The role of government in the workplace health and safety system is multi-faceted. Political leadership from the Government promotes expectations about workplace health and safety performance. Government agencies are the employer of a large number of New Zealanders and have obligations to ensure workers are healthy and safe. Government is also a major purchaser of goods and services and can have influence through its purchasing decisions both directly and indirectly. An example of this is the current requirement for the All-of-Government contract for passenger vehicles, which requires that vehicles have four star or higher ratings from the Australasian New Car Assessment Program. As this is a higher safety standard than the average passenger vehicle in New Zealand currently, when these vehicles are sold there will also be spill-over benefits of increasing the overall safety standards of passenger vehicles in New Zealand. Finally, government sets the rules of the workplace health and safety system and determines the approach that is taken to enforcing these rules and the level of resourcing provided for support, guidance and enforcement activities.

New Zealand's workplace health and safety outcomes are poor, particularly by comparison to other countries

15. Statistics New Zealand reports annually on New Zealand's work related injury and fatality rates through the fatal and non-fatal Serious Injury Outcome Indicators (SIOI).

16. The most recent SIOI figures available for work related injuries (2008—2010[5]) show that New Zealand has:

     - 102 fatalities per annum at a rate of 4.1 per 100,000 workers
     - 369 non-fatal serious injuries[6], at a rate of 16.0 per 100,000 workers

17. Figure 3 below displays work-related fatality rates from 2002 to 2009 for New Zealand, Canada, Australia, Norway and the UK. These selected countries have similar health and safety approaches to New Zealand and we often compare ourselves to them. The UK has the lowest rates followed by Norway. Australia and Canada have similar rates. New Zealand has higher rates, and therefore a higher risk of death at work, than the other four comparable countries.

Figure 3: Work-related fatalities, selected OECD countries, 2002 to 2009[7]
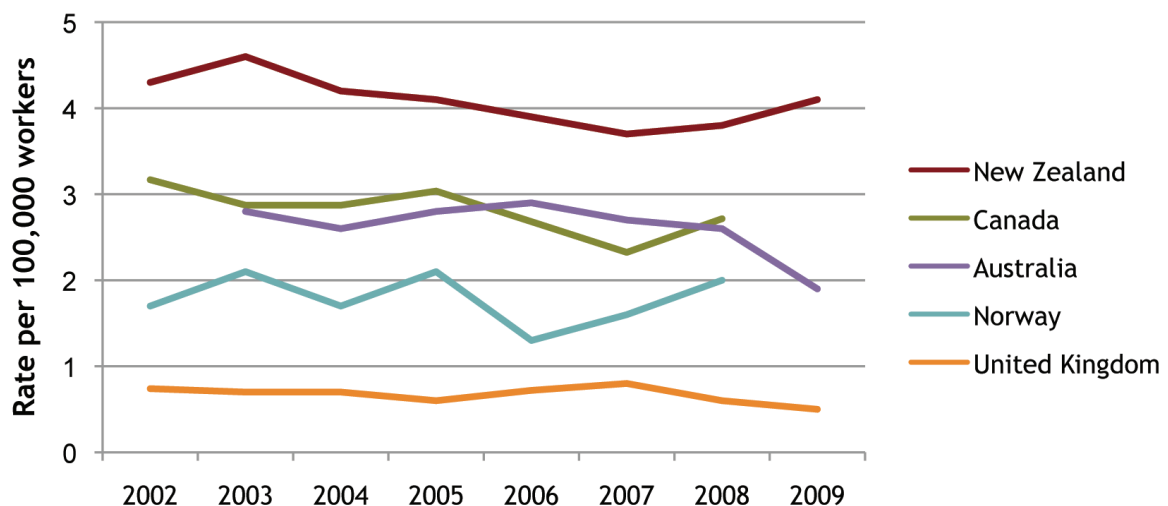
18. Australian research suggests that while the differences in industry composition between countries impact on overall injury rates, these differences do not change the relative performance of countries. In other words if New Zealand's industry composition was more like Australia's then our injury rates would still be worse than Australia's. Differences in data collection methods make it difficult to determine whether New Zealand is performing worse in all industries or whether some New Zealand industries are particularly poor performers compared to the same industry in other countries.
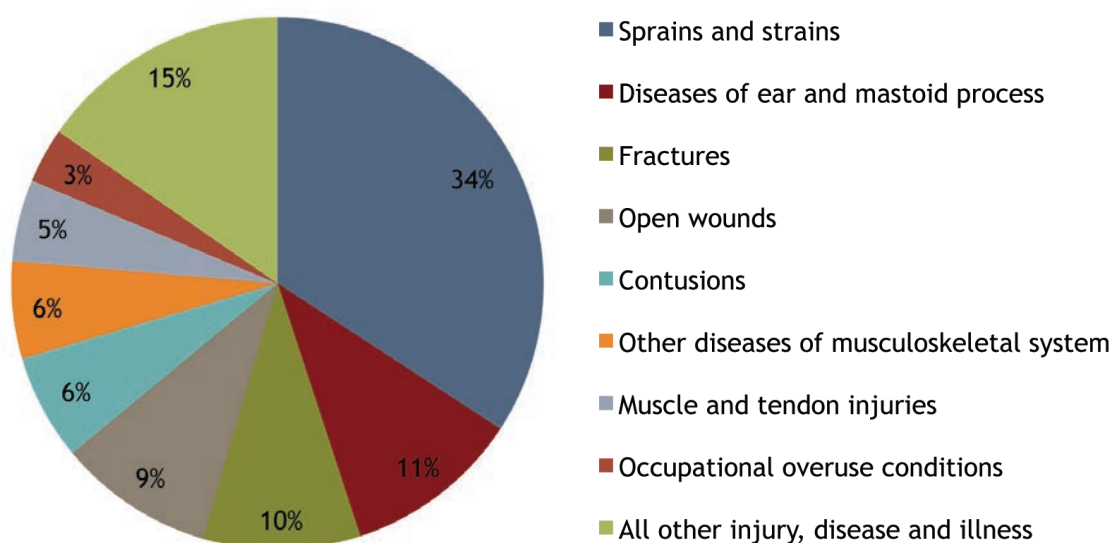
---

5   Data for 2010 are provisional, to be finalised later this year.

6   This subset is those ACC claims with a hospitalisation matched diagnosis with a 6% chance of death.

7   Sources: ILO Laborsta, The Health and Safety Executive Statistics 2010/11, Safe Work Australia (2012) *Work-related traumatic injury fatalities, Australia 2009—10.*

19. There are no official rates for workplace illness and occupational disease due to difficulties in measurement and attributing some illnesses or diseases to specific workplace causes. A 2004 National Occupational Health and Safety Advisory Committee (NOHSAC) study estimated that there are 17,000 – 20,000 new cases of occupational disease each year of which 2,500 – 5,500 were considered severe. The largest contributors were musculoskeletal disease, diseases of the ear (including noise-induced hearing loss), skin disorders, chronic respiratory disease, diseases of the digestive system and cancer (including lung cancer due to asbestos exposure). The report estimated there are 700 – 1,000 premature deaths each year due to work-related disease. The leading causes of death were work-related cancers, respiratory diseases and ischaemic heart disease (NOHSAC, 2004).

20. Between 2003 and 2008, approximately 76% of all entitlement claims in the ACC Work Account were made for injuries, and 23% for illness or disease (1% were classified as "undefined"). Figure 4 shows the leading causes of injury and disease over this period. The most numerous type of injury was sprains and strains, with 34% of all claims, followed by diseases of the ear and mastoid process (11%), fractures (10%), and open wounds (9%).

Figure 4: Total ACC work-related entitlement claims, by type of injury, illness or disease, 2003—2008[8]

- Sprains and strains
- Diseases of ear and mastoid process
- Fractures
- Open wounds
- Contusions
- Other diseases of musculoskeletal system
- Muscle and tendon injuries
- Occupational overuse conditions
- All other injury, disease and illness

Business size impacts on how the system operates

21. In New Zealand, self-employed and organisations employing 19 or less workers (small-to-medium sized enterprises or SMEs) made up 97.21% of all businesses as at February 2011.[9] 40.27% of all workers (including the self-employed and business owners) are employed by SMEs.

---

8   Source: Based on ACC entitlement claims data.

9   (Statistics New Zealand, February 2011)

22. SMEs are likely to interact with the workplace health and safety system, and the ACC system, in different ways to other workplaces. Many SMEs will be contracting to one or more larger enterprise and will be directly influenced by the larger enterprises' practices, systems, processes, requirements, expectations and standards. The working culture within SMEs may also be different to that of larger firms, with SME owners and staff potentially less likely to make ACC claims.

23. There is anecdotal evidence that the self-employed and SMEs are likely to have higher injury rates than medium-sized or large enterprises. The available data from Statistics New Zealand, ACC or the Ministry of Business, Innovation and Employment does not present a clear picture of injury rates or claim rates by firm size.[10] Lack of clear evidence about the impact of firm size is an issue as this information would help identify whether a different approach is needed for the self-employed and SMEs.

24. The Taskforce considers its framework is flexible enough to apply to businesses of all sizes and reflects the different features and worker outcomes of businesses of different sizes.

25. For example, the framework identifies the importance of how the regulatory and knowledge systems influence workplaces. These influences may apply in a different way for SMEs than larger enterprises. SMEs may be less likely to have specialist health and safety knowledge and may place greater reliance on external expert health and safety professionals to assist them with workplace health and safety matters.

26. *In responding to the issues raised in this consultation document, the Taskforce invites submitters to identify how those issues affect different sized businesses and whether a different response is required. Further discussion of issues relating to SMEs is located in paragraphs 259 to 275.*

Industry also impacts on how the system operates

27. ACC data shows there is a wide range in entitlement claim rates between the industries with the lowest entitlement claim rates and the industries with the highest entitlement claim rates.[11] The highest entitlement claim rates were for the fishing and forestry industries, with more than 35 entitlement claims per 1,000 workers each year. These were followed by mining, agriculture, construction and manufacturing, all of which had entitlement claim rates of more than 25 per 1,000 workers.

10   (National Occupational Health and Safety Advisory Committee, 2009) pp 31—38.

11   Source: Based on ACC entitlement claims data. Note – ACC data measures claims information rather than injury rates. Where an injury does not result in an ACC claim, then it will not be counted in the ACC data.

Figure 5: Rate of annual ACC work-related entitlement claims by industry, 2003—08 average[12]

Rate per 1,000 workers
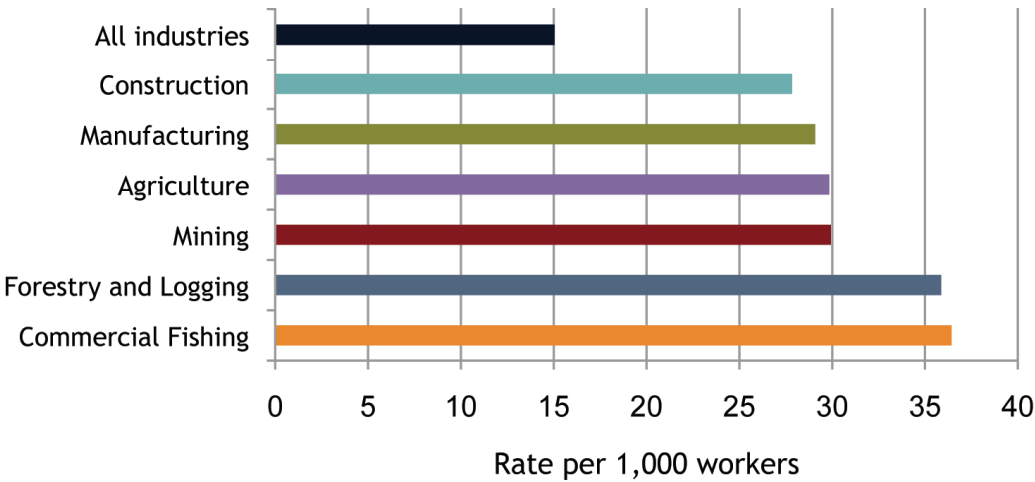
28.   While forestry, fishing and mining are all high-risk industries, the low numbers of workers engaged in these sectors means that they make up a relatively low proportion of all entitlement claims. By contrast, agriculture, manufacturing and construction are not only high-risk, but also have very large numbers of entitlement claims. Figure 6 below shows that these three industries accounted for 54% of all ACC entitlement claims made between 2003 and 2008.

Figure 6: ACC work-related entitlement claims: Proportions by industry 2003—08[13]

---
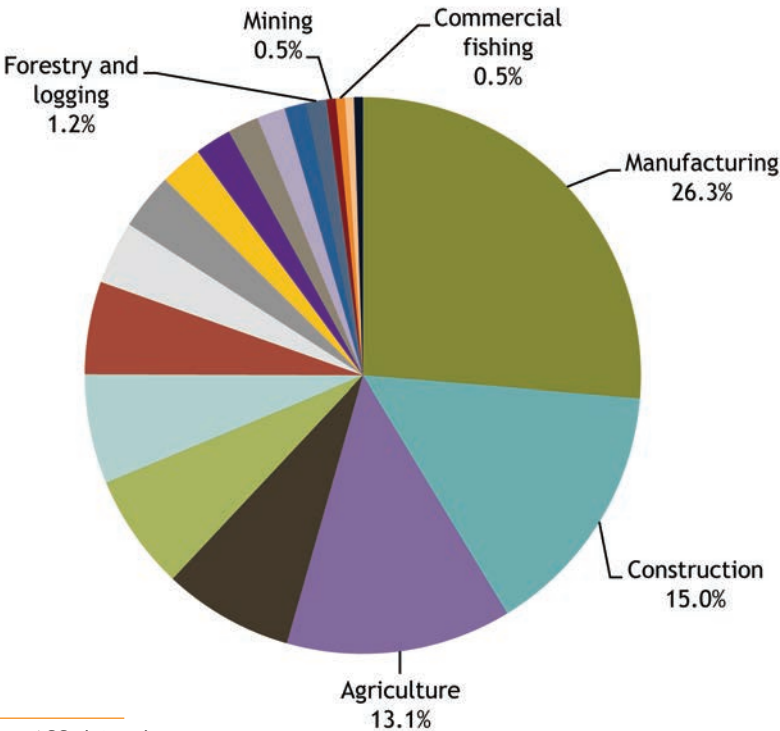
12   Source: Based on ACC claims data.
13   Source: Based on ACC claims data.

29. The construction, manufacturing, agriculture, forestry and fishing industries are the industry groups with the highest level of injury rates. They have action plans in place to reduce workplace injury rates.[14] These action plans have been developed in partnership between government and key industry stakeholders.

30. The role of industry associations is also important. The manner in which these industry associations engage on workplace health and safety issues, the level of capacity and capability they have and the way in which they involve worker representatives, may impact on what actions are needed to improve outcomes in specific industries.

31. *In responding to the issues raised in this paper the Taskforce invites submitters to identify how those issues affect businesses in different industries and whether there is a need for different responses for different industries.*

32. The Taskforce is also required to consider how a successor to the Workplace Health and Safety Strategy for New Zealand to 2015[15], the National Action Agenda 2010 — 2013[16], Sector Action Plans and the Occupational Health Action Plan can contribute more to improving workplace health and safety outcomes. *The Taskforce invites submitters to comment on the effectiveness of the Strategy, Action Agenda and Action Plans in contributing to improving workplace health and safety outcomes.*

Injuries, fatalities and health issues occur at different rates for different groups of people

33. Further information is provided on the demographics of who is injured, killed or has health issues arising from their work in paragraphs 55 to 62. This information describes a number of groups of workers who have particularly poor workplace health and safety outcomes.

34. *In responding to the issues raised in this paper, the Taskforce invites submitters to identify how those issues affect different groups of workers and whether there is a need for different responses for different groups of workers.*

How does New Zealand compare to other countries?

35. When assessing New Zealand's workplace health and safety performance it can be useful to compare ourselves to other countries, particularly those countries that are broadly similar to us. Comparisons can indicate how much better we could be performing and suggest where to look for examples of how to change New Zealand's health and safety system.

36. High-level outcomes indicate that New Zealand is not performing as well as other countries. This naturally leads to the question of why this is the case and what things are being done differently in other countries that may be contributing to their better outcomes.

37. A comparison of the overall structure of other countries' health and safety systems can identify key similarities and differences to New Zealand. A table describing the key features of New Zealand, Australia, the UK, Canada and Norway is included in Attachment 2.

38. It should be noted however, given the complexity of health and safety systems and individual national characteristics a comparison of this nature does not lead to

---

14   (Department of Labour, 2012a)

15   (Department of Labour, 2005a)

16   (Department of Labour, 2011a)

definitive conclusions about why other countries perform better. Different outcomes are likely to result from a combination of factors and the similarities and differences highlighted here are only intended to provide an indicative comparison.

Similarities and differences

39.   Countries used for comparison here are all developed market economies that have relatively good health and safety outcomes and are generally outperforming New Zealand. Norway and New Zealand are considerably smaller than the other three, but all five have broadly similar workforce characteristics. New Zealand's industry distribution does vary slightly, with a much larger proportion of people working in higher-risk primary industries, but research suggests that industry distribution does not account for a great deal of difference in injury and fatality rates.[17]

40.   The basic principles of health and safety legislation are broadly similar in most developed countries. With some variations the countries being compared here have adopted performance-based legislation characterised by broad general duties of care to provide a safe workplace. This kind of legislation specifies what must be achieved, rather than setting out specific steps of how to achieve it. Where more prescriptive rules are required (for example, for particularly high-risk industries), these tend to be included in regulations made under the primary legislation.

41.   Similarities can be seen in requirements for employers and other duty holders to identify and control hazards. In the UK and Norway this is strengthened by regulatory requirements to make formal risk assessments.

42.   There is a common acceptance of the need for employee engagement and participation in health and safety management, and while the emphasis varies between countries, the underlying rights and obligations of workers are also broadly similar.

43.   Key differences can be seen in the countries' approaches to worker compensation. While each country does have provisions in place to ensure that injured workers are compensated for work-related injury, the method to ensure this varies. New Zealand has a comprehensive, no-fault scheme, while the UK and Norway rely on a requirement for employers to take out injury insurance for their workers.

44.   In the UK this results in an extensive culture of litigation to determine who is at fault, while New Zealand workers do not have the right to sue for personal injury. Canada and Australia are characterised by a mixture of compensation models in different provinces or states, and generally a restricted right to sue.

45.   The other significant difference that is apparent from a comparison of these different systems is the institutional arrangements that countries use to administer and enforce the regulatory system. New Zealand has two public agencies, separating responsibility for health and safety regulation and worker compensation. Australian and Canadian jurisdictions have various models, including some combined regulator/compensation arrangements and some that are separated.

46.   These high-level comparisons are included here as an initial overview of what we might learn from other countries and what other models might be worthwhile to explore in greater detail.

47.   *In responding to the issues raised in this paper, the Taskforce invites submitters draw upon their knowledge and experience of health and safety in other countries, and to identify benefits in New Zealand adopting lessons from overseas.*

---

17   See for example: (National Occupational Health and Safety Commission, 2004)

Overview of the issues

48. The remainder of this consultation document discusses issues that the Taskforce considers are important features of the workplace health and safety system, or where specific feedback is sought. You are invited to comment on any issue you think is important for improving workplace health and safety outcomes, even if it is not specifically covered in the following sections.

49. The order and structure of these issues reflects the Taskforce's thinking at the present time. Some of the issues identified may be combined as the Taskforce's review progresses or it may become clear that an issue is not as significant as the Taskforce initially thought.

50. The order of presentation of issues is not a reflection of their significance or, necessarily, their importance. For example, while issues relating to the regulatory system and the regulators' roles and responsibilities are presented first, this does not mean regulatory changes will be appropriate to address all issues. For example, the Taskforce considers that culture may play an important role in our health and safety outcomes.

51. *The Taskforce invites submitters to identify what issues you consider are most important and to consider a wide range of options for improving the performance of the workplace health and safety system, including but not limited to regulatory change.*

52. The issues identified by the Taskforce are linked, for example, there may be elements of capacity and capability, worker participation and engagement, and measurement and data that apply to other issues. *The Taskforce invites submitters to include comments on these issues in their submissions on other issues, if you consider your comment best fits under the other issue.*

List of issues for submissions

53. The Taskforce is seeking feedback on the following issues:

- Who gets hurt, killed or suffers from ill-health or disease as a result of work?
- Regulatory framework
- Regulators' roles and responsibilities
- New Zealand's changing workforce and work arrangements
- Worker participation and engagement
- Leadership and governance
- Capacity and capability of the workplace health and safety system
- Incentives
- Influencing health and safety outcomes beyond one's own workplace
- Major hazards
- Health and hazardous substances
- Small to medium-sized enterprises
- Measurement and data
- Our national culture and societal expectations

54. Attached to this consultation document are the Taskforce's Terms of Reference, a table providing a high level comparison of New Zealand's workplace health and safety system with Australia, the UK, Canada and Norway, and a summary of the consultation questions for the above list of issues.

Issue Discussion

Who Gets Hurt, Killed or Suffers From Ill-Health or Disease as a Result of Work?

What's the issue?

55. Rates of injury, illness and fatality vary across New Zealand's workforce with some groups experiencing significantly poorer health and safety outcomes than others. While higher than average rates of participation in high risk industries and occupations are likely to contribute to demographic differences in outcomes, other factors too are likely to play a role. Better understanding of the underlying causes that may be contributing to differences in outcomes can create opportunities to improve New Zealand's workplace health and safety outcomes.

What's happening in New Zealand?

56. According to claims made to ACC for work-related injury in 2009[18]:

   • *Males are more likely to be injured or killed at work than females.* They are more than twice as likely to be seriously injured, and account for 95% of work-related fatalities

   • *Older workers are more vulnerable than other age groups.* While workers aged 54 and under suffer serious injuries at a rate of about 14 per 1,000 full-time equivalent (FTE) workers, this increases to 18 for 55—64 year olds and 49 for workers aged 65 and over. Fatalities present a similar pattern. Workers aged 55 and older account for 60% of fatalities. Many occupational diseases also disproportionally affect older workers, such as occupational cancers

   • *Māori workers are more likely to be seriously injured at work.* At a rate of 18 per 1,000 FTE, Māori have worse outcomes than Pacific (15 per 1,000), Pakeha (14 per 1,000) or Asian (6 per 1,000) workers. 'Other' workers fare worst, with a rate of 33 per 1,000 FTE[19]

   • *Self-employed workers are more likely to be injured at work than workers in employment relationships.* While self-employed people only account for 18% of all work-related claims, their rate of injury is almost twice as high

57. Occupational disease data relating to specific demographic groups is more limited. However many occupational diseases are known to disproportionally affect particular populations, such as males and older workers.

58. Anecdotal evidence suggests that other sub-populations may also be disproportionately at risk of injury. Employees new to a position or engaged in temporary, casual or seasonal work may be particularly at risk. In addition, young workers are often focussed on as a group at risk.

---

18   (Statistics New Zealand, 2010)

19   The 'other' category includes Middle Eastern, Latin American, African and other ethnic groups.

59. The differences in outcomes observed across these demographic groups may, in large part, reflect their higher rates of employment in industries and occupations that carry a higher risk of injury. For example, Māori workers are over represented in high risk industries like forestry and construction, as are male workers. Other factors are also likely to play a role however, including language barriers and natural aging processes.

What's happening overseas?

60. The patterns of injury detailed above are not unique to New Zealand. For example, males are significantly more likely to be injured or killed across OECD countries. In the UK, higher rates of injury are also of particular concern for less experienced workers.[20]

61. There are also variations in outcomes across other comparable countries. In Australia, rates of injury also vary significantly by age. However Australian statistics show that the highest rate of injury occurred in the 45—54 year old age group, with those aged 65 and over having the lowest rate of any age group.[21]

Tell us what you think

62. Injury, disease and fatality rates vary across sub-populations, with some groups identified as being significantly more at risk than others. While concentration among particular occupations and industries may be contributing to these outcomes, there may be other factors involved. Identifying other contributing factors can help to inform efforts to improve New Zealand's overall health and safety outcomes.

Questions

Q1. **What do you think is driving the differences in workplace health and safety outcomes for different demographic groups?**

Q2. **What changes are needed to the workplace health and safety framework to improve outcomes for demographic groups with higher than average rates of injury and illness?**

20   (Health and Safety Executive, 2011)
21   (Australian Bureau of Statistics, 2010)

Regulatory Framework

What's the issue?

63.   There is an opportunity to update the Health and Safety in Employment Act 1992 (HSE Act)and supporting legislative infrastructure to reflect best practice legislative design and implementation, evolving workplace relations, and the need for continuous improvement in workplace health and safety standards.

What's happening in New Zealand?

The regulator

64.   The regulator has a pivotal role in ensuring that the objectives of the law are achieved. Typically the regulator sets, monitors and enforces standards, and provides guidance. Generally accepted practice is that regulators take a 'fit for purpose' approach to ensuring compliance, from encouraging voluntary compliance through providing guidance and education, to sanctioning law breakers through a range of regulatory mechanisms. Regulators can also have a role in providing leadership and direction, and in ensuring a level playing field domestically and internationally.

The regulatory approach

65.   In common with a number of other countries New Zealand's occupational health and safety regulatory framework is broadly based on the 1974 Robens approach[22]. This model seeks to achieve a balance between State and self-regulation. An underlying assumption is that those who create or work with the risks to occupational health and safety are best placed to identify and manage the risks, but there needs to be a robust regulatory backstop. This has resulted in legislation that imposes duties, particularly on employers but also employees, along with a regulator that sets, monitors and enforces standards and provides guidance. There is also an important role for employer and employee participation through tripartite governance and standard setting processes as well as engagement of health and safety representatives at the workplace level.

66.   Both the UK and Australia have recently reviewed their regulatory frameworks. The Robens approach is still regarded as appropriate, but the way the approach has been reflected in legislation and implemented has evolved significantly across countries which New Zealand often compares itself to. New Zealand may not have implemented the approach as fully as other countries. Drawing on these developments and experiences in New Zealand, there is likely scope to update and enhance the effectiveness of our regulatory framework.

Performance-based regulation

67.   Robens-based regulatory frameworks are often described as performance-based. This description can be applied to both the duties, which describe the outcomes sought rather than the means to achieve them, and regulations which generally set outcome-based standards rather than prescriptive 'must do' requirements.

68.   The strength of performance-based regulatory frameworks is that they provide flexibility and thus accommodate new and innovative ways of achieving the regulatory

---

22   Lord Robens produced a major report into workplace health and safety in the UK that led to the development of the Health and Safety at Work Act 1974 and the formation of the Health and Safety Executive to administer it.

objectives. The weakness of this approach is that it can create uncertainty in terms of what a regulated entity needs to do to comply with the law.

69.   It also requires a high degree of regulatory and specific knowledge and experience among both those with duties under the framework and those who enforce it, which many firms, especially smaller ones, tend not to have. International best regulatory practice is that performance-based regulatory frameworks are underpinned by comprehensive, up-to-date and authoritative guidance to provide certainty to those who require it.

Risk-based regulation

70.   New Zealand's regulatory framework is based on hazard identification and management whilst other countries' regimes are risk-based and align with the overall international approach to risk management[23]. This may appear to be a semantic distinction as the duty on primary duty holders is to take 'all practicable steps' to ensure health and safety and this requires them to assess the risk and consequences of an adverse event occurring, and to eliminate or minimise the risk having regard to the costs and benefits of doing so.

71.   Within the context of risk-based regulation key issues are how much risk is tolerable (to society as well as workers and business) relative to the cost of mitigating it, and to what extent regulated entities are required to put in place formal, documented risk assessment and management systems. Both of these issues are discussed below.

What's happening overseas?

Setting higher standards for health and safety

72.   In setting standards and undertaking enforcement regulators can focus on what is the 'minimum', or something above that. At least one country, Australia, seems to have set the bar at a level higher than the minimum. Specifically, the 2011 Model Health and Safety Act (Model Act)[24] has a principle that '… regard must be had to the principle that workers and other persons should be given the **highest level of protection** against harm…as is reasonably practicable'. This may translate into higher standards and more active enforcement.

Creating a legal framework for an effective regulator

73.   There are three necessary conditions for an effective regulator: a clear role and functions, the legislative tools to carry out the functions, and the capacity and capability (people, resources and systems). Issues of capacity and capability are addressed in paragraphs 105 to 110 and 172 to 187.

Clarifying the role and functions of the regulator

74.   A notable feature of the Australian Model Act is that the role and functions of the regulator are clearly specified, unlike the HSE Act which is largely silent. Functions in the Model Act include:

• monitoring and reporting on the operation and effectiveness of the Act, including collecting and publishing statistics
• providing and coordinating the provision of advice and information on health and safety matters, promoting and supporting education

---

23   See for example ISO31000 Risk Management.

24   The Model Health and Safety Act is at various stages of being implemented in different Australian states.

- monitoring and enforcing compliance with the Act
- fostering a cooperative and consultative relationship between duty holders and those to whom they owe duties and their representative

Compliance and enforcement

75. International best regulatory practice is that regulators take a graduated approach to ensuring compliance with the law, having regard to the characteristics of the regulated entities. For example those who are willing to comply with the law but require clear information on what to do to comply are treated differently to those who have demonstrated that they don't want to comply.

76. The HSE Act provides a reasonably complete set of powers to the regulator, including the making of regulations and approved codes of practice, improvement and prohibition notices, infringement notices and criminal prosecutions, and fines.

77. Given that the regulator has a range of powers, issues associated with ensuring compliance with the law may have more to do with how (and how often) those powers are used, publicity given to enforcement decisions and regulator capacity and capability. However, it is notable that the Australian Model Act provides some additional powers to the regulator (non-disturbance notices and enforceable undertakings), and also authorises health and safety representatives to issue provisional improvement notices.

78. In addition, while the New Zealand regulator issues guidance there is no specific provision providing for guidance in the HSE Act. The Building Act 2004, another performance-based regulatory regime, specifically authorises the regulator to issue guidance and also to make determinations in situations of doubt or dispute.

79. Levels of compliance are influenced by the likelihood that non-compliance will be detected and that penalties will apply. It is notable that an increasing number of overseas jurisdictions are applying broader criminal and civil sanctions to the workplace including consideration of manslaughter and specific offences of corporate manslaughter. These measures can be accompanied by requirements under Companies legislation for exercising due diligence in identifying and managing risk, and reporting of health and safety performance in annual reports, and will be intended to have a significant deterrent effect.

Creating more regulatory certainty

80. Certainty in terms of what is required to comply with the law is a pre-requisite for effective self-regulation and can be achieved through regulations, approved codes of practice, formal standards and guidance (including authoritative advice). In developing and deploying these instruments regulators need to be aware of two risks: (a) setting rigid rules that unduly inhibit innovation and an ability of regulated entities to adopt compliance strategies that are best suited to their workplaces, or (b) not providing sufficient clarity on what is required to comply.

81. A useful approach is to provide 'safe harbours' i.e. 'how to' guidance which, if complied with, is *prima facie* evidence of compliance with the law, but which does not preclude alternative approaches. However, in some situations such as high hazard environments, a 'must do' approach may be required. Knowing when and how to make these judgments is an on-going challenge for regulators around the world. In New Zealand some safe harbours and advice are available, but it is not comprehensive or up-to-date and this has been identified as a material concern.

82. Another approach adopted in some jurisdictions is the reverse onus of proof whereby the duty holder has a legal defence if they can demonstrate they applied due diligence

to prevent an offence being committed. Such an approach has the advantage of creating incentives for organisations and directors to be more proactive in seeking and acting on competent advice, undertaking audits and other formal monitoring activities.

83. Given New Zealand's experience, it may also be useful to provide a more prescriptive approach where it is known that using an accepted practice will make work safer, particularly in firms with low capacity for assessing alternatives.

DUTY HOLDERS AND DUTIES

Modernising and extending the definition of Primary Duty Holder

84. In the HSE Act and legislation in comparable countries the primary duty holder is defined as the 'employer'. However, the traditional employer/employee relationship is now only one of the many ways that work and workplaces are organised, rather than the dominant way. Australia has modernised its legislation to reflect this, by broadening of the primary duty holder to 'a person conducting a business or undertaking' rather than an employer. In this context 'persons' include designers, manufacturers, installers and sellers.

Creating a duty on those in a governance capacity (such as directors)

85. Reflecting the important role that governance plays in setting health and safety expectations in the workplace, Australia has also created a new duty holder, being an officer of the person conducting a business or undertaking. Officers include directors. The duty holder must exercise 'due diligence' to ensure compliance with the law. New Zealand law does not impose a comparable duty.

Requiring formal risk assessment and management systems

86. Risk-based regulation requires a systematic approach to assessing the risk and consequences of an adverse event occurring, and either eliminating the risk or putting in place control measures to manage it to acceptable levels, having regard to the costs and benefits of mitigation.

87. Primary duty holders have duties to eliminate or reduce harm, and must therefore make risk-based assessments. Regulatory best practice, applied in countries such as the UK, Canada, Sweden and Norway, is that primary duty holders are expected to undertake formal risk analysis and establish formal risk management programmes (although there may be exceptions to having written systems for very small firms). New Zealand has no such requirement.

Creating a presumption in favour of higher health and safety

88. In common with other many other countries, New Zealand has an 'all practicable steps' type of standard that must be applied by primary duty holders in relation to their duty to ensure health and safety. The Australian Model Act modifies the interpretation of its standard (couched as 'reasonably practicable') to the extent that 'Although the cost of eliminating or minimising the risk is relevant in determining what is reasonably practicable, there is a clear presumption in favour of safety ahead of cost.'[25] New Zealand law creates no such presumption.

---

25   (Safe Work Australia, 2012a)

Tell us what you think

89.   The issues that have been identified based on international comparisons are all relevant to New Zealand. Relative to some other jurisdictions our HSE law:

- has a traditional employer-employee focus
- has weaker provisions for employee participation
- has no explicit duties on designers of buildings and systems, consultants and other advisors or agents
- does not cover the duty of care on directors in as robust a manner as in other countries
- has not adopted a requirement for formal health and safety management systems
- is neutral on what level of workplace health and safety we aspire to

90.   At the operational level, there is a recognised need to create greater regulatory certainty, for example through more and better guidance from the regulator and greater clarity about the role and functions of the regulator. A question remains whether the regulator has a sufficiently broad suite of dispute resolution mechanisms and powers to deliver fit for purpose responses to non-compliance.

Questions

Q3.   What do you think the challenges are with the current workplace health and safety regulatory framework?

Q4.   How do you think the workplace health and safety regulatory framework could be improved?

Regulators' Roles and Responsibilities

What's the issue?

91. Government functions and roles aimed at reducing workplace harm are spread over several government agencies. The agencies that administer and regulate workplace health and safety have diverse mandates and sometimes take different and potentially inconsistent approaches to their work. Coordination, integration across agencies, capacity and capability are essential for the agencies to be effective.

What's happening in New Zealand?

There are a number of government bodies and agencies with workplace health and safety roles

92. There are four key pieces of legislation related to workplace health and safety and injury prevention:

- The Health and Safety in Employment Act 1992, which relates to workplace health and safety
- The Hazardous Substances and New Organisms Act 1996, which relates to hazardous substances
- The Accident Compensation Act 2001, which relates to the rehabilitation and compensation of accident victims
- The Employment Relations Act 2000, which interfaces with the Health and Safety in Employment Act 1992

93. Government functions and roles aimed at reducing workplace harm are spread over several government bodies and agencies in New Zealand.

94. The Workplace Health and Safety Council is a tripartite body intended to lead and oversee the implementation of the Workplace Health and Safety Strategy. It was established in 2007, in part to meet International Labour Organisation Convention 155, which identifies a need for a central body to assist in ensuring the coherence of policy on workplace health and safety at a national level. The Council provides leadership and co-ordination, advising government on workplace health and safety legislation, strategy, standards and policies. The Workplace Health and Safety Council has little visibility and limited impact on lifting accountability for health and safety outcomes. *The Taskforce invites submitters to comment on how the roles and responsibilities of a body like the Council could be delivered more effectively.*

95. The agencies involved have a range of legislative mandates, responsibilities, objectives and levers available to them to influence workplace health and safety decisions and behaviours. The agencies are:

The Ministry of Business, Innovation and Employment

- Primary administrator[26] of the Health and Safety in Employment Act 1992
- Administrator of the Employment Relations Act 2000
- Administrator of the Accident Compensation Act 2001

---

26   The administering agency is generally responsible for the operation of the legislation and for making recommendations to the Government of the day about improving it. It does not mean the agency is responsible for the day-to-day operation (regulation) of the legislation.

- Primary regulator[27] for workplace health and safety
- Enforcer[28] of both the Health and Safety in Employment Act 1992 and the Hazardous Substances and New Organisms Act 1996 in relation to workplaces

The Ministry for the Environment
- Administrator of the Hazardous Substances and New Organisms Act 1996

The Accident Compensation Corporation
- Quasi-regulator responsible for workplace injury prevention activity, enabling and motivating businesses to reduce workplace harm

The Environmental Protection Authority
- Regulator of the Hazardous Substances and New Organisms Act 1996 (Other agencies are responsible for enforcing that act)

The Civil Aviation Authority
- Designated administrator, regulator and enforcer of Health and Safety in Employment Act 1992 for aircraft while in operation
- Enforcer of Hazardous Substances and New Organisms Act 1996 for aircraft

Maritime New Zealand
- Designated administrator, regulator and enforcer of the Health and Safety in Employment Act 1992 for ships while in operation
- Enforcer of Hazardous Substances and New Organisms Act 1996 for ships

The Commercial Vehicle Investigation Unit (Police)
- Enforcer of both the Health and Safety in Employment Act 1992 and the Hazardous Substances and New Organisms Act 1996 for commercial vehicles

Local Government and the Ministry of Health
- The involvement of local and regional councils and the Ministry of Health in health and safety is important to acknowledge. Some specific health and safety issues endanger workers and the public. For example, building safety, food safety, smoke-free environments, biological hazards, radiological hazards and environmental pollution. For these and other health and safety issues, jurisdiction may be shared or may pass to local/regional councils or the Ministry of Health

Regulators rely on most businesses performing well voluntarily

96. The majority of Health and Safety Inspectors work for the Ministry of Business, Innovation, and Employment. There are currently fewer than 150 Health and Safety Inspectors. They visit about 10,000 workplaces every year. Contact with the regulators is unlikely for the majority of businesses, so the system relies on them performing well voluntarily. This assumes they are able and willing to do so.

97. The regulators aim to support people and businesses to comply with the law by engaging directly with them individually and collectively. They also promote their expectations and warnings through the media and their publications. The effectiveness of the regulators is dependent on the clarity and efficacy of their strategies and plans, and their capacity and capability to implement them.

---

27   The Regulator is resonsible for ensuring that the legislation is being complied with. Generally this involves clarifying, reviewing, and enforcing its application; however, enforcement is sometimes the responsibility of another agency.

28   Enforcement involves monitoring compliance with the law through inspections and investigations. Enforcers influence compliance by engaging with companies, and if necessary taking legal action to compel compliance or punish non-compliance.

98. Workplace health and safety regulatory interactions are generally focused on those areas of greatest risk or greatest cost to New Zealand. The regulators' annual reports[29] identify the number of interactions with businesses, but do not explain whether those interactions are effective in successfully detecting and resolving issues, and tend to remain silent on what enforcement tools were used.

99. Employee participation, in particular by particular health and safety representatives, is intended to support the workplace health and safety system and the role of the regulators. However, it is unclear how effective employee participation is and how well health and safety representatives work with the regulators.

Mechanisms are in place for agency coordination but may not always be effective

100. While this multiple agency approach is intended to use the specialist knowledge of each agency, it can also to lead to public confusion about who does what. The Workplace Health and Safety Council has noted there is currently a lack of clarity in the area of regulatory roles in New Zealand and that this may have implications for health and safety outcomes[30]. The recent merger of the Department of Labour into the Ministry of Business, Innovation and Employment may create further confusion about who is leading workplace health and safety regulatory development and enforcement. Anecdotal evidence suggests there is still confusion after the discontinuation of the "OSH" brand more than seven years ago. An agency whose sole focus is workplace health and safety, with matching branding, may alleviate this confusion.

101. A number of mechanisms are designed to support interagency cooperation and alignment. These include:

• legislation requiring agencies to work together
• Memorandums of Understanding (MOUs) between agencies
• whole of government injury prevention strategies
• the tripartite Workplace Health and Safety Council

102. While agency operations frequently complement and reinforce each other, this is not always the case. The Taskforce understands that there is also:

• inconsistent practices across agencies
• overlapping jurisdictions
• a lack of coordination in activity between agencies
• ambiguity regarding the lead workplace health and safety agency for the public in relation to specific events

103. While ACC is not strictly a regulator its incentive schemes and injury prevention programmes are an important part of the workplace health and safety system. The Taskforce is to consider a number of aspects related to how the ACC system impacts on health and safety outcomes, including the incentives provided by the ACC system, ACC's role in workplace injury prevention and rehabilitation, how ACC supports the New Zealand Injury Prevention Strategy and how ACC engages with the Ministry of Business, Innovation and Employment's health and safety inspectorate and other government agencies. Making recommendations in relation to providing more choice for employers in ACC or recommending changes to the no-fault nature of New Zealand's accident compensation system is outside the Taskforce's terms of reference.[31]

---

29 (Civil Aviation Authority of New Zealand), (Ministry of Business, Innovation and Employment, 2012a), (Maritime New Zealand, 2012)

30 (Workplace Health and Safety Council, 2012)

31 (Independant Taskforce on Workplace Health and Safety)

104. *The Taskforce invites submitters to comment on how the current no-fault ACC system impacts on workplace health and safety outcomes and how effectively ACC's activities contribute to improvements in workplace health and safety outcomes.*

Capacity and capability of the regulators

105. The health and safety performance of businesses depends on their knowledge of what they need to do to perform well and their motivation and willingness to do it. Effective regulation is essential to ensure system performance, including through the support that they provide to businesses.

106. The regulators must provide credible, up-to-date, relevant, accurate, reliable, and readily available information so that everyone understands and appreciates what they need to do to meet regulators' expectations.

107. *The Taskforce invites submitters to comment on whether the regulators are able to provide the information needed for organisations and individuals to perform well from a workplace health and safety perspective.*

108. The regulators must be consistent, fair, transparent, and efficient when they engage with businesses, workers and sector and industry groups. Their ability to achieve this is dependent on having enough of the right people with the right knowledge and skills and the right tools and equipment, working together to support the system.

109. These people need to:

   • gather intelligence about trends in workplace harm, including emerging threats
   • develop, lead, and manage strategies and tactics
   • produce information and policy
   • monitor and enforce compliance

110. *The Taskforce invites submitters to comment on whether the regulators have the capacity or capability to effectively engage with businesses, workers, and sector and industry groups.*

Level playing field

111. Businesses must feel confident that if they comply with workplace health and safety regulations they will be protected from other businesses that may attempt to gain an unfair competitive advantage through not complying.

112. The ability of the regulators to achieve this outcome is dependent on their ability to efficiently intervene when necessary and be proportionate in their approach. Available enforcement options should match the seriousness of the offence and effectively deter future offending. Enforcement options range from guidance and negotiation, legally compelled improvements, infringement notices, through to prosecution with the possibility of fine or imprisonment. Successful protection from anticompetitive behaviour and practices is dependent on efficient enforcement.

113. Information provided to the Taskforce suggests some regulatory agencies have a light presence and their interactions are of variable quality and are inconsistently delivered. *The Taskforce invites submitters to comment on whether the regulators are currently able to provide the level playing field that businesses need to perform well in our nation's health and safety system.*

What's happening overseas?

114. There are a number of approaches seen internationally relating to government agency roles and responsibilities as they relate to workplace health and safety:

Single-focus versus multi-focus

115. Organisations that regulate workplace health and safety in some countries have this as a single focus. Single-focus agencies are seen in the UK, Ireland and, in Australia, in Victoria and New South Wales. Having a single-focus agency sends a clear signal about the priority placed on workplace health and safety[32]. The countries with single focus agencies tend to have the lowest injury rates[32].

116. Other countries have agencies that focus on regulatory activities other than workplace health and safety. This is similar to New Zealand. Multi-focus regulatory organisations are seen in Queensland[32], and in Washington State in the United States of America[33].

Single versus multiple regulators

117. In some other countries there is a single organisation that regulates workplace health and safety, sometimes with other labour market functions also (similar to how the Ministry of Business, Innovation and Employment is also responsible for other functions). This is seen in Washington State of the United States of America, British Columbia in Canada[34], and Ireland[32].

118. Other countries divide regulation of the system amongst multiple agencies, sometimes with multiple foci (similar to the New Zealand situation). Often the divisions are formed for different business sectors, such as mining. Effective collaboration can help to prevent jurisdictional boundary problems from arising (gaps and overlaps), and to ensure consistent priority setting. This approach is taken in South Australia and Queensland[35].

Integrated versus non-integrated regulation, compensation and rehabilitation functions

119. Some countries combine their compensation and rehabilitation functions into the same agency as their regulator. This practice can be seen in the regulator and the compensation agent of British Columbia (WorkSafe British Columbia). In this arrangement data sharing and cross-divisional work can occur more easily[35].

120. Still other countries separate their compensation and rehabilitation functions from their regulatory system. This may involve a stand-alone public agency for compensation and rehabilitation functions (like New Zealand). This approach is taken in South Australia and Queensland. Under this approach the performance of the regulatory system can be enhanced by having a close working relationship with the compensator including developing and implementing initiatives jointly[36]. By separating the compensation and rehabilitation functions they can be opened up to the private sector, such as in the UK where these functions are fully privatised.

---

32   (Allen + Clarke Policy and Regulatory Specialists Limited, 2012, pp. 33—34)

33   (Washington State Department of Labour and Industries, 2012)

34   (Strategic Policy Consulting, 2002)

35   (Strategic Policy Consulting, 2002)

36   (Allen + Clarke Policy and Regulatory Specialists Limited, 2012, p. 34)

Tripartite Involvement

121. Tripartite involvement relies on a culture of social partnerships between government, employer and worker organisations. A tripartite approach enables greater input from employer and worker organisations into the regulatory framework and service delivery. This approach is seen to varying degrees internationally. Extensive tripartite involvement can be seen in the UK, Denmark and Netherlands[35].

Tell us what you think

122. Government functions and roles aimed at reducing workplace harm are spread over several government agencies in New Zealand, none of which are solely focussed on workplace health and safety regulation. The mechanisms in place for ensuring agency coordination may not always be effective — the system relies on most businesses performing well voluntarily — and it is unclear if the regulators have the capacity and capability to effectively regulate the system.

Questions

Q5. **How effective are the regulators in influencing workplace health and safety outcomes?**

Q6. **How could the regulators' roles and responsibilities be changed to improve their effectiveness in influencing workplace health and safety outcomes?**

New Zealand's Changing Workforce and Work Arrangements

What's the issue?

123. New Zealand's working environment has undergone significant changes over the last twenty years. There have been demographic shifts resulting in a different workforce composition, changes in the type of work being carried out, and increasing diversity of working arrangements and employment relationships. These changes have significant implications for workplace health and safety. Changing work arrangements in particular are associated with inferior outcomes in terms of worker safety, health and well-being, and create significant problems for the regulation of workplace health and safety[37].

What's happening in New Zealand?

124. The HSE Act implemented many of the principles of the UK's Robens Report on workplace health and safety. However the Robens model was developed in an era (the 1970's) when the working environment was predominantly made up of unionised, male, permanent employees, working for a single employer in large workplaces. Many of these assumptions underpinning the regulatory framework are becoming less and less applicable as the working environment evolves.[38]

Workforce demographics and the changing nature of work

125. Key changes include:

- there are increasing numbers of older workers, women and migrant groups participating in the workforce
- New Zealand industry is moving away from primary and secondary industries such as agriculture, forestry, fishing and manufacturing towards more service-oriented industries
- union membership has declined steadily and is particularly low in the higher risk industries of construction, agriculture, fishing and forestry

126. Demographic changes create particular workplace health and safety risks. Older workers tend to have much higher rates of injury than other age groups. Migrant workers face a complex set of challenges including language barriers, different cultural practices and low levels of literacy in English.[39]

127. New risks are emerging from the changing content of work as well as from technological developments across all types of industry. While the need for heavy, physical labour is declining there has been an increase in risks associated with sedentary work, repetitive physical activity and work related stress.

128. 'Black market' labour, often involving vulnerable immigrant workers, can involve unsafe work that the workers feel powerless to complain about.

---

37 (Quinlan, Flexible work and organisational arrangements, 2004)

38 (Gander, Pearce, Langley, & Wagstaffe, 2009)

39 For example, see: (Department of Labour, 2012b). Low levels of literacy and numeracy can also form a barrier to safe work for other parts of the workforce. See paragraph 174 for more detail.

Changing work arrangements

129. Key changes include:

    - an increase in the use of temporary, casual and seasonally employed workers
    - more people working part-time, holding multiple jobs and engaging in irregular working arrangements such as working from home
    - significant proportions of workers working more than 40 hours per week and working irregular hours such as weekends and evening work
    - an increase in the use of various forms of contracting, outsourcing, franchising and self-employment

130. Different forms of employment bring different workplace health and safety challenges which often require different approaches to manage effectively. As these non-standard forms of employment become increasingly prevalent the existing regulatory framework becomes increasingly inadequate.

131. The range of different employment and contract arrangements can make it difficult to determine who the duty holders are under the Act and to ensure that all workers are adequately covered by the workplace health and safety system. There may be several duty holders, each with a different approach, whose employees work side by side on the same site.

132. Workers engaged in non-standard work arrangements, such as temporary and casual work, are at greater risk of injury than those in permanent full-time positions. They are more likely to carry out hazardous jobs, often work in poorer conditions and are less likely to receive health and safety training.[40] Continual changes in staffing can lead to a lack of experience and job specific health and safety knowledge. Young workers are often in these kinds of work arrangements which can add to their risk of injury.

133. These types of changing work arrangements can also result in reduced opportunities for worker participation and engagement and make it harder to ensure that workers are aware of their legal rights and obligations. A lack of job security can reduce the willingness of workers to raise health and safety concerns, as they fear they may lose their job as a result. These issues are likely to be exacerbated by declining levels of unionisation.

134. Longer and irregular working hours are associated with increased injury risks, particularly related to fatigue. While other jurisdictions do have regulations for working hours, there is no maximum set out in New Zealand health and safety legislation. The omission of a statutory maximum number of work hours has been the subject of recommendations from international bodies.[41]

135. Performance targets and similar arrangements as well as contracting arrangements based primarily on cost competition may put pressure on workers to work in unsafe conditions. This may lead to stress or create expectations of working long hours. The same competitive cost pressures that induce employers to engage workers under non-standard work arrangements can also encourage various forms of corner-cutting on workplace health and safety, further increasing the risk of harm.[42]

136. Internationalisation of production has brought other pressures. While some international firms have brought their own health and safety management practices to New Zealand, outsourcing to countries with lower workplace health and safety standards puts competitive pressure on New Zealand firms to reduce their workplace health and safety standards in order to cut costs.

---

40   (Gander, Pearce, Langley, & Wagstaffe, 2009)

41   For example, see: (The United Nations Office at Geneva, 2012)

42   (Johnstone, 2009)

What's happening overseas?

137. Other countries are experiencing similar trends to those observed in New Zealand. The Australian labour market has undergone similar changes to New Zealand. The need to take these changes into account was recognised in the development of the Australian Model health and safety legislation and the resulting primary duty of care is broad enough that it can capture a wide range of work arrangements[42].

138. Changing work arrangements have also been identified in European countries, Canada and the USA. But while these changes are increasingly being linked to poor health and safety outcomes, strategies on how to deal with them tend to be less clear.[43]

139. A 2010 review of occupational health and safety in Ontario considered how to manage changing work arrangements in the context of providing better protection for vulnerable workers. The review made a number of recommendations, including targeted enforcement and inspections in sectors where vulnerable workers are concentrated, campaigns to raise health and safety awareness, and establishing an advisory committee to consult parties who are knowledgeable about vulnerable workers and have a role in protecting them.[44]

Tell us what you think

140. There have been significant changes to New Zealand's working environment over the past two decades including changes to the workforce, the nature of work, and the way in which work is organised and carried out. There are significant implications for both workplace health and safety outcomes and health and safety management in workplaces, and in many cases the existing regulatory system is struggling to address these effectively.

Questions

Q7. **What impacts are New Zealand's changing workforce and work arrangements having on workplace health and safety outcomes?**

Q8. **What changes to the workplace health and safety framework, if any, are needed as a result of the changing workforce and work arrangements?**

---

43   (Evans & Gibb, 2009)

44   (Expert Advisory Panel on Occupational Health and Safety, 2010)

Worker Participation and Engagement

What's the issue?

141. New Zealand has requirements for worker participation and engagement in workplace health and safety, but more research is needed on how worker participation is operating and whether it could contribute more to improving workplace health and safety outcomes. There appears to be limited opportunities for contracting and labour hire workers to engage on workplace health and safety issues in the current system.

What's happening in New Zealand?

Worker participation at the national and industry level

142. Worker participation occurs at a national level through the Workplace Health and Safety Council[45] which brings together government, business and employee representatives to provide advice to government about workplace health and safety[46].

143. In the National Action Agenda government has committed to develop closer working partnerships with workers and industry to address workplace health and safety issues. For the priority sectors industry health and safety leadership groups are to be established (where they do not already exist), including worker representation where possible[47]. In practice, the level of worker engagement at the industry level is variable with some industries engaging well with worker representatives and other industries having limited engagement with worker representatives.

Worker participation provisions are provided in legislation

144. In New Zealand the Health and Safety in Employment Act 1992 (HSE Act) includes provisions about employee participation in workplace health and safety[48]. The intent is to ensure that employer decisions on workplace health and safety are informed by the expertise of their employees and others with relevant knowledge to make workplaces and healthier and safer. The form this participation takes depends on whether the business is large or small.

145. The HSE Act provides for elected health and safety representatives whose role includes:

- identifying hazards
- working with employers on responses to hazards – trained health and safety representatives can also issue a formal hazard notice to an employer[49]
- consulting with health and safety inspectors
- promoting employees' interests in health and safety in the workplace
- being a part of health and safety committees

---

45   (Ministry Of Business Innovation and Employment, 2012b)

46   For further information and discussion on the Workplace Health and Safety Council in this consultation document refer to paragraph 94.

47   (Ministry of Business, Innovation and Employment, 2012c)

48   (Health and Safety in Employment Act 1992)

49   Health and safety representatives have the option of providing a copy of the hazard notice to the Ministry, however very few notices have been provided. The Ministry has been involved in only 22 matters between 2006 and 2010 that could not be resolved between the employer and the health and safety representative after a hazard notice was issued.

- maintaining their knowledge around workplace health and safety by attending training (employers are required to provide paid leave for this training)[50]

146. A report published in 2008 found "sufficient evidence to suggest that many Health and Safety Representatives have been able to take the learning from the training courses they have attended and apply them in their workplace"[51].

147. The Taskforce believes that the approach taken to worker participation and engagement may need to be tailored to the level of risk in a workplace with higher risk workplaces (in high hazard industries) potentially needing a different form of worker participation and engagement.

Right to refuse unsafe work

148. Employees also have collective and individual rights to refuse unsafe work that is likely to cause serious harm. This reinforces the importance of employee participation in workplace health and safety matters as the refusal can only happen where the employee and employer cannot agree on how to deal with an unsafe situation. There is no requirement to notify the Ministry of refusals to do unsafe work so no comprehensive information is available on how workers use this right. There have been a limited number of formal employment relations disputes on workplace health and safety matters, either individual or collective, which suggest these rights are used infrequently.

What's happening overseas?

149. Internationally, worker participation and engagement in workplace health and safety is acknowledged through conventions and directives by organisations like the International Labour Organisation[52] and the European Union[53].

150. International research and evidence base suggests "where the active involvement of workers is underpinned by legal entitlements to perform OHS functions, and to receive training and information, that is most effective in improving OHS outcomes."[54]

151. Australia's Model Work Health and Safety Act harmonises the various states statutes and acts about workplace health and safety[55]. The Model Act provides for representatives to:

- represent workers and monitor workplace health and safety activity
- investigate complaints and inspection of workplaces
- request information and establish health and safety committees
- issue provisional improvement notices and direct unsafe work to stop
- accompany an inspector on an inspection

---

50 Since 2002 over 60,000 health and safety representatives have attended health representative training courses funded by the Employment Relations Education Fund and ACC. Employers have privately funded 7,500 people since 2003 through these courses not using the government subsidies. The bulk of this training has been provided by the NZCTU, Business NZ and Impac Ltd.

51 (Research New Zealand, 2008, p. 9)

52 (International Labour Organisation, 1981)

53 (European Agency For Safety and Health at Work, 2002)

54 (Gunningham and Associates, 2009, p. 17)

55 (Safe Work Australia, 2012b)

152. In the UK there are two forms of health and safety representative; those appointed by unions and those elected by the workforce[56]. Both representatives are independent of management, represent the workforce on health and safety, attend training and have contact with inspectors. Only union health and safety representatives can request a health and safety committee be established, investigate potential hazards and causes of accidents, investigate complaints and inspect the workplace.

153. Support for workers in remote areas or in workplaces with reduced unionism such as small to medium enterprises in the UK can come through the use of roving health and safety representatives and regional health and safety advice centres. For example roving health and safety representatives work on farms to help overcome issues that geographical isolation presents relating to worker participation and engagement[57].

154. Canada allows for the establishment of two types of health and safety committee — Policy and Workplace.[58] In larger workplaces there is a requirement to have both committee types. In medium to large workplaces there is only a requirement to have Workplace health and safety committees with Policy health and safety committees optional. Policy health and safety committees lead the development, implementation and monitoring of health and safety programs and Workplace health and safety committees implement those programs and deal with health and safety complaints. Small businesses only need to have a health and safety representative. To provide more protections for health and safety committees and representatives, Ontario legislated that representatives cannot be dismissed, disciplined or penalised for acting in compliance with health and safety legislation[59].

Tell us what you think

155. Worker participation and engagement has been shown by international research to be important and most effective when workers are supported in their roles with training and legislation[60]. New Zealand has a variety of mechanisms in place to support worker participation and engagement and a significant number of health and safety representatives have been trained since 2002. More research is needed about worker participation and engagement, in particular about how worker participation and engagement operates in small to medium enterprises, contracting and for labour hire workers.

---

56   (Health and Safety Executive)

57   (Knowles, 2006, p. 5)

58   (Department of Justice, 1985)

59   (Ontario Ministry Of Labour)

60   (Gunningham and Associates, 2009, p. 17)

Questions

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

Q10. What improvements can be made to worker participation in workplace health and safety so as to get better workplace health and safety outcomes?

Leadership and Governance

What's the issue?

156. Company directors, owners, chief executives and other senior leaders play a critical role in the creation of safe workplaces through their governance and leadership practices in their own and, sometimes in other organisations. These leaders make decisions about resourcing, training and investment in plant and equipment and they set the organisation's direction. Through other directorships, or through membership of industry associations, directors can also influence workplace health and safety outcomes in other organisations.

What's happening in New Zealand?

Directors and senior leaders take a variable approach to workplace health and safety

157. Anecdotal evidence suggests that directors and senior leaders demonstrate a variable approach to workplace health and safety. While there are examples of exceptional practices there are also many examples of a lack of appropriate focus or a focus on the wrong areas (for example, personal safety risks being monitored when process safety is the primary issue of concern).

158. Many directors and senior leaders tend to view workplace health and safety as a compliance issue, not related to business or governance risk practices. The main focus is compliance with the law. Workplace health and safety may be seen by directors and senior leaders as a function of human resource management. While this may be appropriate it can also lead to a focus on people management and behaviour-based workplace health and safety programmes that do not focus on technical or operational risk.

159. One measure of senior leadership involvement is tracking what they measure and report on in relation to organisational performance. High performing leadership teams and boards will monitor a wide range of relevant workplace health and safety performance outcomes and measures and will report against these openly. Many boards do not report on workplace health and safety outcomes and those that do often focus on lagging injury outcome measures like "Lost time injury frequency rates".[61]

160. It is unclear whether New Zealand directors and senior leaders place production performance above workplace health and safety performance. However, there is evidence from major industrial accident investigations that production pressure can lead to workplace health and safety being overlooked or not prioritised.

161. There is no evidence to explain why some directors and senior leaders focus on workplace health and safety in New Zealand and others do not. It may be because some directors and other leaders in firms have had experience with a workplace health and safety incident or investigation, or have a general interest in these workplace health and safety issues. In others it could relate to the risk profile of the business, costs, compliance, and influence from overseas parent companies, suppliers and clients.

---

61   (Department of Labour, 2005b)

Directors and senior leaders have specific responsibilities under the Health and Safety in Employment Act

162. The Health and Safety in Employment Act 1992 (HSE Act) provides that officers, directors and agents of companies can be held accountable for workplace health and safety issues where they have directed, authorised, assented to, acquiesced in or participated in a failure to address a workplace health and safety issue.[62] These requirements are rarely enforced by the Ministry of Business, Innovation and Employment (MBIE), as the standard of evidence required for an officer, director or agent to be held accountable is difficult to establish.

163. There are also no specific safety performance-related requirements for directors or senior leaders set by MBIE or by the Institute for Directors in New Zealand[63] and no guidance material is available targeted at directors and senior leaders.

The Business Leaders' Health and Safety Forum

164. Directors and business leaders have not been a visible player in the health and safety system to date. Recently a group of business leaders have joined together in an effort to improve health and safety performance. Members of the Business Leaders' Health and Safety Forum are chief executives or other senior leaders who have made a public pledge in conjunction with the Minister of Labour to make health and safety a critical part of their business.[64] The Forum currently has over 100 members.

165. A self-assessment of safety leadership maturity by members of the Forum indicated they see themselves as having a high level of maturity when it comes to safety leadership practices.[65] The report indicated these senior leaders had higher levels of maturity in key areas related to understanding that health and safety is an investment, clarifying the vision and focus and letting people get on with their job. It found lower levels of maturity in areas related to getting personally involved and recognising contributions and health and safety achievements.

The approach to workplace health and safety may reflect general management capabilities

166. There are few examples of qualifications which incorporate workplace health and safety requirements into general management competencies. As a consequence, existing management capacity and capability to deal with workplace health and safety issues is variable.

167. A comparison of New Zealand managers in manufacturing firms, which considered broader management capabilities, found New Zealand managers surveyed were 'average to middling' by global standards. This survey did not directly focus on workplace health and safety management practices, but elements of these practices would be covered across the range of operations, performance and people management capabilities that survey questions were asked about. The survey concluded:[66]

   Among the three areas of management, certain dimensions within operations and performance management have room for improvement to catch up with the global best performer. People management emerges as the weakest area, where New

---

62 Health and Safety in Employment Act 1992, section 56(1).

63 (Institute of Directors in New Zealand Inc, 2012)

64 (Business Leaders Health and Safety Forum)

65 (Business Leaders' Forum on Workplace Health & Safety, 2011, p. 4)

66 (Agarwal, 2011, p. 3)

Zealand firms trail most behind global best practice. Hence, management of human capital through attracting, developing and retaining talent is where most attention is required from both corporate leaders and public policy.

What's happening overseas?

168. The role of directors and senior leaders has been well recognised in a number of other countries with positive safety obligations upon either directors or senior managers of companies.[67] For example, as noted in paragraph 85, Australia requires that officers of firms, including directors, must exercise 'due diligence' to ensure compliance with the law. Progress by Australian companies in reporting about their health and safety performance has been monitored and reported on by Citibank, who produced a report for potential investors in 2009.[68]

169. In the UK the Institute of Directors and the Health and Safety Executive have produced guidance material for directors and senior leaders.[69] The guidance material identifies core actions for boards and individual board members that relate directly to their legal duties, and provides good practice guidelines that set out ways to give the core actions practical effect.

170. A range of organisations focus on the role leadership has in achieving positive workplace health and safety outcomes. For the London 2012 Games construction project the Olympic Delivery Agency (ODA) "made a strong commitment to the health and safety of workers from the outset and made a safe working environment one of their priority themes." The ODA worked with its delivery partner to achieve these outcomes and has shared the lessons learnt from its experience publicly.[70] Over a period to June 2011, 62 million hours were worked and the workplace health and safety outcomes involved "an Accident Frequency Rate of 0.17 (calculated per 100,000 hours worked). This compares to construction industry averages of 0.4."[71]

Tell us what you think

171. The evidence indicates directors and senior leaders are most effective when they demonstrate governance and leadership practices that support a workplace safety culture. The Taskforce is interested in how well the current workplace health and safety system supports and hold leaders to account for developing and leading workplace health and safety. It appears that a significant opportunity exists to improve workplace health and safety outcomes by increasing the involvement, focus, competency and accountability for directors and senior leaders on matters related to health and safety.

---

67   (Centre for Corporate Accountability for the Health and Safety Executive, 2007) p vii.

68   (Citi Investment Research & Analysis, 2009)

69   (The Institute of Directors and the Health and Safety Executive, 2011)

70   (Tamkin & Lucy, 2011)

71   Ibid.

Questions

Q11. To what extent do directors and other senior leaders provide effective leadership and governance of workplace health and safety?

Q12. What improvements can be made to directors' and other leaders' participation in workplace health and safety, so as to get better workplace health and safety outcomes?

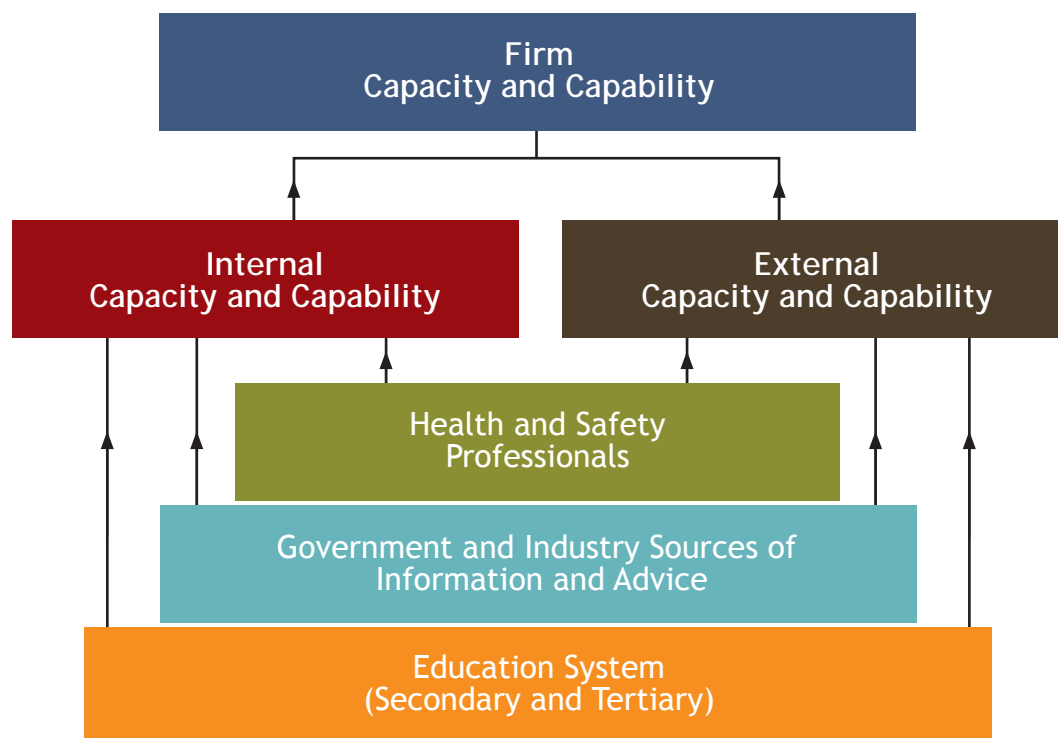# Capacity and Capability of the Workplace Health and Safety System

What's the issue?

172. Feedback to the Taskforce suggests there is variable capacity and capability in New Zealand businesses to effectively manage workplace health and safety issues. Improving the availability and quality of information, training and guidance available to businesses through external organisations presents an opportunity for improvement of the workplace health and safety system.

What's happening in New Zealand?

173. Building capacity and capability involves equipping people and organisations with the necessary skills, motivation and confidence to effectively manage workplace health and safety issues. Firm capacity and capability to effectively manage workplace health and safety issues can either be internal or external, as represented in the Figure 7 below.

Figure 7: Factors influencing organisational capacity and capability

Education and training

174. The education system can contribute to workplace health and safety capacity and capability in a number of ways. Basic language, literacy and numeracy competencies of employees and managers are important features of the workplace environment

which have been linked to improved health and safety outcomes[72]. The secondary education system could also build awareness of health and safety risks and promote responsibilities in managing these in life generally, equipping future workplace participants with important life skills for thinking about and managing health and safety risks.

175. Firms can build on foundation skills with health and safety-related training courses available to workers, supervisors and managers though a range of tertiary education providers. These include:

- *Health and safety representative training for employees* — Since 2002, around 67,500 employees have been trained through approved courses run by the Council of Trade Unions, Business New Zealand and private training organisations[73]
- *Formal qualifications* — 77 health and safety specific unit standards and five health and safety specific qualifications are offered through the New Zealand qualifications framework.[74] These standards and qualifications are used by a range of bodies including Industry Training Organisations, Private Training Establishments, polytechnics and institutes of technology. Further, international training organisations such as The National Examination Board in Occupational Safety and Health issue a range of globally-recognised, vocationally-related health, safety, environmental and risk management qualifications. At the higher end of tertiary education, some Universities include workplace health and safety components into professional degrees (e.g. engineering, management and medicine)
- *Trade certification* — Health and safety content and requirements in the certification processes for trade qualified professionals (e.g. electricians, builders) provides a further avenue for building firm capability and capacity for managing health and safety issues
- *Firm specific training* — Firms can also access unaccredited training opportunities through consultants providing in-house training and other industry-led initiatives

176. Funding for different forms of training comes from a range of sources. Some are government funded or subsidised while others are fully funded through private organisations. Government funding of health and safety training programmes reflects societal interest and the public good. Employers may face disincentives, which limit their willingness to fund training, where they cannot capture the benefits of that training. The Taskforce invites submitter's to comment on the appropriate balance between government and private funding and approaches that can mitigate the disincentives that employers may face.

177. The Taskforce is also interested in how effective New Zealand's education system, including schooling and the industry training system, is in building the capacity and capability of New Zealand's workforce and organisations. For example, school level education might be able to contribute more to improving workplace performance though fostering a culture of safety, awareness of legal obligations and building health and safety competence for students entering the workforce.

178. While a significant number of unit standards are currently gained in health and safety, there is potential for industry-led training to further lift worker and manager competence through better use of current standards and through incorporating health and safety assessments into a wider range of training activities.

---

72   (Department of Labour, 2012b) (Ministry of Business, Innovation and Employment, 10 August 2012)

73   (Ministry of Business, Innovation and Employment, 31 August 2012)

74   (New Zealand Qualifications Authority)

179. The 2009 review of the Workplace Health and Safety Strategy for New Zealand to 2015 identified a shortage of training availability for managers and supervisors in workplace health and safety[75].

Government and industry sources of information and guidance

180. Information and guidance can also help provide people and organisations with the capacity and capability to manage workplace health and safety issues. Firms are able to access information and guidance from a range of workplace health and safety regulators and from ACC. These include web-based tools, generic and industry-specific best practice guidelines and face-to-face advice from inspectors and specialists.

181. Besides central government support, the workplace health and safety system relies on industry leadership for guidance and standard setting across all sectors. In some sectors, for example construction, industry-led guidance and standards setting appears to be working effectively (although the construction sector still has high injury rates). Organisations such as Site Safe provide health and safety advice, training and accreditation for a significant proportion of individuals and organisations working in the construction sector. In other sectors health and safety leadership in standard setting may be less well developed and there is room for a more substantive contribution to improving firm capacity and capability.

Health and safety professionals

182. A further method through which a firm can build or access capability and capacity is through the contracting of health and safety advisors to provide intermittent or on-going advice on practices and/or to build internal competence.

183. In 2006 the National Occupational Health and Safety Advisory Committee identified around 550 registered specialist occupational health and safety practitioners to be working in New Zealand. Registration is compulsory for medically trained professionals (for example, occupational physicians, occupational nurses and physiotherapists), who make up the vast majority of identified registered professionals. For other professions registration is voluntary (e.g. occupational hygienists and ergonomists). It is likely there are numerous health and safety advisors operating outside of any registered professional body, leaving open the question of their qualifications for providing expert advice. Professional health and safety advice is likely to be underutilised in New Zealand.

184. The 2009 review of the Workplace Health and Safety Strategy concluded that there is a lack of reliable competency standards for health and safety consultants and intermediaries in New Zealand[76]. As a result of the review, the Workplace Health and Safety Strategy's National Action Agenda committed to establishing 'Health and Safety Professional Alliance', a network of qualified, accessible health and safety qualified professionals in New Zealand, by June 2012. The establishment of the alliance has been delayed[77].

What's happening overseas?

185. In Australia there is a legal requirement that businesses seeking health and safety advice must obtain it from suitably qualified people. To support the demand for

---

75 (Department of Labour, 2009)

76 (Department of Labour, 2009)

77 (New Zealand Injury Prevention Strategy, 2012)

quality advice, WorkSafe Victoria is supporting the introduction of the Health and Safety Professionals Alliance, is which intended to bring together occupational health and safety associations and education providers. It is the first alliance of its kind in Australia, intended to help deliver sustained improvements in workplace health and safety.

186.   In Ontario, as part of a 'preventative approach' that recognises that attitudes to safety are established early in life, health and safety content is included in the primary and secondary school curriculum[78].

Tell us what you think

187.   High quality workplace health and safety related information on standards and advice, or training on how to achieve them, is currently under-developed or not readily accessible for many businesses. The New Zealand education and qualifications system may not be adequately preparing workers, managers and supervisors to effectively recognise and manage workplace health and safety risks.

Questions

Q13.   To what extent do firms have the capacity and capability to effectively manage workplace health and safety issues (including through accessing external resources)?

Q14.   What options are there for improving firm level capacity and capability to deliver better workplace health and safety outcomes?

---

78   (Expert Advisory Panel on Occupational Health and Safety, 2010)

Incentives

What's the issue?

188. Financial and non-financial incentives for businesses and communities are thought to improve workplace health and safety outcomes, although the evidence on the effectiveness of incentives is limited. The Taskforce is interested in whether incentives can be better used or designed to improve New Zealand's workplace health and safety outcomes.

What's happening in New Zealand?

189. The Ministry of Business, Innovation and Employment (MBIE) and ACC are the two main providers of incentives for workplace health and safety in New Zealand. They both use some financial incentives (levies, levy discounts or loading, tax incentives, subsidies and enforcement mechanisms such as penalties) and non-financial incentives (pledge schemes, sponsorship, and rating systems) to influence workplace health and safety. Non-financial incentives are also provided by a range of non-government schemes.

Levies

190. All businesses are charged a flat rate levy to cover the cost of the administration of the HSE Act by MBIE, the Civil Aviation Authority and Maritime New Zealand. This rate is reviewed annually and is currently set at five cents per $100 of payroll.

191. ACC charges levies to all business to cover workplace compensation, rehabilitation and injury prevention activities. ACC levy rates are set on a risk classification system that groups businesses with similar activities and risk profiles together[79].

Levy/premium discounting or loading

192. ACC has a variety of incentives relating to its levies to promote better workplace health and safety (Figure 8). The first two incentive mechanisms are based on the processes that a firm has in place while the last three incentive mechanisms are based on the health and safety outcomes of a firm.

---

79   (ACC, 2011a)

Figure 8: ACC incentive mechanisms

Incentive:	Targeted at:	Impact on levies:
Workplace Safety Discount[80]	Smaller businesses in agriculture, construction, fishing, forestry, motor trades, road transport and waste industries that show sound health and safety practices	10% discount off levy
Workplace Safety Management Practices[81]	Medium to larger businesses recognising good safety management practices	Levy discount: 10% at primary level 15% at secondary level 20% at tertiary level
Workplace Safety Evaluation[82] (not often used)	All businesses who have a significantly higher injury rate compared with others in their industry	50% increase in the ACC WorkPlace Cover component of the levies if an audit is failed
Accredited Employers Program[83]	Larger businesses who demonstrate effective workplace safety and are financially able to take on the costs and responsibility for their employees' injury claims	Up to 90% discount on their standard levy rate, but businesses must also meet the cost of their employees' claims
Experience Rating[84]	For all businesses that meet liable earnings and time in business criteria — adjusts the amount of levy payable depending on their claims history	Small businesses — 10% increase or decrease Medium to large businesses — up to 50% increase or decrease

Subsidies or grants

193. MBIE and ACC provide subsidies and grants to encourage workplace health and safety, such as:

- funding for health and safety representative training
- funding for business improvements that have a workplace health and safety focus[85]

---

80   (New Zealand Injury Prevention Strategy, 2012)

81   (ACC, 2011b)

82   (ACC, 2010a)

83   (ACC, 2010b)

84   (ACC, 2012)

85   MBIE currently provides funding for businesses wanting to introduce high performing working practices (Ministry of Business, Innovation and Employment). MBIE are exploring options to provide further support for industry-led initiatives and services that would support health and safety systems improvement in small to medium enterprises.

Enforcement mechanisms including penalties

194. Enforcement mechanisms including penalties act as incentives to differing degrees of effect depending on how businesses perceive risk and consequence related to workplace health and safety compliance (and non-compliance). Regulators have a range of enforcement mechanisms available to them however there is a low number of visits and a very low number of enforcement actions (Figure 9). Of note, infringement notices introduced in 2003 as a low level alternative to prosecution are barely utilised — questions have been raised about the practicability of the infringement notice regime.

Figure 9: Frequency of compliance and enforcement notices issued by he Department of Labour 2006 — 2011[86]
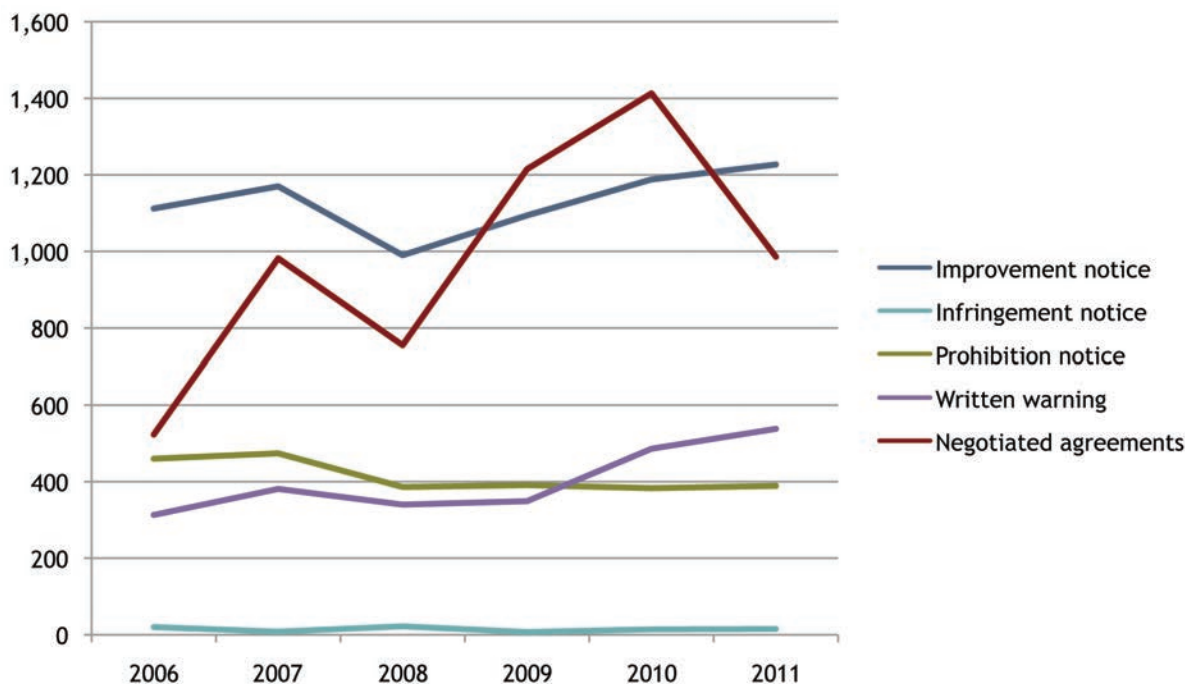
195. The consequences of a prosecution range from a discharge without conviction to a fine of $500,000 and two years imprisonment. Of the 2,438 fines imposed by the courts since 1992 the average fine is $8,275.[87]

196. If the risk of being found non-compliant is low and the financial penalties or the effects on reputation are also low then the incentives for non-compliant firms to invest in workplace health and safety are low. The decision to be non-compliant may therefore be perceived to be worth the risk as the result of being caught has little impact.

---

86   Source: Ministry of Business, Innovation and Employment Data.

87   The maximum fine levels were increased in 2003. The average fine since that date has been $16,091.

Unintended consequence of incentives

197. The use of incentives can create unintended consequences in workplace health and safety behaviour. For example, providing businesses with financial incentives for reducing injuries, or making fewer claims, could encourage investment in workplace health and safety initiatives. However, it could also have the effect of encouraging underreporting of injuries by workers due to pressure from their employer to reduce claim numbers.

Non-financial incentives

198. Non-financial incentives can influence workplace health and safety by either positively or negatively highlighting a business's reputation. MBIE has a programme called the "partners in action pledge". This is a symbolic pledge committing businesses to specific actions on workplace health and safety and to have their branding displayed on MBIE's website. Both MBIE and ACC use sponsorships and awards to highlight workplace health and safety to businesses. For example, Safeguard has a national conference and awards promoting workplace health and safety with sponsorship from MBIE and ACC[88].

199. Non-financial incentives schemes provided independent of the government include Passport to Safety New Zealand[89], which is focussed on safety for youth.

What's happening overseas?

Levy/premium discounting or loading

200. Experience rating[90] is the most widely used incentive of this type overseas, although discount schemes are also used. For example:

   • in Canada, Worksafe British Columbia offers discounts for workplace health and safety management that exceeds regulatory requirements[91]
   • in Germany a small to medium enterprises scheme in the butchery industry gave an insurance premium variation to businesses that reduced injuries and invested in workplace health and safety[92]
   • In Finland, Farmers' Workers Compensation Insurance gave rebates to companies that had fewer injuries in agriculture[93]

Subsidies or grants

201. Internationally subsidies and grants are used with a strong education focus and are often weighted towards building small to medium enterprises capability related to workplace health and safety. For example:

   • the UK gave subsidies for small to medium enterprises to have access to low cost workplace health and safety consultancy[94]
   • the Italian Workers Compensation Authority provided financing for programmes and initiatives for small to medium enterprises and some sector groups by subsidising bank credit with a lower interest rate[95]

---

88   (Safeguard)

89   (Passport to Safety New Zealand)

90   Refer to Table 1.

91   (Workplace Health and Safety Council, 2012)

92   (European Agency For Safety And Health At Work, 2010, pp. 106–115)

93   (European Agency For Safety And Health At Work, 2010, pp. 120–123)

94   (Health And Safety Executive)

95   (European Agency For Safety And Health At Work, 2010, pp. 157–169)

- the Netherlands provided a subsidy to companies to purchase innovative and worker friendly equipment to reduce risk and harm to employees. The aim was to stimulate the market for workplace health and safety equipment to reduce the cost for business[96]
- SafeWork South Australia provides a subsidy for health and safety representative training[97]

Penalties and enforcement

202. In Australia depending on the category that a penalty falls into or who it applies to (Bodies corporate, Officers and persons conducting business or other undertakings or an individual) the maximum penalty can range from $50,000 to $3,000,000. Various States also use alternative penalties such as adverse publicity orders (naming and shaming), orders to undertake a health and safety improvement project or attend training. In the UK financial penalties on convictions in the Crown Courts are uncapped, with financial penalties in the Magistrates Court capped at £20,000.

Non-financial incentives

203. In the UK the British Safety Council (a private charity)[98] uses a star rating program where on completing an audit, businesses can display the rating they achieved[99].

204. The Danish Working Authority has a system that uses coloured smiley faces to indicate the business's performance[100]. These incentives are reputational and influence areas such as consumer choice and the receiving of contracts.

Tell us what you think

205. For financial and non-financial incentives to be successful they need to be easy to understand and significant enough to motivate behaviour.

206. Particularly important are incentives that are focussed on rewarding injury prevention activity, provide targeted support directed at small to medium enterprises or lead to innovative solutions. The possibility of detection, leading to enforcement actions (including penalties), also needs to be high enough and of significant consequence to change behaviour.

---

96 (European Agency For Safety And Health At Work, 2010, pp. 177—186)

97 (Safe Work SA)

98 (British Safety Council, 2012b)

99 (British Safety Council, 2012b)

100 (Arbejdstilsynet)

Questions

Q15. How effective are existing financial and non-financial incentives in improving workplace health and safety outcomes?

Q16. How could incentives be better used to improve workplace health and safety outcomes?

Influencing Health and Safety Outcomes Beyond One's Own Workplace

What's the issue?

207. Workplaces, be they government, industry, corporate or other potentially influential bodies (e.g. industry associations, professional bodies, the education sector and voluntary organisations), can influence health and safety outcomes beyond their own workplaces. The Taskforce is interested in whether all these types of workplaces could exercise greater leadership to influence health and safety outcomes beyond their own workplaces. At present, it appears that few are doing so.

What's happening in New Zealand?

208. Workplaces can influence suppliers, competitors, other workplaces, professional colleagues and counterparts and even employees' families to make greater efforts to improve workplace health and safety outcomes.

209. Influence can take a number of forms. Perhaps the most obvious are procurement or investment rules, or statements of expectation of suppliers. These set minimum health and safety requirements for businesses that are part of an organisation's supply chain or can send signals to the market. However, membership eligibility criteria for business associations and professional bodies, gentle persuasion (e.g. through articles in industry magazines), and simply encouraging public debate on workplace health and safety issues are also forms of influence that can be used.

210. Requirements of licensing or certification/accreditation regimes, eligibility criteria for funding grants, statutorily-backed arrangements for large business entities, and appropriate powers delegated to agencies that deliver services for government could also wield significant influence.

211. In the private sector, the Business Leaders' Health and Safety Forum is taking a lead to lift workplace health and safety outcomes through its members' supply chains. Health and safety training providers — for instance BusinessNZ, the New Zealand Council of Trade Unions and Impac Services — are also active. Some industry associations and corporates also exercise leadership and use their influence to effect workplace health and safety outcomes beyond their own workplaces. It appears, however, that such initiatives have limited reach and much more could be done.

212. Similarly, some government agencies are taking a lead to lift workplace health and safety outcomes through their supply chains. The Taskforce notes, however, that while government is a very large procurer, key guidelines and draft principles for government procurement do not refer to workplace health and safety practices that all government agencies must require of suppliers. Instead, government agencies largely develop their own procurement policies and only some of these incorporate health and safety requirements.

213. It has been suggested that some procurement policies and practices are making the current workplace health and safety situation worse by creating an incentive for suppliers to take shortcuts in their health and safety practices to win contracts by offering lower prices. However, it may be that contractors are not consciously dropping their standards and it is more the case that clients are not holding them accountable for health and safety.

214. Across all sectors, it appears there are under-utilised opportunities for people and organisations to encourage public debate on health and safety issues, show leadership by commenting on events from a health and safety perspective and take other actions to improve workplace health and safety outcomes beyond their own workplaces. It is probable, for example, that very large corporates with near monopolies could exert significantly more influence. Local government, influential professions such as the medical profession, iwi leaders and the education sector could also make a significant contribution.

What's happening overseas?

215. As in New Zealand, Australia, the UK and the US have strategies and processes in place through which scrutiny occurs of contractors' and suppliers' workplace health and safety practices through the supply chain. In New Zealand, however, this is generally limited to the ACC Workplace Safety Management Practices Programme, the self-made policies of individual government agencies and some of the larger corporates, and a limited number of contractor pre-qualification schemes.

216. Key overseas initiatives to influence workplace health and safety include:

- *Fair Work Principles* to guide government procurement policies (Australia)
- government tender documents for procurement which require contractors to comply with materially relevant laws, with any breach (e.g. of health and safety laws) also constituting a breach of the contract or potentially affecting the awarding of a contract (Australia)
- the *Australian Government Building and Construction OHS Accreditation Scheme*, which requires that builders are accredited before they can enter into head contracts for building work that is funded directly or indirectly by the Australian Government
- the *UK's Construction (Design & Management) Regulations 2007*, which stipulate that clients assess the workplace health and safety competence of contractors and consultants working in the construction industry where any notifiable work is being carried out
- UK health and safety pre-qualification schemes to save construction companies from having to provide evidence of competence every time they bid for work offered by the public or private sectors
- voluntary programmes recognising employers and workers in the private and government sectors who have implemented effective safety and health management systems (incentivised by a promise of reduced formal monitoring) (USA)
- independent 'health and safety groups' in the UK which provide a local forum for communication between employers, educational establishments, local authorities, health and safety inspectorates and trade unions
- BSR is a large international non-profit organisation focused on business social responsibility that incorporates a focus on human rights[101]

Tell us what you think

217. It appears that government, industry, corporate or other potentially influential bodies could do more to influence health and safety outcomes beyond their own workplaces. Interventions for this purpose could range from tougher licensing regimes, to requiring

---

101 (BSR)

better health and safety practices from suppliers, to having stricter criteria to access membership benefits, to gentle persuasion, with many other options in between.

Questions

Q17. **How successful are government, industry, corporate or other potentially influential bodies in influencing health and safety outcomes beyond their own workplaces (for example through influencing their suppliers, counterparts, and competitors)?**

Q18. **What could be done to get government, industry, corporate or other potentially influential bodies to exert greater influence on improving workplace health and safety outcomes beyond their own workplaces?**

Major Hazards

What's the issue?

218.	Major hazard incidents usually involve deep seated systems or process failures which may not be addressed by conventional approaches to health and safety management.[102]

What's happening in New Zealand?

219.	Major hazard facilities are those that have a particular set of inherent risks or hazards which can result in catastrophic outcomes. These outcomes are characterised by being unlikely to occur if well managed, but having very serious consequences if they do, and can often be of a sufficient scale to affect the wider community and environment as well as the individual workplace.

220.	Given the extremely serious consequences of these types of events, a rigorous approach to safety and a higher level of regulatory focus is required to minimise risks and to provide broader assurance to the community.

Major hazard facilities

221.	Certain major hazard industries in New Zealand are subject to specific regulation (such as underground mining and petroleum extraction, as detailed below). These regulations have been made in recognition of the particular risks of these industries. In some cases these risks have resulted in catastrophic workplace accidents, the most recent example in New Zealand being the disaster at the Pike River Coal Mine which resulted in the tragic loss of 29 miners.

222.	New Zealand has numerous major hazard facilities, such as oil refineries, chemical manufacturing sites and some storage and transport depots. However there is currently no national health and safety register for major hazards and as a result the size of the risk of a major accident in New Zealand is relatively unknown. By way of contrast, the Australian state of Victoria (of a similar size to New Zealand), which requires registration of major hazard facilities based on the type and quantity of material present[103], has 46 sites that are currently registered.

223.	The Hazardous Substances and New Organisms Act 1996 (HSNO) is designed to protect both the environment and the health and safety of people by preventing or managing the adverse effects of hazardous substances. It is administered by the Ministry for the Environment, but the Ministry of Business, Innovation and Employment (MBIE) has the responsibility to ensure it is complied with in workplaces.

224.	The HSNO Act requires that hazardous substances are first approved for importation or manufacture in New Zealand, and then are subject to a specific set of controls that regulate their use, depending on the nature of the substance. In many cases a minimum threshold applies before certain controls become applicable, but there is not a higher threshold at which additional controls apply because of the risk of catastrophic outcomes. There are also controls specific to on site emergency management and emergency response plans, again dependant on the hazard classification of the substance.

102	See for example, (Hopkins, 2008)

103	Materials that require registration include, for example: chlorine (with a threshold quantity of 25 tonnes), hydrogen (50t), ammonia (200t) and LPG (200t).

225. New Zealand does have an approved code of practice for 'Managing hazards to prevent major industrial accidents' created in 1994. The code describes methods to control hazards which might result in a major industrial accident, minimise the consequences of a major accident and ensure that appropriate emergency planning is in place. Awareness of, and compliance with, the approved code of practice is weak and it lacks detail about its application making it difficult to apply.

226. Multiple government agencies and laws can have a role in major hazard operations, ranging from initial consenting processes through to emergency response. There is potential for confusion about compliance, conflicting regulatory objectives and gaps in enforcement.

High hazard industry regulations

227. Regulations made under the Health and Safety in Employment Act 1992 set out requirements for a number of specific work situations. There are regulations in force for two high hazard industries: underground mining; and petroleum exploration and extraction. There are also stand-alone regulations covering geothermal energy safety and pipelines.

228. While the general provisions of the Act still apply to high hazard workplaces, the regulations provide more prescriptive measures for assessing and managing particular types of hazards specific to those industries. However, with the exception of off-shore petroleum installations, these regulations are generally not concerned with managing major hazard incidents and ensuring appropriate on and off-site emergency planning.

229. The petroleum regulations are currently under review by MBIE, and the regulatory framework about underground mining will be the subject of recommendations made by the Royal Commission on the Pike River Coal Mine Tragedy.

High hazard unit

230. MBIE has a dedicated high hazard unit that coordinates and carries out its inspection and enforcement work in selected high hazard industries. At present the unit is focused on petroleum and geothermal operations and underground mining, although MBIE has not excluded the possibility of broadening the unit's focus in the future.

231. The high hazards unit takes a more intensive, proactive approach to regulating industries. It assesses safety cases for petroleum operations (although currently there is no requirement for a safety case to be formally approved by MBIE) and carries out safety systems audits for underground mines, placing the onus on operators to demonstrate that they can adequately manage the hazards involved. This is backed up with a strong reactive response to health and safety incidents, including near misses. The unit is also focussed on improving guidance and standards, ensuring adequate qualifications for workers and improving engagement with international regulators to improve New Zealand's capability.[104]

Other agencies' approaches

232. The Civil Aviation Authority is responsible for aircraft safety and takes an approach which has a very low tolerance of risk, given the severe consequences of aircraft failure. The Authority requires operators to make an exposition of how they intend to comply with safety standards before they receive a license to operate. A safety case regime is also in place for railways, administered by the New Zealand Transport Agency under the Railways Act 2005. However the focus of these regimes is primarily on passenger and community safety rather than the safety of workers in these workplaces.

---

104   (Department of Labour, 2011b)

What's happening overseas?

233. There have been numerous international examples of major accidents with extremely severe consequences, such as the 2005 Texas City oil refinery disaster in the USA which killed 15 workers and injured 170 more, or the explosion in 1998 at the Esso natural gas plant in Longford, Australia, which killed two workers and injured eight. The impact of these events is not always limited to the workplace. One of the worst examples of this is the Bhopal disaster in India, where a gas leak resulted in the deaths of thousands of people living near a large pesticide plant.

234. Industries such as petroleum extraction and underground mining are the subject of specific legislation and regulation in many overseas jurisdictions and often have a separate resource for health and safety regulation. They are generally the subject of industry-specific regulations under broader health and safety legislation, or even stand-alone legislation, as in the case of mining in Queensland and Western Australia.[105] Inspection and enforcement capabilities are separated out in some cases, such as mining inspectorates in Queensland and New South Wales, or specialist regulators for offshore petroleum that exist in Australia, the UK, Norway and Ireland.

235. Most developed countries also have specific regulations regarding the potential for major industrial accidents. In Europe, the European Commission issued the Seveso II Directive, which aims to both prevent accidents from occurring, and limiting the consequences of accidents to people and the environment.

236. The Seveso requirements are implemented in the UK through the Control of Major Accident Hazards Regulations. These regulations require operators to notify the relevant authority with details of dangerous substances they are managing, take all measures necessary to prevent a major accident, and prepare a major accident prevention policy. Operators that hold larger quantities of hazardous substances are additionally required to prepare a safety report, demonstrating that all necessary measures have been taken, before an operation begins.[106]

237. In Australia, the model workplace health and safety regulations requires major hazard facilities (such as oil refineries, chemical plants or large fuel and chemical storage sites) be licensed before they are able to operate and at regular intervals thereafter. As part of the licensing requirements, operators have to prepare a safety case showing how hazards will be managed, and an emergency plan in the event of a major accident.[107] With some variations, this approach has been implemented throughout the various Australian states and territories.

Tell us what you think

238. Some workplaces in New Zealand have the potential for major accidents that can result in catastrophic outcomes and significant loss of life, both for people in the workplace and in the community that the workplace is located in. As such, they require a particularly rigorous approach to workplace safety. New Zealand has specific rules and regulations to manage risks in some kinds of major hazard industries, but not in all. In particular, facilities that store, process or produce significant quantities of hazardous substances are not subject to the same level of regulation in New Zealand as they are in other countries.

---

105 (Quinlan, Report comparing mine health and safety regulation in New Zealand with other countries, 2011)

106 (Health and Safety Executive)

107 (Safe Work Australia, 2012b)

Questions

Q19. How strong is New Zealand's current approach to regulating major hazards?

Q20. What improvements to the regulation of major hazards would lead to better workplace health and safety outcomes?

Health and Hazardous Substances

What's the issue?

239. There are a wide range of hazards present in workplaces that can lead to numerous forms of disease and ill-health for New Zealand workers. In many cases however, it can be difficult to determine exactly what contribution occupational exposures have played in the causation of disease. There is also often a long latency period between exposure and the onset of disease.

240. These difficulties make occupational disease much more difficult to understand, measure and manage effectively, particularly compared to the more obvious hazards that result in occupational injury. For these reasons, disease and ill-health has tended to receive much less focus from the workplace health and safety regulator, despite the scale of harm that occurs.

What's happening in New Zealand?

The scale of harm

241. A large body of knowledge exists about the range of hazards in the workplace that can lead to disease. What is not particularly well known is the level of harm that results from exposure to these hazards due to problems of latency and attributing causation. There is little monitoring of exposure in the workplace and occupational health surveillance and record keeping is poor.

242. The best estimate of the full scale of harm that is occurring comes from a 2004 study by the National Occupational Health and Safety Advisory Council. They estimated that every year in New Zealand there are 17,000 to 20,000 new cases of occupational disease and 700 to 1,000 deaths. The leading causes of death are cancer, respiratory disease and ischaemic heart disease.[108] Other common occupational diseases include infectious diseases such as tuberculosis or leptospirosis, diseases of the nervous system, musculoskeletal disorders, skin conditions such as dermatitis, noise induced hearing loss and a range of psychosocial disorders.[109]

243. Much of the harm caused is the result of long-term exposure to workplace hazards. If hazards are not identified early, very harmful levels of exposure can occur before any serious health problems are observed. This can be illustrated by the example of asbestos exposure. While awareness of the hazards of asbestos is now fairly widespread, cases of asbestos related cancers and other diseases continue to grow steadily, as a result of historic exposure over previous decades.

244. This scale of harm indicates the significant challenge to the regulator and employers in dealing with known hazards.

Challenges of managing health hazards

245. The Health and Safety in Employment Act 1992 (HSE Act) imposes an obligation on employers to identify and manage all hazards in their workplaces, but most employers (and employees) are much more conscious of hazards that lead to injury than exposure to hazards that lead to disease.

---

108   (Pearce, 2004)

109   (Department of Labour, 2011c)

246. In general, acute health risks can and should be managed in much the same way as hazards that lead to injury with a similar degree of effectiveness. Managing chronic health risks can be much more difficult however.

247. For many diseases the chronic harm that occurs as a result of exposure to workplace hazards is not as visible or clearly attributable to the hazard as it may be with more acute injuries or diseases. It can be hard to establish whether, and to what degree, the harm is caused in the workplace as opposed to other sources, and it can also be difficult to attribute an occupational health problem to a particular workplace or employer. As a result of these issues, it can be more difficult to identify and to control hazards effectively, and to raise awareness of risks.

248. Managing occupational health is complicated by the fact that new risks are continually emerging through the use of new materials and technologies. For example, manufactured nanomaterials are becoming increasingly prevalent in workplaces and evidence suggests they may have serious health implications to the degree that they have been recognised as one of the top emerging risks in European workplaces.[110] New Zealand's Environmental Protection Agency (EPA) has described the adverse effects of nanomaterials as "uncertain", but will still require presence of nanomaterials in cosmetic products to be identified on labelling from July 2015.[111]

249. Regulatory controls can often struggle to keep pace with newly emerging health risks. This presents an additional challenge for the regulator of needing to continually identify new hazards, often once harm is already becoming apparent in workplaces, and work out how to best ensure they are managed.

Hazardous substances

250. Certain types of hazards that may lead to disease need to be managed under the Hazardous Substances and New Organisms Act 1996. This Act places specific controls on certain hazardous substances to manage the adverse effects that they may have on people and communities. The Ministry of Business, Innovation and Employment (MBIE) is responsible for seeing that the Act is complied with in workplaces.

251. Under the HSE Act, employers are required to eliminate or isolate hazards, or where this is not possible, to minimise and monitor employees' exposure to them. In regard to exposure to hazardous substances, MBIE, together with the EPA, establishes Workplace Exposure Standards, which set exposure limits for about 700 individual substances. The standards are not intended to provide a guarantee of protection however, due to variable tolerance levels and often incomplete knowledge about the effects of these substances. The standards only act as a guide for ensuring compliance with the HSE Act.[112]

The regulator's approach

252. The current regulatory system for occupational health is widely recognised as being complex, particularly in regard to the HSNO. Businesses often struggle to understand the complexities of what is required of them, which can create challenges for ensuring widespread compliance.

---

110   (European Agency for Safety and Health at Work, 2009)

111   (Environmental Protection Authority, 2012)

112   (Department of Labour, 2011d)

253. The Occupational Health Action Plan to 2013 sets out the direction for the Ministry's current approach to occupational health. It sets out three priority areas for action: reducing exposure to five specified occupational health hazards; developing capability to address occupational health issues; and building relationships between government, industry, researchers and health practitioners. In each of these areas the plan details a number of specific actions to be completed by 2013.

254. MBIE is also taking steps to improve its regulation of hazardous substances, by aligning activities to a wider health and safety approach. The intention is to take a more focused approach to exposure reduction in selected sectors, such as vehicle repair, allowing MBIE to gain a better understanding of non-compliance and to ensure more rigorous monitoring, evaluation and enforcement.

255. MBIE also operates the Notifiable Occupational Disease System. The system is used to notify MBIE of harm that has been caused by exposure to workplace health hazards. MBIE uses notifications to assess and investigate individual cases and to look for national patterns in notifications. The system is voluntary and receives about 270 notifications per year.

What's happening overseas?

256. Other countries are grappling with similar challenges as New Zealand in regard to occupational health with the problems of long latency diseases and attributing causation well recognised. Other regulators have historically tended to place a greater focus on the prevention of acute injuries with only belated attempts now being made to better understand the burden of and solutions to the problem of occupational disease and ill-health.

257. In Australia, the National OHS Strategy 2002—2012 highlighted the need to "prevent occupational disease more effectively" as one of five priority areas. Under this strategy, Safe Work Australia produces biannual Occupational Disease Indicators reports to track progress in this area.[113] Similarly in the UK, targeting key health issues is a priority in the national health and safety strategy and the problems of latency and causation are specifically highlighted as issued to be managed more effectively.[114]

Tell us what you think

258. Occupational disease and ill-health is a major contributor to the harm that occurs in New Zealand workplaces. Its management has tended to be overshadowed by the more immediate and visible hazards that result in injuries. Both the management and measurement of occupational health is complicated by the difficulties in attributing causation to work-related factors and the latency that often occurs between exposure and the diagnosis of disease. However the hazards that lead to disease still can and should be identified and controlled in workplaces.

---

113   (Safe Work Australia, 2010)

114   (Health and Safety Executive, 2009)

Questions

Q21. What are the most significant challenges to managing occupational health risks and exposure to hazardous substances?

Q22. What changes could be made to the existing workplace health and safety framework to reduce the harm caused by occupational disease and ill-health?

Small to Medium-Sized Enterprises

What's the issue?

259. The current workplace health and safety regulatory system may impact on small-to-medium sized enterprises (SMEs), who employ 19 or less workers, differently to other businesses. The system, and how it is implemented, should consider the characteristics of SMEs so that the system is fit-for-purpose for all firms based on the risks they face, regardless of the size of the enterprise.

What's happening in New Zealand?

SMEs approach workplace health and safety issues differently to other firms

260. SMEs may approach workplace health and safety issues in a different way to other businesses. This may reflect differences in the characteristics of small-to-medium sized enterprises, such as:[115]

- management by the owner in a personalised (non-formal) manner — management styles in SMEs reflect the owner's experience and training and tend to involve predominantly oral communication
- having high resource constraints, operating under extreme financial pressure and having a high potential for failure
- having limited access to external sources of advice and support and to business information/expertise
- lacking formal documentation

261. Owners and managers of SMEs may also be more focussed on the products they sell or services they provide, with less focus on management or administrative activities. This is often described as the owner or manager working in the business not on the business.

262. As a consequence SMEs might be expected to rely more on external advice to manage workplace health and safety issues than larger firms. There is some evidence, however, that SMEs are less likely to use external advice than larger firms, although SMEs will spend proportionately more on advice when they seek it than larger firms.[116]

263. SMEs also generally ask for workplace health and safety obligations to be clear and for consistency and certainty in monitoring and enforcement.

264. The quality, suitability and cost of complying with regulatory requirements, including through using external advice, is of particular concern to SMEs. Estimates of compliance costs across a range of areas, including workplace health and safety, consistently show that the smaller a business is the higher the average compliance cost is per employee.[117]

---

115   (National Occupational Health and Safety Advisory Committee, 2009) p. 9

116   (Business NZ, October 2008) p. 49, Table 60: Employment Compliance Costs by FTE Group (2006—2008).

117   (Business NZ, October 2008) p. 13, Table 2: Summary of Compliance Costs by FTE Group (2006—2008).

265. These features of SMEs are reflected in the Small Business Advisory Group's (SBAG) comments about workplace health and safety regulation:[118]

- where regulation is justified there must be clarity in defining obligations, together with consistency, certainty and transparency in their monitoring and enforcement
- there is a lack of clarity in definition, monitoring and enforcement obligations as it applies to SMEs
- there has been a proliferation of consultant-delivered and paper-based systems providing 'tick box' compliance, with little obvious relevance to the day-to-day activities or the health and safety performance of the SMEs that use them

The number of small-to-medium sized enterprises differs across sectors

266. In New Zealand, self-employed and SME enterprises made up 97.21% of all businesses and 40.27% of workers as at February 2011.[119]

267. In the agriculture, forestry and fishing and construction sectors where action plans are in place due to high risk or hazard, a slightly higher percentage of enterprises are SMEs than across all sectors. These sectors have a significantly higher proportion of employment by SMEs than across all sectors. A different approach may need to be taken to workplace health and safety issues in these sectors to reflect the significant presence of SMEs and any differences in risk profiles for those enterprises.

268. By contrast the manufacturing and mining sectors have a slightly lower percentage of SMEs than across all sectors and a significantly lower proportion of employment by SMEs than across all sectors (Figure 10).

Figure 10: Proportion of Enterprises and Workers in SMEs[119]

	Enterprises that are SMEs	% of Enterprises that are SMEs	Worker count in SMEs (including self-employed)	% Worker count in SMEs (including self-employed)
A) Agriculture, forestry, & fishing	70,472	98.89%	119,703	74.62%
B) Mining	561	93.19%	1,426	23.20%
C) Manufacturing	19,112	91.32%	61,982	26.40%
E) Construction	48,822	98.41%	91,838	62.74%
All other industries	317,962	97.05%	625,009	37.05%
Total	456,929	97.21%	899,958	40.27%

269. Paragraph 23 notes the available data from StatisticsNZ, ACC or the Ministry of Business Innovation and Employment does not present a clear picture of injury rates or claim rates by firm size — this reflects an earlier finding from the National Occupational

---

118   (Small Business Advisory Group, 2012) p. 20.

119   (Statistics New Zealand, February 2011)

Health and Safety Advisory Committee (NOHSAC).[120] The same data availability issues apply to information about injury or entitlement claim rates for the self-employed and SMEs in different industries. The lack of a clear evidence base about the impact of firm size and industry is a problem in itself, as this information, if available, would help to identify whether a different approach needs to be taken to workplace health and safety issues for the self-employed and SMEs in different industries.

Challenges for SMEs

270. Anecdotal evidence suggests that self-employed and SMEs who are contracting to larger businesses or government may face competitive pressures in order to gain contracts. While there are examples of supply chains that clearly value workplace health and safety investments by self-employed and SMEs who contract to them, there are also examples of self-employed and SMEs being placed under pressure to cut costs, leading to low levels of investments in workplace health and safety. There is also anecdotal evidence of pressure on self-employed and SMEs not to report workplace health and safety incidents and issues, and to not make ACC entitlement claims, in order to retain contracts.

271. Owners and managers in SMEs may face particular challenges in ensuring worker participation. On the one-hand the personalised management style by the owner of a SME may support the close involvement of their workers in workplace health and safety matters. However, the opportunities for SMEs to more formally involve their workers in workplace health and safety matters as a workplace health and safety representative are likely to be limited, due in part to the low likelihood that workers at SMEs will be union members. Even if there are union members present at a SME, it may be difficult for them to participate actively in the same way a workplace health and safety representative in a medium-sized or large firm can.

What's happening overseas?

272. The challenges faced by SMEs in managing workplace health and safety issues appear to be similar across a range of countries, with a similar range of approaches taken to address those challenges. NOHSAC note that the most common approaches included "the use of different types of checklists, implementation of OHS management systems and other preventive programmes. … the most successful methods appear to be action oriented low-cost approaches, combining health and safety with other management goals, that are based on trust and dialogue."[121]

273. A range of subsidy and grant schemes have been used internationally to support SMEs with workplace health and safety initiatives. (These schemes are discussed in paragraph 201.)

274. Support for workers in SMEs, where there are low levels of union membership or unions are not present, is provided in the UK through the use of roving health and safety representatives and regional health and safety advice centres. (This approach is discussed in paragraph 153.)

---

120   (National Occupational Health and Safety Advisory Committee, 2009) pp. 31—38.

121   (National Occupational Health and Safety Advisory Committee, 2009) p. 11.

Tell us what you think

275. Self-employed and small-to-medium sized enterprises may approach workplace health and safety issues in a different way to other businesses, and the current workplace health and safety system may impact on small-to-medium sized enterprises differently to other businesses. The Taskforce considers that system, and how it is implemented, needs to be fit-for-purpose for all firms based on the risks they face, regardless of the size of the enterprise. *The Taskforce invites submissions on whether this is currently the case.*

Questions

Q23. **What workplace health and safety challenges are specific to the self-employed and small-to-medium enterprises?**

Q24. **What improvements could be made to the workplace health and safety framework, and its implementation, to ensure that it's effective for self-employed and small-to-medium sized enterprises?**

Measurement and Data

What's the issue?

276. Robust, wide reaching and integrated workplace injury and disease data collection and monitoring systems are critical for a well-functioning health and safety system. Effective surveillance regimes enable the timely identification of signals and trends, deep causal analysis, evidenced-based intervention and the sensitive evaluation of preventative measures[122]. While New Zealand has a number of data sets available for analysing and reporting on workplace related injury and occupational disease, there is no purpose built, comprehensive data set for robustly monitoring high level outcomes. Nor is there a reliable, accessible, and information-rich source for undertaking robust causative analysis and developing and evaluating targeted interventions.

What's happening in New Zealand?

National level data

277. In New Zealand there are a range of data sets that collect information on workplace injuries and workplace related disease. These data sets have been developed for particular administrative purposes rather than for national surveillance. For example, some routinely capture information such as occupation or cause of injury, while others do not or do so poorly. Further, because there are difficulties in matching personal data across data sets, there is no single, readily accessible, comprehensive and reliable data set for monitoring and examining workplace fatality or serious injury rates and incidences in New Zealand.

278. There are five main types of workplace injury and disease related data collected and reported on or available for national level monitoring and reporting purposes. Each of the data sets is used to report 'lag', outcome measures and are not able to report on 'lead' indicators of national levels of resilience or preparedness to manage workplace health and safety risks[123]. The data sets are:

- ACC claims management data
- Workplace fatal and non-fatal Serious Injury Outcome Indicators, which are Statistics New Zealand's 'official' indicators of workplace injury based only on the most 'severe' ACC injury claims to minimise threats to validity over time
- regulators' case file investigations (including the Ministry of Business, Innovation and Employment, the Civil Aviation Authority, Maritime New Zealand and the Ministry of Transport)
- Coronial Office files
- The Ministry of Health's Mortality Collection, Cancer Register and National Minimum Dataset (covering hospital events)

279. There are three main annual reports on workplace illness and injury outcomes at the national level in New Zealand. These tend to focus on lag indicators of fatality and injury. The New Zealand Injury Prevention Strategy updates and analyses the Serious Injury Outcomes Indicators. Statistics New Zealand produces summaries of all ACC

---

122 (Kendall, 2005)

123 Leading indicators are measures of *process or inputs* essential to deliver desired safety outcomes while lagging indicators show when a desired safety *outcome* has failed. (UK Health and Safety Executive, 2006).

work related claims. The Ministry of Business, Innovation and Employment produces a wider range of indicators in the State of Workplace Health and Safety report, including selected statistics from ACC and the Serious Injury Outcomes Indicators, and lead indicators from survey and administrative sources.

Data integration across enforcement agencies

280. The Ministry of Business, Innovation and Employment (MBIE) receives around 6,000 notifications per annum for work related health and safety incidents in workplaces outside of ships, aeroplanes and motorways. Investigation files from the Civil Aviation Authority, Maritime New Zealand or the Police Commercial Vehicles Investigation Unit are not shared with the Ministry. In part this is due to a lack of consistency in operating practice between the regulatory agencies, including differences between agencies on what the key issues are, how events and causes are defined, what information is captured and how the data is recorded. There is a lack of common, shared language for similar events.

281. Information on the most serious ACC claims is shared with the Ministry (under section 286 of the Accident Compensation Act 2001), so that it can inform employers of their reporting obligations under the HSE Act, undertake investigations and to improve agency co-ordination. This covers approximately 10 percent of ACC's claims for work-related entitlements. However, beyond the most serious ACC claims shared with the Ministry, the Ministry does not follow-up compensation claims with subsequent investigations, keeping the unit records between the chief regulator and ACC separate.

Monitoring outcomes over time through ACC claim data

282. As a result of limitations in regulator data capture, trend analysis in New Zealand relies predominantly on ACC data. The ACC's claim based record of workplace related injuries is the most comprehensive available in New Zealand[124], with around 190,000 medical claims and 25,000 weekly compensation claims per annum. This volume of cases enables claimants to be confidently analysed by key demographics, including industry and occupation (but not size). There are issues however with relying too heavily on ACC data for monitoring and investigation purposes. Claim numbers are necessarily limited by ACC's claim parameters and the inclination of injured parties to seek compensation (which varies across sub-populations, economic cycles and industries). For example, ACC, through its cover and recording of motor vehicle incidents separate to the ACC Work Account, exclude motor vehicle incidents from the work related statistics available.

283. While the Serious Injury Outcome Indicators improve the robustness of ACC measures for trend analysis over time, motor vehicle incidents remain excluded and, further, these measures are not able to be disaggregated by subpopulation.

Causative analysis

284. For causation, in-depth analysis relies principally on investigation case data. In the case of fatal injuries, access to Coroner reporting and Ministry of Health mortality data (which do not capture occupation or workplace relatedness reliably) can also be used. Investigations are typically focussed on collecting evidence to demonstrate a breach of legislation, and are not designed for causal analysis. While serious harm reporting to the regulator from employers is mandatory in New Zealand, this is unreliable with only a small proportion of incidences being reported compared to the number ACC claimants. Reasons for this include avoidance of subsequent investigation and possible

---

124   (Health Outcomes International Ltd, 2005)

sanction, and a lack of clarity on the part of many employers of what constitutes 'serious harm'.[125]

285. While all MBIE investigations result in case files, only some of this information is recorded in a manner which is readily extracted from the Ministry's national electronic data management system INSITE. This results in limited causality related data being readily available for aggregate monitoring or exploratory purposes.

Occupational disease and illness

286. The capture of occupational illness and disease at the national level is particularly patchy in New Zealand[126]. In part this is due to the complexities of the health conditions, characterised by long latency periods following exposure and difficulties in attributing the contribution of occupational causes to the disease or illness. Further, anecdotal evidence suggests that General Practitioners in New Zealand are not adequately trained to identify occupational illness nor to record work histories. It is estimated that there are 17,000 — 20,000 new cases of work related disease in New Zealand and 700 — 1000 deaths each year[127].

287. MBIE's Notifiable Occupational Disease System, New Zealand's only purpose built occupational disease recording system, relies predominantly on voluntary notifications from General Practitioners and captures around 270 cases each year. ACC does better at capturing occupational illness, however with a subset of diseases included in the schedule for occupational disease related compensation, a higher burden of proof required to establish causality and a low rate of claim for many occupational diseases[128], this data set is recognised as less complete than for injuries and unreliable for national monitoring purposes. Like many overseas jurisdictions, New Zealand does not have a reliable, timely and comprehensive mechanism for tracking, investigating and intervening in work related disease.

Firm level data

288. Businesses vary in their capacity to effectively monitor their health and safety performance. While some do this well, capturing lead and lag indicators[129], others focus only on lag indicators and investigations following an adverse event to identify failings in their risk control systems. Low levels of consistency across firms in what they capture and record make it difficult for firms to compare the performance of their systems against other firms.

What's happening overseas?

289. Accurately measuring work-related fatality, non-fatal serious injury and occupational disease is complex and practices adopted internationally are generally patchy and inconsistent. Like New Zealand, most overseas jurisdictions are 'data driven'[130], i.e. rely on a tapestry of health, insurance and regulatory data sets derived for administrative specific purposes to monitor and explore health and safety trends and to hypothesise causes. Some countries, such as the UK, use expert opinion and self-reported injuries and illness from work in labour force surveys to supplement and

---

125   The definition of 'serious harm' has been under review since 2007 and legislative changes to this definition are pending.

126   (Health Outcomes International Ltd, 2005)

127   (Ministry of Business, Innovation and Employment, 2012c)

128   (Health Outcomes International Ltd, 2005), (Pearce, 2004)

129   See footnote 123 for a description of lead and lag indicators.

130   (Kendall, 2005)

interpret this data. This approach has similarities to the supplementation of police statistics with crime victim surveys in New Zealand.

290. While rare, there are examples of purposeful, comprehensive and integrated data collection systems[131]. Finland's data collection system most notably has a single integrated data set, with equal emphasis on occupational ill-health and workplace injury. This data set is informed by mandatory reporting across a range of parties and data collection mechanisms. Parties with mandatory reporting responsibilities include health practitioners (reporting occupational illness), employers (reporting on injuries), and insurance providers (reporting on claims). Notably the data system is managed by the government funded Institute of Occupational Health. All claims for compensation are included in the register, not just approved claims, ensuring data is collected and made available promptly.

Tell us what you think

291. Work related injury and illness data sets in New Zealand are not well suited for robust national level injury and disease surveillance. Data sets used for this purpose have been developed for specific administrative purposes such as investigations or compensation claim management, with limited reliability and comprehensiveness beyond this, and are not easily integrated. This limits capacity for robust monitoring and investigation.

Questions

Q25. To what extent are New Zealand's workplace injury and occupational disease data collection mechanisms conducive to robust monitoring, investigation and comparative analysis?

Q26. What opportunities are there for improving data collection, integration and reporting?

---

131   (Kendall, 2005)

Our National Culture and Societal Expectations

292. Our workplace health and safety record is poor when compared to other countries. Throughout this consultation document we have considered a range of issues that might help to explain this but what remains puzzling is why the difference is so large.

293. This is not limited just to workplace health and safety. In New Zealand we are also more likely to have accidents outside of work or be harmed in a crash on the road (refer Figure 11) when compared with Australia and the UK.

Figure 11 — Accidental Fatality rates per 100,000 persons (in workplaces[132],[133], on roads[134], in all settings[135])
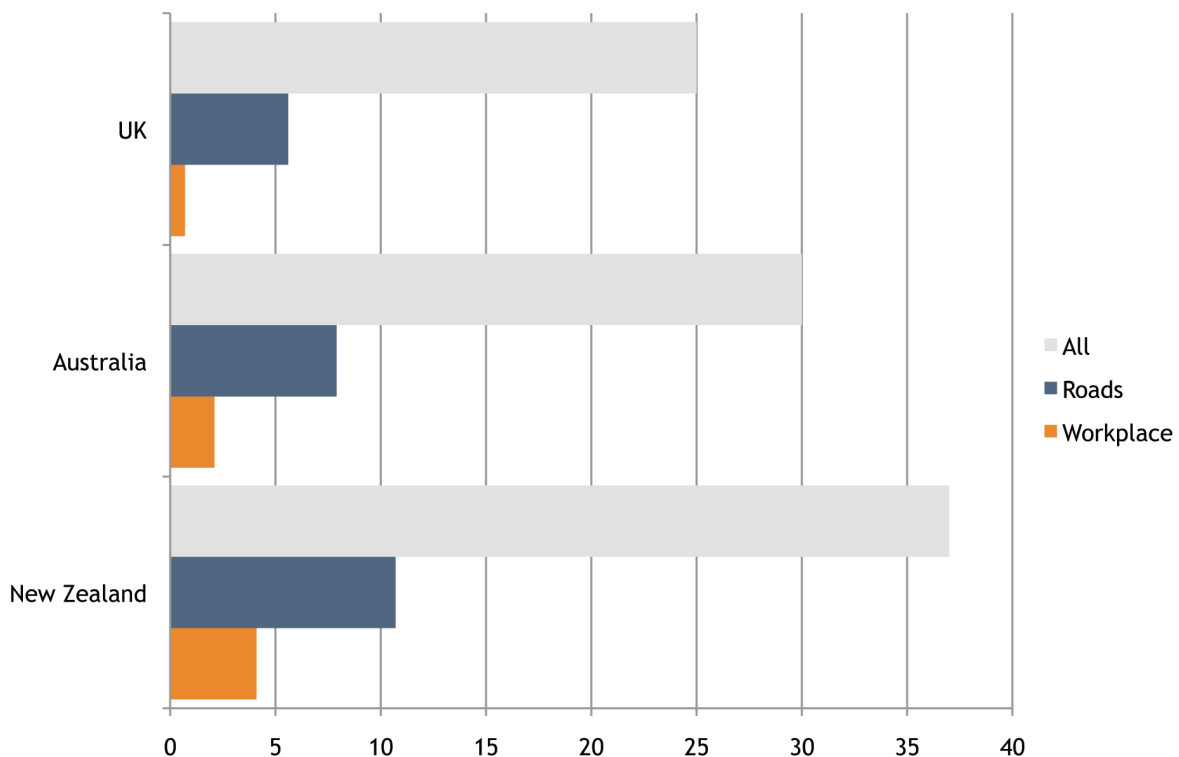
294. The common factor across these different contexts may simply be us and our approach to safety. What is it about us, or our culture, that is causing us to have worse health and safety outcomes?

295. When we talk about culture we often do this by referring to the behaviours, perceptions, attitudes, beliefs, and values, that we consider ourselves to have as a society.

---

132   (Statistics New Zealand, 2010)

133   (International Labour Organisation, 2012)

134   (Connor, Langley, & Cryer, 2006)

135   (World Health Organisation, 2011)

296. We are a diverse nation made up of many different cultural groups, each with its own customs and traditions. Māori migrated to New Zealand generations ago with other groups settling in New Zealand after that. But together we consider New Zealand our home. The way we distinguish our culture from others, particularly from our original or ancestral countries, is by emphasising the aspects and expressions of our culture that are not normally found in those other countries. Inevitably, these aspects and expressions include a high proportion that draw on Māori culture, since Māori culture is unique to New Zealand and forms a positive part of our identity in the outside world[136]. Our culture is a rich and diverse blend of many cultures.

297. We sometimes express our awareness of some aspects of our culture in the way we talk about things. Perhaps these expressions of our culture provide us with clues about our poor health and safety outcomes?

298. Some would say we have a "she'll be right…" attitude to safety as the examples below show:

- How often have you walked in the supermarket and seen a "wet floor" sign, and wondered how much more effort would it have taken for the floor simply to have been dried? After all, the sign doesn't magically stop people from finding the floor slippery, does it?
- How many of us wear protective equipment when at work only to be guilty of mowing the lawn without safety glasses, boots, or earmuffs?
- How many times have we done things that are dangerous, when with a little more planning and effort we could have done things safely? How many times have we used the excuse that "it will only take a minute"?

299. When we tell ourselves, she'll be right, we are meaning "near enough". Too often it isn't. Too often we say this because we want to get on with things and so we ignore or dismiss the ways that things may go wrong or fail to last.

300. At the same time we are sometimes reluctant to be seen as standing out from the crowd. Some say we are suspicious of experts, specialists, and specialist knowledge as a result. We seem to have more respect for practical achievements and success against the odds than for achievements from academic or commercial prowess (New Zealand Trade and Enterprise, 2009). We talk about "tall poppy syndrome" when we explain our tendency to disparage prominent or successful people (Oxford English Dictionary, 2012).

301. "Tall poppy syndrome", is uncommon in Māori Leadership. The collectives (whānau, hapū, iwi) have a different approach to leadership with the value of humility accentuated. An example is provided in the form of a proverb: "Kāore te kumara e whaakii ana tana reka", or in English, "The kumara (sweet potato) does not speak of its own sweetness".

302. In some cultures humility and respect may be dominant values making it difficult for people to raise issues or complain to people in authority. More recent migrants may be less connected to New Zealand culture, preferring to maintain the culture of their group identity.

- How often have you felt reluctant to tell someone about a hazard or your concerns because it would make you stand out?
- How often have you done things the same way as everyone else, even though you knew it was not the best or safest way to do it?

---

136   (Ministry for Culture and Heritage — Te Manatu Taonga, 2009, p. 41)

303. Intertwined with these concepts is a history of resourcefulness that underpins our culture. Kiwi ingenuity and our "number eight wire" mentality are commonly used to characterise this resourcefulness. The term has become a metaphor for our inventiveness where we easily outrank all other developed nations, with Māori outpacing the general population[137].

304. We don't know what it is about our culture that contributes to our high rates of harm. But do we need to? We could simply accept that there is "something" about our culture that is influencing our health and safety outcomes, and instead focus our effort toward moving our culture to where we want it to be: a safer New Zealand.

305. We know this is achievable. We have repeatedly shown the world we can outshine every other nation when we put our heart into it. Not knowing all the answers has never been an obstacle to this and we can do it again. Ironically, as a nation, we love standing out from the crowd. But we do it together.

306. Our journey does not need to be without a map and compass. In fact, we have already begun:

- we now wear seat belts a lot more than we used to
- we don't drink and drive as much
- we are no longer smoking in bars or at work and we don't tolerate second-hand smoke
- we now "slip, slop, slap and wrap" to protect ourselves from the sun

307. Our national efforts in these areas have changed our nation for the better. Our culture and behaviours have changed for the better for these issues. We can learn from these initiatives about how to effectively change.

Tell us what you think

Questions

Q27. **Do you think New Zealand culture influences our workplace health and safety outcomes?**

Q28. **What might we do to improve our culture relating to workplace health and safety?**

---

137   (Frederick & Chittock, 2006)

Consultation Process

We are interested in your responses to this consultation document — in particular, whether you think we have identified the right causes of New Zealand's workplace health and safety problems, and what you think needs to be done to reduce those problems.

How to tell us what you think

Here are the ways that you can tell us what you think:

A. COMPLETE THE ON-LINE QUESTIONNAIRE

The easiest and quickest way to tell us what you think is by completing the on-line questionnaire. The questionnaire can be accessed by going to our website at http://hstaskforce.govt.nz/ and clicking on the 'on-line questionnaire' button.

Information to help you answer the questions can be found next to the questions on-line — just hover your mouse over the blue question mark symbols. That same information can be found in this consultation document. There are also guides to help you that can be found on our website. Click on 'Individual submissions guide' or 'Workplace and group submission guide'.

B. COMPLETE A SUBMISSION TEMPLATE

If you would prefer to provide us with a longer submission, you can download the submission template by going to our website at http://hstaskforce.govt.nz/

You can save the submissions template to your computer, type in your answers and email it to us (we'd prefer to receive your answers this way), or you can type your answers in, print your completed submission template and post it to us. If doing the submission this way doesn't work for you, print off the submission template and fill it in by hand.

Information to help you answer the questions can be found in this consultation document.

You can email us at secretariat@hstaskforce.govt.nz or ring us on (04) 915 4215 and request that a hard copy of the submission template and consultation document be sent to you if you wish.

C. WRITE TO US

If you do not want to use the submission template to make your submission, that's OK. Simply write down what you think is important for us to consider and send it to us (see below for how to get your submission to us).

D. ATTEND A PUBLIC MEETING

Public meetings, hui and fono will be held in early October to early November to hear directly from interested individuals, groups and organisations. The public meetings will be held in Auckland, Hamilton, Wellington, Christchurch and Dunedin. The hui will be held in Auckland, Hamilton, Rotorua, Wellington and Christchurch. The fono will be held in Auckland and Porirua. A list of dates and venues for these meetings will be placed on our website.

If you would like to make a submission on behalf of a workplace or group, a guide for doing so, including how to hold a workplace meeting, can be found on our website at http://hstaskforce.govt.nz/. Click on 'Workplace and group submission guide'.

Note that we will not be hearing oral submissions from the public, however there may be an opportunity to raise any concerns at one of the public meetings.

Deadline for submissions

We would appreciate it if you could get your submission to us as early as possible, but at the latest, you must get your submission to us *by 5pm, Friday 16 November 2012*, whether you use the on-line questionnaire or the submission template. If you are sending your submission to us by mail, you should put it into the post by 5pm, Wednesday 14 November 2012.

How to get your submission to us

We prefer to receive submissions electronically. If you are completing the on-line questionnaire, it will go to us automatically when you click on 'Submit'. If you are completing the submission template or writing a submission, the email address to send your submission to is secretariat@hstaskforce.govt.nz.

If you want to mail your submission to us, please post it to:

> Submissions
> Independent Taskforce on Workplace Health and Safety
> PO Box 3705
> Wellington 6140

What we'll do with the submissions

Information you provide may be used in our final report. Additionally, we may wish to place your submission on our website.

Please tick the applicable boxes on the submission template or tell us in your written submission if you:

- Consent to your submission being placed on our website
- Wish your name to be withheld from publication (submissions from individuals only).

Please note that all submissions to the Taskforce can be requested under the Official Information Act 1982. If that happens, we will delete names of people and identifying information if you sought anonymity.

After submissions have closed, we will begin to develop our final report. To help us do this, we will test our thinking with our broader network of experts and reference groups. We will provide our final report to the Government by 30 April 2013.

Summary of Key Dates

- **Taskforce holds public meetings**
  — early October to early November 2012

- **Submissions to the Taskforce close**
  — 16 November 2012

- **Taskforce reviews submissions and begins writing final report**
  — mid-November 2012 — February 2013

- **Final report presented to the Government**
  — 30 April 2013.

Works Cited

ACC. (2010a). *ACC Workplace Safety Evaluations.* Retrieved September 05, 2012, from ACC: http://www.acc.co.nz/for-business/small-medium-and-large-business/workplace-safety-for-small-medium-and-large-businesses/BUS00064

ACC. (2010b). *ACC Partnership Programme.* Retrieved September 05, 2012, from ACC: http://www.acc.co.nz/for-business/small-medium-and-large-business/how-to-pay-less/BUS00052

ACC. (2011a). *Current years levy rates.* Retrieved September 05, 2012, from ACC: http://www.acc.co.nz/about-acc/levies/current-years-levy-rates/index.htm

ACC. (2011b). *ACC Workplace Safety Management Practices.* Retrieved September 05, 2012, from ACC: http://www.acc.co.nz/for-business/small-medium-and-large-business/how-to-pay-less/BUS00054

ACC. (2012). *Experience rating — making ACC work levies fairer for individual businesses.* Retrieved September 05, 2012, from http://www.acc.co.nz/for-business/experience-rating/index.htm

Agarwal, R. G. (2011). *Management Matters in New Zealand: How Does Manufacturing Measure Up?* Ministry of Economic Development.

Allen + Clarke Policy and Regulatory Specialists Limited. (2012). *Report to the Department of Labour: Effective Service Delivery for the Health and Safety Inspectorate.*

Arbejdstilsynet. (n.d.). *Red, yellow and green Smileys and Smiley with a crown.* Retrieved September 05, 2012, from Arbejdstilsynet: https://arbejdstilsynet.dk/en/engelsk/inspection/smiley-26-6-07.aspx

Australian Bureau of Statistics. (2010). *Work-Related Injuries, Australia, 2009—10.* Canberra: Australian Bureau of Statistics.

British Safety Council. (2012a). *About the British Safety Council.* Retrieved September 10th, 2012, from British Safety Council: https://www.britsafe.org/about

British Safety Council. (2012b). *Audits.* Retrieved September 5th, 2012, from British Safety Council: https://www.britsafe.org/audit-and-advisory/audits

BSR. (n.d.). BSR. Retrieved September 10th, 2012, from https://www.bsr.org/en/

Business Leaders' Forum on Workplace Health & Safety. (2011). C*EO Safety Leadership Assessment — Summary Report.* Retrieved September 10th , 2012, from http://www.zeroharm.org.nz/documents/CEO-assessment.pdf

Business Leaders Health and Safety Forum. (n.d.). *Pledge.* Retrieved September 10th, 2012, from http://zeroharm.org.nz/pledge.html

Business NZ. (October 2008). *Summary report of the Business New Zealand — KPMG compliance cost survey.*

Centre for Corporate Accountability for the Health and Safety Executive. (2007). *International comparison of health and safety responsibilities of company directors.*

Citi Investment Research & Analysis. (2009). *Safety Spotlight: ASX100 Companies & More.*

Civil Aviation Authority of New Zealand. (n.d.). A*nnual Reports, Statements of Intent and Profiles.* Retrieved September 6th, 2012, from Civil Aviation Authority of New Zealand: http://www.caa.govt.nz/publicinfo/annualrepandprof.htm

Connor, J., Langley, J., & Cryer, C. (2006). *International comparison of injury deaths: Road Traffic.* New Zealand Injury Prevention Strategy Secretariat.

Department of Justice. (1985). *Canada Labour Code (R.S.C., 1985, c. L-2).* Retrieved September 05, 2012, from Department of Justice Canada: http://laws-lois.justice.gc.ca/eng/acts/L-2/index.html

Department of Labour. (2005a). *Workplace Health and Safety Strategy for New Zealand to 2015.* Retrieved September 10th, 2012, from http://www.dol.govt.nz/whss/strategy/index.asp.

Department of Labour. (2005b). *Reporting on Workplace Health and Safety and Employment Relations: a stock-take of current practice.*

Department of Labour. (2009). *The Workplace Health and Safety Strategy for New Zealand to 2015: Review report.* Wellington.

Department of Labour. (2011a). Workplace Health and Safety Strategy for New Zealand to 2015 — National Action Agenda 2010–2013. Retrieved September 10th, 2012, from http://www.dol.govt.nz/whss/action-agenda/index.asp

Department of Labour. (2011b). *Practical proposals for improving the Department of Labour's approach to high hazard industries.* Wellington: Department of Labour. Retrieved September 10th, 2012, from http://www.dol.govt.nz/news/media/pikeriver/high-hazard-industries/high-hazard-industries.pdf

Department of Labour. (2011c). *Occupational Health Action Plan to 2013.* Retrieved September 10th, 2012, from http://www.dol.govt.nz/whss/sector-plans/occupational-health/

Department of Labour. (2011d). *Workplace Exposure Standards and Biological Exposure Indices.* Wellington: Department of Labour.

Department of Labour. (2012a). *Workplace Health and Safety Strategy.* Retrieved September 10th, 2012, from Ministry of Business, Innovation and Employment: http://www.dol.govt.nz/whss/sector-plans/index.asp.

Department of Labour. (2012b). *In Harm's Way: A case study of Pacific Workers in Manukau Manufacturing.* Wellington.

Environmental Protection Authority. (2012, June 29). *Cosmetic products regulations updated.* Retrieved September 6, 2012, from Environmental Protection Authority: http://www.epa.govt.nz/news/erma-media-releases/Pages/Cosmetic-Products-regulations-updated.aspx

European Agency For Safety and Health at Work. (2002, March). *Directive 2002/14/EC — establishing a general framework for informing and consulting employees in the European Community.* Retrieved September 05, 2012, from European Agency For Safety and Health at Work: http://osha.europa.eu/en/legislation/directives/sector-specific-and-worker-related-provisions/osh-related-aspects/directive-2002-14-ec-establishing-a-general-framework-for-informing-and-consulting-employees-in-the-european-community

European Agency for Safety and Health at Work. (2009). *Expert forecast on emerging chemical risks relating to occupational safety and health.* Luxembourg: Office for Official Publications of the European Communities.

European Agency For Safety And Health At Work. (2010). *Economic incentives to improve occupational safety and health: a review from the european perspective.* Retrieved from European Agency For Safety And Health At Work: http://osha.europa.eu/en/publications/reports/economic_incentives_TE3109255ENC

Evans, J., & Gibb, E. (2009). *Moving from precarious employment to decent work.* Geneva: International Labour Organisation.

Expert Advisory Panel on Occupational Health and Safety. (2010). *Report and Recommendations to the Minister of Labour.* Toronto: Ministry of Labour.

Expert Advisory Panel on Occupational Health and Safety. (2010). *Report and Recommendations to the Minster of Labour.* Ontario: Ontario Ministry of Labour.

Frederick, A., & Chittock, G. (2006). *The Global Entrepreneurship Monitor — Aotearoa New Zealand.* Auckland: Unitec New Zealand.

Gander, P., Pearce, N., Langley, J., & Wagstaffe, M. (2009). *The evolving work environment in New Zealand — implications for occupational health and safety. Report to the Minister of Labour.* Wellington: NOHSAC.

Gunningham and Associates. (2009). *Underground Mining Information: Contextual Advice on International Standards and Literature Review.*

Health and Safety Executive. (2009). *The Health and Safety of Great Britain.* Health and Safety Executive.

Health and Safety Executive. (2011). *At a glance guide to health and safety statistics.* Health and Safety Executive.

Health and Safety Executive. (n.d.). *Control of major accident hazards Regulations 1999 (COMAH).* Retrieved September 5, 2012, from Health and Safety Executive web site: http://www.hse.gov.uk/comah/background/comah99.htm

Health And Safety Executive. (n.d.). *RR260 — Evaluation of the small firms allowance scheme.* Retrieved September 05, 2012, from http://www.hse.gov.uk/research/rrhtm/rr260.htm

Health and Safety in Employment Act 1992. (n.d.). Retrieved 09 05, 2012, from New Zealand legislation: http://www.legislation.govt.nz/act/public/1992/0096/latest/DLM278829. html?search=ta_act_H_ac%40acur%40anif_an%40bn%40rn_25_a&p=2

Health Outcomes International Ltd. (2005). *Methods and Systems Used to Measure and Monitor Occupational Disease and Injury in New Zealand: NOHSAC Technical report 2.* Wellington.

Hopkins, A. (2008). *Failure to Learn: The BP Texas City Refinery Disaster.* Sydney: CCH Australia.

Independant Taskforce on Workplace Health and Safety. (n.d.). Retrieved September 6th, 2012, from http://www.hstaskforce.govt.nz/documents/TermsofReference.pdf

Institute of Directors in New Zealand Inc. (2012). *Founding Documents.* Retrieved August 1st, 2012, from Institute of Directors in New Zealand Inc: https://www.iod.org.nz/ Publications/Foundingdocuments.aspx

International Labour Organisation. (1981). *C155 — Occupational Safety and Health Convention, 1981 (No. 155).* Retrieved September 06, 2012, from International Labour Organisation: http://www.ilo.org/dyn/normlex/en/f?p=1000:12100:0::NO::P12100_ INSTRUMENT_ID:312300

International Labour Organisation. (2012). *LABOURSTA.* Retrieved from International Labour Organisation: http://laborsta.ilo.org/STP/guest

Johnstone, R. (2009). *Regulating occupational health and safety for contingent and precarious workers: the proposed Australian 'primary' duty of care.* Canberra: National Research Centre for OHS Regulation.

Kendall, N. (2005). *International Review Of Methods and Systems Used To Measure and Monitor Occupational Disease and Injury: Technical Report 3.* Wellington : NOHSAC.

Knowles, D. J. (2006). *Measuring the effect of health and safety advisors and roving health and safety representatives in agriculture.* Retrieved September 05, 2012, from Health And Safety Executive: http://www.hse.gov.uk/research/rrpdf/rr417.pdf

Maritime New Zealand. (2012). *Corporate publications and forms.* Retrieved September 6th, 2012, from http://www.maritimenz.govt.nz/Publications-and-forms/Maritime-NZ-corporate-publications/Publications-and-forms.asp

Ministry for Culture and Heritage — Te Manatu Taonga. (2009, June). *CULTURAL INDICATORS FOR NEW ZEALAND — Tohu Ahurea mō Aotearoa.* Wellington, New Zealand. Retrieved from http://www.mch.govt.nz/files/CulturalIndicatorsReport.pdf

Ministry Of Business Innovation And Employment. (2012b). *Workplace Health And Safety Council.* Retrieved September 05, 2012, from Ministry Of Business Innovation And Employment: http://www.dol.govt.nz/whss/whsc/index.asp

Ministry of Business, Innovation and Employment. (10 August 2012). *Information for the Independent Taskforce on Workplace Health and Safety.* Wellington.

Ministry of Business, Innovation and Employment. (2012a). *Department of Labour Annual Reports.* Retrieved September 6th, 2012, from Ministry of Business, Innovation and Employment — Labour: http://www.dol.govt.nz/publications/general/gen-annual-report.asp

Ministry of Business, Innovation and Employment. (2012c). *Background papers for Health and Safety Strategic Review Independent Taskforce.* Wellington.

Ministry of Business, Innovation and Employment. (31 August 2012). *Information for the Independent Taskforce on Workplace Health and Safety.* Wellington: MBIE.

Ministry of Business, Innovation and Employment. (n.d.). *High Performance Working Initiative.* Retrieved September 10th, 2012, from http://www.dol.govt.nz/er/bestpractice/hpwi/index.asp

National Occupational Health and Safety Advisory Committee. (2009). *Occupational health and safety in small businesses.* NOHSAC Technical report 12. Wellington.

National Occupational Health and Safety Commission. (2004). *Fatal Occupational Injuries — How does Australia compare internationally?* Canberra: Commonwealth of Australia.

New Zealand Injury Prevention Strategy. (2012). *The New Zealand Injury Prevention Outcomes Report — June 2012.* Wellington: ACC.

New Zealand Qualifications Authority. (n.d.). *Directory of Assessment Standards (results of search for health and safety).* Retrieved 2012, from http://www.nzqa.govt.nz/framework/search/results.do

New Zealand Trade and Enterprise. (2009). *Section 1: National Culture.* Retrieved from Playing to Our Strengths: Creating value for Kiwi firms: http://www.nzte.govt.nz/features-commentary/In-Brief/Documents/playing-to-our-strengtths.pdf

Ontario Ministry Of Labour. (n.d.). *Improved Protection from Reprisals.* Retrieved September 05, 2012, from Ontario Ministry Of Labour: http://www.labour.gov.on.ca/english/hs/eap/report/improved.php

Oxford English Dictionary. (2012). Retrieved from Oxford English Dictionary online version June 2012: http://www.oed.com/view/Entry/197266

Passport to Safety New Zealand. (n.d.). *Passport to Safety.* Retrieved September 10th, 2012, from http://www.passporttosafety.com/newzealand/About.php.

Pearce, N. D. (2004). *The Burden of Occupational Disease and Injury in New Zealand.*

Quinlan, M. (2004). Flexible work and organisational arrangements. In L. Bluff, N. Gunningham, & R. Johnstone, *OHS regulation for a changing world of work* (pp. 120–145). Sydney: The Federation Press.

Quinlan, M. (2011). *Report comparing mine health and safety regulation in New Zealand with other countries.* Wellington: Department of Labour.

Research New Zealand. (2008). *Health and Safety Representative Training Evaluation: Final Report.*

Safe Work Australia. (2010). *Occupational Disease Indicators.* Commonwealth of Australia.

Safe Work Australia. (2012a). *INTERPRETIVE GUIDELINE—MODEL WORK HEALTH AND SAFETY ACT.* Retrieved September 10th, 2012, from Safe Work Australia: http://www.safeworkaustralia.gov.au/sites/SWA/AboutSafeWorkAustralia/WhatWeDo/Publications/Documents/607/Interpretive%20guideline%20-%20reasonably%20practicable.pdf

Safe Work Australia. (2012b). *Guide to the Model Work Health and Safety Regulations.* Retrieved September 5, 2012, from Safe Work Australia: http://www.safeworkaustralia.gov.au/sites/SWA/AboutSafeWorkAustralia/WhatWeDo/Publications/Pages/Guide-WHS-Regulations.aspx

Safe Work SA. (n.d.). *Incentives and Subsidies*. Retrieved September 7th, 2012, from Business SA: http://business-sa.com/training-courses/incentives-and-subsidies

Safeguard. (n.d.). *And the winners are…* Retrieved September 05, 2012, from Safeguard: http://www.safeguard.co.nz/events/awards/default.asp

Small Business Advisory Group. (2012). *Small and Medium Businesses in New Zealand.*

Statistics New Zealand. (2010). *Injury Statistics — Work Realated Claims: 2010: Hot Off The Press.* Retrieved September 2012, from http://www.stats.govt.nz/browse_for_stats/health/injuries/InjuryStatistics_HOTP10.aspx.

Statistics New Zealand. (February 2011). *Business Demography Statistics.*

Strategic Policy Consulting. (2002). *A Comparative Analysis of Government Systems for Promoting Workplace Health and Safety in Ten Jurisdictions: report for the Department of Labour.*

Tamkin, P., & Lucy, D. (2011). *Leadership and worker involvement on the Olympic Park: Learning legacy — Lesson learnt from the London 2012 Games construction project.* Retrieved September 10th, 2012, from http://learninglegacy.london2012.com/publications/leadership-and-worker-involvement-on-the-olympic-park.php

The Institute of Directors and the Health and Safety Executive. (2011). *Leading Health and Safety at Work — Leadership Actions for Directors and Board Members.* Retrieved September 10th, 2012, from http://www.hse.gov.uk/pubns/indg417.pdf

The United Nations Office at Geneva. (2012). *COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS CONCLUDES FORTY-EIGHTH SESSION.* Retrieved September 10th, 2012, from http://www.unog.ch/80256EDD006B9C2E/(httpNewsByYear_en)/C2126B1B80ACCE10C1257A020032D5C3?OpenDocument

UK Health and Safety Executive. (2006). *Developing process safety indicators: a step-by-step guide for chemical and major hazard industries.*

Washington State Department of Labour and Industries. (2012). *Safety.* Retrieved September 6th, 2012, from http://www.lni.wa.gov/safety/

Workplace Health and Safety Council. (2012, August 13th). Letter to the Independant Taskforce on Workplace Health and Safety.

World Health Organisation. (2011). *World Health Statistics 2011.* Retrieved from World Health Organisation: http://www.who.int/whosis/whostat/2011/en/index.html

Attachment 1: Terms of Reference for Independent Taskforce undertaking the Strategic Review of the Workplace Health and Safety System

Background

1. On 16 April 2012 Cabinet agreed to the establishment of an Independent Taskforce to undertake a strategic review of whether the New Zealand workplace health and safety system remains fit for purpose (the strategic review) [CAB Min (12) 12/14].

2. The strategic review is timely as it has been 20 years since the enactment of the Health and Safety in Employment Act 1992 and 10 years since the last significant review of the regulatory framework.

3. New Zealand has relatively poor rates of work-related fatality when compared to other countries with similar health and safety frameworks, notably Australia and the UK, and the trends in our official rates of fatality and serious injury are not improving.

4. Work-related fatalities and serious injuries are a tragedy for New Zealand's workforce and have high financial costs. Direct costs, such as employers' short-term production disturbance costs and human capital costs of fatal injuries, were conservatively estimated at approximately $1 billion in a 2010 cost of injury estimate prepared for the New Zealand Injury Prevention Strategy (NZIPS).[138] Even a one percent reduction would equate to about $10 million p.a. in reduced economic costs.

Objectives of the review

5. The Taskforce are to undertake the strategic review to:

   a) identify whether the overall workplace health and safety system remains fit for purpose

   b) recommend a package of practical measures that would be expected to result in at least a 25 per cent reduction in the rate of fatalities and serious injuries by 2020.

6. The workplace health and safety system can be defined as being made up of a number of complex factors:

   a) the system is comprised of and underpinned by the legislation, regulation, standards, guidance documents and codes of practice relating to workplace health and safety. It is impacted by a number of influences, including the levels of regulatory compliance, enforcement policies, financial and other incentives, workplace culture, leadership and worker engagement

   b) within the system there a number of key players, including the Department of Labour, professional bodies, unions, duty holder, employees and training

---

138 *New Zealand estimates of the total social and economic cost of "all injuries"*: O'Dea D and Wren J (2010), technical report prepared for NZIPS evaluation (total costs ~$1.3b in 2010 dollars). Other estimates of the costs of work-related injury, fatalities and disease are New Zealand Institute of Economic Research (NZIER) (2008) *Volume 1: Risk Landscape*, Report to the Department (total costs ~$16b, in 2008 dollars); and *The Economic and Social Costs of Occupational Disease and Injury in New Zealand*: Access Economics (2006), National Occupational Safety and Health Advisory Committee (NOHSAC) Technical Report (total costs ~$21b, in 2006 dollars).

organisations. The interactions between these actors influences how the system works and how effective it is

c) the effectiveness of the system can be measured by outcome indicators which include: improvements in industry and employee engagement in workplaces; and improved responsiveness to government activity; the work-toll -rates of fatality, injury and disease; the social and economic costs of the work-toll.

Scope of issues to be considered in the review

7. The Taskforce will:

a) provide an assessment of the current performance of the workplace health and safety system

b) recommend a package of practical measures that would be expected to reduce the rate of fatalities and serious injuries by at least 25 percent by 2020. In developing this package of measures the Taskforce may explore the workplace health and safety system from a number of perspectives including (but not limited to):

   i.   what changes are required to the current workplace health and safety legislative and regulatory framework (and supporting guidance material) to ensure that it remains fit for purpose

   ii. how culture change initiatives can be extended to a broader range of businesses, including through greater support of small to medium sized enterprises (SMEs)

   iii. whether and how economic and other incentives can better influence workplace health and safety outcomes (eg the HSE levy, enforcement actions, penalty levels)

   iv. how worker participation and engagement should be supported to ensure that the workplace health and safety legislative and regulatory framework is effective, and workers' perspectives are taken into account in identifying ways to improve workplace health and safety

   v.   whether and how improved government agency collaboration, co-operation and data-sharing can better influence workplace health and safety outcomes

   vi. whether and how supply chains be better used to influence workplace health and safety outcomes (e.g. through procurement practices, business and Government leadership)

c) in respect of the package of measures to improve workplace health and safety outcomes, identify:

   i.   the net and gross fiscal and economic cost and benefit of the measures and (if applicable) how they should be financed

   ii. the policy, legislative, regulatory, and/or administrative changes required to implement the measures, and a proposed timetable for implementation

   iii. how the impact of the measures should be monitored and evaluated

   iv. what impact the measures would be expected to have on sectors and firms at the highest risk of fatalities and serious injuries, and workers and firms with different characteristics, such as SMEs

d) consider how a successor to the Workplace Health and Safety Strategy (2005-2015), the National Action Agenda (2010-2013), Sector Actions Plans and the Occupational Health Action Plan can contribute more to improving workplace health and safety outcomes.

8. In identifying a package of measures under paragraph 6, the Taskforce will:

   a) identify linkages to other issues that have the potential to impact on the workplace health and safety system; including matters relating to workplace exposures to hazardous substances that result in occupational ill-health and disease

   b) consider the following aspects of the role of ACC that impact on health and safety outcomes:

   - The incentives provided to the health and safety system by the existing accident compensation system and the ACC
   - ACC's role in workplace injury prevention and rehabilitation (return to work outcomes)
   - How ACC supports the NZ Injury Prevention Strategy
   - How ACC engages with the Ministry of Business, Innovation and Employment's health and safety inspectorate and other government agencies.

   c) consider aspects of the work-related road toll and public safety arising directly out of work activities, insofar as these issues arise from an examination of the systems and processes in workplaces that impact on fatalities and injuries in those areas.

   d) consider international best practice in regards to workplace health and safety

   e) be mindful of the findings of the Pike River Royal Commission and the Government's response, which will have impact in the area of workplace health and safety beyond the mining sector alone

   f) generate bold and innovative thinking, and not to be otherwise constrained in its recommendations (other than by the matters outside of the scope of the strategic review, as indicated below)

9. The following are outside of the scope of the strategic review:

   a) recommendations related to policy changes about providing more choice for employers in ACC (the Minister for ACC has a separate decision making process for that area)

   b) changes to the no-fault nature of New Zealand's accident compensation system

   c) issues related to public safety (other than those outlined in paragraph 8 (c) above)

   d) matters related to the administration of the Hazardous Substances and New Organisms Act 1996 (other than those outlined in paragraph 8 (a) above.

10. In relation to the exclusions in paragraph 9c and d, the Government is mindful of the need to improve outcomes in these areas as well. The Government proposes to specifically look at these areas in early 2013, drawing from the recommendations and findings of this Taskforce.

Process

11. The Taskforce will proceed as it thinks fit to obtain relevant information, including the engagement of expert services to assist it to examine issues covered by the review.

12. The Taskforce are expected to make recommendations to the Minister of Labour by consensus, but where consensus is not possible may include minority recommendations.

13. Appointees are expected to take a broad and fresh approach rather than representing an organisation's current or previous position.

14. The Taskforce will be provided with administrative and secretariat support coordinated by the Ministry of Business, Innovation and Employment.

Deliverables

15. The specific deliverables of the Taskforce are for the Taskforce to determine but should include:

    a) an initial report to the Minister of Labour by the end of July 2012 on the significant issues of the strategic review and the proposed approach to public consultation

    b) by mid-September 2012 the Taskforce will produce a public document for consultation and submissions from the public

    c) the delivery of a recommendations report to the Minister of Labour by 30 April 2013, which provides detailed information on the Taskforce's recommendations.

Biographies of Taskforce Members

Rob Jager is Chairman of the Shell Companies in New Zealand and General Manager, Shell Todd Services. Rob currently also chairs the Business Leaders' Health and Safety Forum. Rob has over 30 years' experience in the oil and gas industry in a variety of technical, project, operational, business, management, and governance roles both locally and overseas. In his current role at Shell, Rob is fully accountable for all aspects of both personal and process safety and has been providing visible leadership in these critical areas.

Mavis Mullins is Director of Paewai Mullins Shearing Limited, where she is involved in health and safety issues in the workplace, strategic planning and new business development. Mavis has strong connections in rural and farming communities, and is currently involved in hands on roles both in farming operations and in providing governance for rural and farming organisations.

Michael Cosman has worked in the health and safety field for 33 years, the majority of which has been in a regulatory role. This includes 25 years in operational, managerial and strategic roles with the HSE (UK) and three years with the Department of Labour as National Operations Manager and Chief Advisor. He is currently Managing Director of Impac Services and has experience as a consultant in the private sector. Michael also has experience in working with a number of international health and safety jurisdictions.

Paula Rose is a consultant whose experience in health and safety includes over four years as the Police lead on road safety. Paula has held leadership roles within the Police, worked with partner agencies, reviewed the previous Road Safety Strategy to 2010, developed and implemented Safer Journeys, New Zealand's Road Safety Strategy 2010-2020 as well as the Safer Journeys Action Plan.

William Rosenberg is Policy Director/Economist at the New Zealand Council of Trade Unions (NZCTU), whose affiliates represent 350,000 workers. William will reflect the perspectives of the NZCTU and its affiliates in relation to both policy and practice regarding health and safety.

Paul Mackay has nearly 30 years' experience in the areas of health and safety and employment relations. He is currently Manager of Employment Relations Policy at Business New Zealand, following employment relations roles for Carter Holt Harvey Ltd, Transpower, the State Services Commission and MAF.

Attachment 2: Compare and Contrast

	New Zealand	Australia	United Kingdom	Canada	Norway
Workforce characteristics	2.2 million people employed • 11.1% manufacturing • 7.7% construction • 6.6% agriculture, forestry and fishing • 0.3% mining, oil and gas extraction 97.2% small firms (0—19 employees)	11.5 million people employed • 8.4% manufacturing • 8.7% construction • 3.0% agriculture, forestry and fishing • 2.3% mining, oil and gas extraction 95.9% small firms (0—19 employees)	29.1 million people employed • 8.0% manufacturing • 6.5% construction • 1.3% agriculture, forestry and fishing • 0.2% mining, oil and gas extraction 95.4% small firms (0—9 employees)	17.3 million people employed • 10.2% manufacturing • 7.3% construction • 1.8% agriculture • 1.9% forestry, fishing, mining, oil and gas extraction 87.4% small firms (1—19 employees — excludes self-employed)	2.5 million people employed • 9.3% manufacturing • 7.5% construction • 2.3% agriculture, forestry and fishing • 2.1% mining, oil and gas extraction 94.8% small firms (0—19 employees)
Health and safety regulatory framework	Legislation administered at national level. Places primary duty on employers to identify and manage hazards. Other duties on employees, self-employed, principals, persons in control of a workplace and persons supplying plant for use in a workplace. Legislation supported by range of hazard/industry specific regulations, codes of practice and guidance.	Multiple frameworks administered at state level. Increasingly based on Australian model health and safety law. Model laws place primary duty on "person conducting a business or undertaking" (PCBU). Other duties on officers, workers and other persons in the workplace, designers, manu-facturers, importers, suppliers, erectors, installers and consultants. Range of regulations made at state level, but also set of model regulations, and codes of practice.	Legislation administered at national level. Primary duty on employers to manage risks. Other duties on employees and self-employed people, directors, manufacturers and persons "concerned with the premises". Universally applicable regulations make legal requirements more specific, particularly the need for formal risk assessments. Further regulations cover particular industries and hazards.	Multiple frameworks administered at provincial level, though federal legislation applies for some industries. Provincial legislation varies, but broad similarities in responsibilities of employers to keep workplaces safe and to identify and control hazards.	Legislation administered at national level. Primary duty on employers to ensure that enterprises maintain a healthy and safe working environment. Regulations require all enterprises to take systematic approach to health and safety, including risk analysis and assessment. Must be done in collaboration with employees.
Accident compensation model	State owned corporation provides comprehensive, no-fault injury cover. No right to sue for personal injury.	Compulsory workers compensation, but administered at state level with some variations. Limited right to sue for personal injury in some states.	No comprehensive compensation scheme, but employers have a legal obligation to take out insurance against civil liabilities. Compensation may require courts to establish negligence of an employer through litigation.	Mandatory compensation, but administered at provincial level, with considerable variations. Association of Workers' Compensation Boards of Canada provides link between provincial compensation boards. Generally no right to sue for personal injury, with some exceptions.	Employers have a legal obligation to take out occupational injury insurance for their workers.

	New Zealand	**Australia**	**United Kingdom**	**Canada**	**Norway**
Institutional arrangements	Multiple public agencies. Health and safety regulator separate from compensation provider.	Varies between states. Mixture of single public agency models, multiple public agencies and public health and safety agency with private workers compensation. Federal agency (Safe Work Australia) tasked with improving workplace health and safety and workers' compensation arrangements across Australia.	Health and Safety Executive, governed by a tripartite board, is responsible for health and safety inspection and enforcement, supported by local authorities in low risk workplaces.	Multiple governance bodies at provincial level. Mixture of models including single and multiple public agencies. Federal agency (Canadian Centre for Occupational Health and Safety) for promotion and injury prevention activity.	Labour Inspection Authority charged with supervising enterprises to ensure they comply with legal requirements. Compensation managed by private insurers.
Worker rights and obligations	Duty on employees to ensure their own and others' safety. Provisions in Act for employee participation in the management of health and safety, including the election of health and safety representatives. Representatives can issue hazard notices. Employees have right to refuse dangerous work.	Under the Model Act, employees must take reasonable care of their own and others' safety. Duty to comply with reasonable instruction from the PCBU, and to co-operate with reasonable health and safety policies. Act places duties on PCBUs to consult with workers, provides for the election, functions and powers of worker health and safety represent-atives. Represent-atives can direct workers to cease dangerous work and can issue provisional improvement notices.	Employees must take reasonable care of their own and others' safety. Duty to co-operate with employers as far as is necessary to ensure compliance. Employers have to consult employees, either directly or through appointed or elected represent-atives, on health and safety matters. Inspectors have a duty to provide health and safety information to employee represen-tatives where it concerns their workplace.	Varies between provinces, but many similarities, including right to be informed of workplace hazards, refuse dangerous work and participate in health and safety through employee representatives or employer/employee Joint Health and Safety Committees. Obligations include working in compliance with health and safety laws and as required by employers, using protective equipment as required and reporting workplace hazards.	Employees have the right and obligation to participate in health and safety management. Businesses with 10 or more employees must elect a safety delegate. Larger businesses must establish a Working Environment Committee, with equal membership of employers and employees.

Attachment 3: Summary of Consultation Questions

Who Gets Hurt, Killed or Suffers From Ill-Health or Disease as a Result of Work?

Q1. What do you think is driving the differences in health and safety outcomes for different demographic groups?

Q2. What changes are needed to the workplace health and safety framework to improve outcomes for demographic groups with higher than average rates of injury and illness?

Regulatory Framework

Q3. What do you think the challenges are with the current workplace health and safety regulatory framework?

Q4. How do you think the workplace health and safety regulatory framework could be improved?

Regulators' Roles and Responsibilities

Q5. How effective are the regulators in influencing workplace health and safety outcomes?

Q6. How could the regulators' roles and responsibilities be changed to improve their effectiveness in influencing workplace health and safety outcomes?

New Zealand's Changing Workforce and Work Arrangements

Q7. What impacts are New Zealand's changing workforce and work arrangements having on workplace health and safety outcomes?

Q8. What changes to the workplace health and safety framework, if any, are needed as a result of the changing workforce and work arrangements?

Worker Participation and Engagement

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

Q10. What improvements can be made to worker participation in workplace health and safety so as to get better workplace health and safety outcomes?

Leadership and Governance

Q11. To what extent do directors and other senior leaders provide effective leadership and governance of workplace health and safety?

Q12. What improvements can be made to directors' and other leaders' participation in workplace health and safety, so as to get better workplace health and safety outcomes?

Capacity and Capability of the Workplace Health and Safety System

Q13. To what extent do firms have the capacity and capability to effectively manage workplace health and safety issues (including through accessing external resources)?

Q14. What options are there for improving firm level capacity and capability to deliver better workplace health and safety outcomes?

Incentives

Q15. How effective are existing financial and non-financial incentives in improving workplace health and safety outcomes?

Q16. How could incentives be better used to improve workplace health and safety outcomes?

Influencing Health and Safety Outcomes Beyond One's Own Workplace

Q17. How successful are government, industry, corporate or other potentially influential bodies in influencing workplace health and safety outcomes beyond their own workplaces (for example through influencing their suppliers, counterparts, and competitors)?

Q18. What could be done to get government, industry, corporate or other potentially influential bodies to exert greater influence on improving workplace health and safety outcomes beyond their own workplaces?

Major Hazards

Q19. How strong is New Zealand's current approach to regulating major hazards?

Q20. What improvements to the regulation of major hazards would lead to better workplace health and safety outcomes?

Health and Hazardous Substances

Q21. What are the most significant challenges to managing occupational health risks and exposure to hazardous substances?

Q22. What changes could be made to the existing workplace health and safety framework to reduce the harm caused by occupational disease and ill-health?

Small to Medium-Sized Enterprises

Q23. What workplace health and safety challenges are specific to the self-employed and small-to-medium enterprises?

Q24. What improvements could be made to the workplace health and safety framework, and its implementation, to ensure that it's effective for self-employed and small-to-medium sized enterprises?

Measurement and Data

Q25. To what extent are New Zealand's workplace injury and occupational disease data collection mechanisms conducive to robust monitoring, investigation and comparative analysis?

Q26. What opportunities are there for improving data collection, integration and reporting?

Our National Culture and Societal Expectations

Q27. Do you think New Zealand culture influences our workplace health and safety outcomes?

Q28. What might we do to improve our culture relating to workplace health and safety?

Other factors

Q29. Are there any other factors (not already covered) that influence workplace health and safety outcomes in New Zealand?

Q30. Do you have any other suggestions for how to improve workplace health and safety outcomes in New Zealand?

Other comments

Q31. Are there any other comments that you would like to make?