Evidence Briefing

Evidence to Dame Carol Black's Review of the Health of Britain's Working Age Population

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Introduction

The Institute of Employment Rights (IER) was established in 1989. It is an independent organisation, given charitable status in 1994. Members of the Institute constitute a unique network of lawyers, academics and trade unionists. Our aim is to provide information, promote new ideas and progress the case for fair rights and free unions.

The Institute of Employment Rights welcomes this opportunity to contribute to the above review. In so contributing, it does not seek to engage comprehensively with the various questions asked. Rather it seeks to make some additional observations relating to issues around workplace health and safety and to reinforce (and in some cases extend) a number of those already expressed by the TUC in its submission. The IER believes the TUC submission makes a number of points of fundamental importance, points which we feel should loom large in the conclusions and recommendations that flow from this important and much needed review.

More specifically, the IER takes the opportunity provided by the review to make comments which address the following themes:

- how better compliance with relevant legal requirements can best be achieved
- the need to more adequately financially incentivise employers to protect worker health
- the actions needed to extend access to worker representation
- the need to improve the current managerial infrastructures to address occupational health issues within the country's workplaces and
- the occupational health challenges posed by the growth of temporary agency working and 'organisational outsourcing'.

Compliance with legal requirements

Much of the current thrust of government policy to improving the health of Britain's workforce is concerned with reducing the number of working age people who are economically inactive, and in receipt of benefits, on the grounds of their ill health. This objective is undoubtedly an important one. It is, however, one that tends to downplay the importance of work as a source of ill health and labour market inactivity. This is despite the fact that the existing evidence suggests that over 600,000 new cases of work-related ill health occur each year and that, annually, many workers leave their jobs as a result of such ill health. Such evidence suggests that a significant proportion of current health-related economic inactivity continues to be the outcome of failure to protect worker health at the workplace level.

A substantial body of statutory law exists which imposes duties on employers regarding the protection of worker health and safety. This body of law, although far from perfect (see further below), does provide a framework that, if more comprehensively complied with, could do much to reduce ill health related job loss and economic inactivity, not least by requiring

employers to conduct risk assessments and to identify and put in place appropriate protective and preventive measures in the light of them.

Unfortunately, while there are many employers who take due cognisance of their legal duties and do their utmost to comply with them, there is ample evidence to indicate that all too often employers are ignorant of their legal obligations and/or do not do enough to act in accordance with them. There is also ample evidence to indicate that these problems are particularly pronounced among small and medium sized enterprises.

Both the HSC and the HSE acknowledge these problems of legal ignorance and non-compliance. Against the backcloth of recommendations advanced in the Hampton report and by the Better Regulation Task Force, they have, however, increasingly taken the view that they can best be addressed by devoting more resources to educational and awareness raising activities and reducing those allocated to routine workplace inspections and associated enforcement, and other types of compliance orientated, actions; an interpretation that can be seen to be strongly supported by the marked decline that has occurred in such inspections and action in recent years.

Yet, notwithstanding the current emphasis on evidence-based policy, there is little in the way of firm evidence to support this shift of approach towards the devotion of more resources to educational and awareness raising activities. Indeed, in contrast, existing evidence lends much more weight to the utility of workplace inspections and associated compliance orientated actions, including ones that are educational and persuasive in nature. This disjunction between evidence and policy, furthermore, becomes more worrying when account is taken of the significant reduction in the inspection resources of both the HSE and local authorities which has occurred, and continues to occur, as a result of funding cuts.

In short, current policy and resourcing decisions are misguided in the light of existing evidence. The evidence indicates that a much more productive approach to reducing levels of work-related ill health, and related job loss, is likely to be found in a significant expansion in inspector numbers and a corresponding rise in the provision of advice and other compliance based actions, including legal enforcement, based on the carrying out of workplace inspections.

It is consequently the IER's view that:

a) **recent funding cuts in the HSE should be reversed and**
b) **that future funding levels should support a substantial expansion in inspector numbers within both the HSE and local authorities with associated increases in workplace inspections and related compliance based actions.**

Financial incentives for employers

The already noted lack of workplace inspections and enforcement action clearly means that employers can fail to protect worker health adequately, with little fear of legal consequences under the existing statutory framework of health and safety law. This lack of incentive to provide such protection is, in turn, compounded by the way in which the costs of work-related ill health are currently distributed.

HSE evidence shows clearly that employers bear only a small proportion of the costs associated with work-related ill health and that it is the harmed workers themselves (and their families) and the taxpayer who together bear by far the higher burden. In other words, under the current health and safety system, the health of workers is inadequately protected *and* it is 'the polluted' rather than 'the polluter' who bears primarily the subsequent financial consequences in terms of medical treatment, income loss and financial support.

This situation is clearly inequitable. It is also one that seems likely to be counter-productive in the context of policy goals aimed at reducing work-related ill and, more generally, improving the health of the working age population.

Successive governments since 1997 have, in effect, acknowledged the unsatisfactory nature of this situation by highlighting the need to explore how the system of employers' liability insurance and the industrial injuries disablement scheme can be amended to provide employers with greater incentives to protect worker health and safety. Concrete actions to achieve this have, though, yet to be taken.

Meanwhile, as the government has also noted, problems exist in the 'rehabilitation dynamics' that exist between ill workers, GPs and employers. It is not intended to explore all these problems here. One point, though, is stressed. Rehabilitation of employed workers cannot be undertaken effectively where those concerned face employment and financial insecurity, which together can act to lead them to be dismissed or choose to leave their jobs. In this regard, the current situation where the provision of sick pay is left to the determination of employers, subject only to the entitlement of workers to statutory sick pay set at a minimal level, would seem problematic. There would consequently seem a strong case to provide workers with some minimum period of time within which their employment and income is guaranteed legally, which at the same time acts to support early return to work rather than act as a barrier to it.

In the light of the above, the IER believes that:

a) **real action is needed to provide employers with greater financial incentives to protect the health of workers and to provide rehabilitative support to them.**
b) **such action should be supported by the introduction of a statutory system of sick pay which ensures, for a certain specified period of time, that workers receive a substantial proportion of their 'normal pay' during periods of ill health related absence.**

Occupational health infrastructures and 'good work'

Worker and employer access to occupational health support in Britain compares unfavourably to that available in a number of other European counties and is, at the aggregate level, extremely limited, even when account is taken of that provided by employers and the NHS in combination. That this is the case has been effectively acknowledged via the setting up of NHS Plus and the initiation by the HSE of its pilot Workplace Health Connect project.

In logic, this lack of access to occupational health support must have serious adverse implications in terms of both the protection and promotion of worker health, and the provision of rehabilitative support to ill and injured workers. This logic is, in the case of the former, supported by research that highlights the difficulties that workers can experience in obtaining access to work-orientated rehabilitation support, and further supported by other evidence which highlights the value of the workplace as a focus for health promotion activities.

A further point to note in relation to this lack of occupational health provision is that it is particularly apparent if attention is focussed on the support available to ensure that work tasks and processes are designed to afford protection against psychosocial disorders – the most common forms of self-reported, work-related, ill health. Yet other research evidence suggests that the need for support of this type is growing given that the trends in two key determinants of such ill health - work intensity and autonomy - , have, at the aggregate level, been deteriorating, with the former increasing and the latter declining.

The limited scale of services available under NHS Plus and the pilot nature of Workplace Health Connect, as well as the doubts that exist with regard to its future roll-out, point to the fact that there is little likelihood that these problems are in the process of being meaningfully addressed. On top of this, the Workplace Health Connect initiative can be seen to compound the problem of the 'polluted paying' already mentioned in that it involves taxpayers' money being provided to often provide support that an employer should, in order to comply with their legal obligations, already be providing.

This is not to say that some 'community-based' occupational health provision is not needed. It is difficult, for example, to see how certain types of contingent workers would otherwise be able to access occupational health support. It is, though, to say that employers should have explicit obligations to provide (and fund) such support to those they directly employ.

Against this backcloth, the IER believes that:

a) statutory provisions should be introduced requireing employers to have access to multidisciplinary occupational health services whose role extends to encompass specified activities in relation to

- **the protection and promotion of worker health and**
- **the rehabilitation of ill and injured workers.**

b) These services could be in-house or, in the case of smaller organisations, be provided through local, perhaps sectoral bodies, funded on the basis of employer contributions.

Extending worker representation

There is now strong evidence of the positive effect of health and safety representatives on improving health and safety at work. Despite the decline in trade union membership in recent decades there are still comparatively large numbers of these representatives that are well-trained and active in health and safety matters at the workplace. Yet there is also much evidence to indicate that these representatives face considerable barriers to undertaking their functions as defined by law and to receiving training to enable them to do so.

As the TUC points out in its evidence, if the Government is really serious about supporting the improvement of health at work, trade union health and safety representatives constitute a powerful resource and are especially significant at a time when other supports such as those provided by HSE inspectors and occupational health services are relatively few and diminishing. Despite this, the Government has consistently failed to do anything tangible to support the development of their role since the regulations covering them were introduced in the 1970s. This is clearly a missed opportunity. As the TUC further points out, extending the legal rights of health and safety representatives to include better coverage for workers in small firms and in precarious employment, provisions to issue formal notices and a right of response from employers to their representations, have been shown to be effective in other counties. Such measures would certainly aid the role of health and safety representatives in supporting healthy work in the UK.

The IER therefore believes that a strong case exists for:

a)extending the legal rights of health and safety representatives to:

- **ensure better coverage for workers in small firms**
- **issue formal notices**
- **a right to a response from employers to enable them to play a more extensive role in improving health at work**

The challenges of contingent work

Over the last quarter of a century marked changes have occurred in the British labour market. These changes have included a growth in the role played by temporary employment agencies and a trend towards organisations externalising work to other, often smaller, organisations.

Both of these developments have potentially important implications in the area of occupational health. Thus, the rise in the importance of temporary employment agencies has been noted to cause confusion between agencies and 'user organisations' as to their respective responsibilities for health and safety and to, more specifically, create problems in terms of ensuring that those placed with the latter possess the necessary skills and knowledge to undertake work safely and without risks to their health. Meanwhile, the growth of outsourcing has frequently led to the 'exportation of work' to smaller employers with less adequate health and safety arrangements and whose capacity to invest in such arrangements is influenced by the prices willing to be paid by their larger, and more powerful', clients.

These problems are not easily addressed. However, action to address them is clearly needed.

In the case of agency work, the IER argues for:

a) the introduction of a more specific legal framework governing the respective health and safety responsibilities, of agencies and 'user organisation', including the provision of occupational health support and sick pay.

b) consideration to be given , in the case of some sectors of activity, to bringing agencies within the scope of the existing gangmasters licensing legislation.

In relation to outsourcing, the IER argues for:

a) serious consideration to be given, at least in relation to certain higher risk areas of activity, to the introduction of 'supply chain provisions' under which the organisation at the 'head' of such chains have responsibilities for ensuring compliance with health and safety requirements throughout the chain (an approach which it should be noted has been utilised in parts of Australia in respect of garment manufacturer and long-distance trucking).

Summary of recommendations

- **Recent funding cuts in the HSE should be reversed**
- **Future funding levels should support a substantial expansion in inspector numbers with associated increases in workplace inspections and related compliance based actions.**
- **Greater financial incentives on employers to protect the health of workers and to provide rehabilitation.**
- **The introduction of a statutory system of sick pay which ensures that workers receive a substantial proportion of their 'normal pay' , for a specified period of time, during periods of ill health related absence.**
- **Statutory provisions should be introduced requiring employers to have access to multidisciplinary occupational health services to protect and promote worker health and the rehabilitation of ill and injured workers.**
- **These services could be in-house or, in the case of smaller organisations, be provided through local, perhaps sectoral bodies, funded on the basis of employer contributions.**
- **The legal rights of health and safety representatives should be extended to ensure better coverage for workers in small firms, the right to issue formal notices and a right to a response from employers to enable them to play a more extensive role in improving health at work**
- **In the case of agency work, a more specific legal framework governing the respective health and safety responsibilities of agencies and 'user organisation' should be introduced including the provision of occupational health support and sick pay.**
- **Consideration should be given to bringing more agencies within the scope of the existing gangmasters licensing legislation.**
- **In relation to outsourcing, serious consideration should be given, at least in relation to certain higher risk areas of activity, to the introduction of 'supply chain provisions' under which the organisation at the 'head' of such chains have responsibilities for ensuring compliance with health and safety requirements throughout the chain.**