The role of Worker Participation in deploying Occupational Health Services

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Introduction:
Both Swedish law and the EU's Framework Directive, as well as research on occupational health and safety management (OHS), emphasise the importance of worker participation for identifying, eliminating and preventing risks at work (1, 2). Through participation, workers can improve the OHS by contributing their knowledge of their work and the workplace, and its risks and shortcomings, all of which may affect their physical or psychological health.

The regulated dialogue between employer and employees within OHS also include how expert knowledge and services shall be accessed and utilized in the organisation. When competence within the employer's own activity is insufficient for any part of the systematic work environment management, regulation states that the employer shall engage occupational health services (OHS) or corresponding external expert (3). The Work Environment Act (Chap. 3, Sect 2b) defines occupational health services as an independent expert resource in the domains of the working environment and rehabilitation, holding a neutral position in relation to the labour market parties. The employer shall make sure that the OHS receive information concerning current work environment risks, and factors affecting or suspected of affecting the employees' health and safety, which further points to the necessity for OHS to include workers knowledge and experiences in the process (1).

The regulation further claims that “it is essential that employees and safety delegates should be given the opportunity of participating in the procurement of OHS and in decision-making on the structuring and discharge of the assignment” and that OHS services shall be at the disposal of both employer and employees. (3)

The use of OHS services, hence, is an important area for worker participation in OHS.

Method:
The analysis in this paper is based on data from a study on how OHS can contribute to effective preventive OHS in public employers. About 80 qualitative interviews were conducted in organisations from 11 municipalities and counties and in their respective OHS provider. The 11 cases were selected after screening interviews with about 30 organizations, made by telephone with the human resource managers or similar functions. For the studied cases, interviews were conducted with managers, safety representatives and personnel from the human resources department at the municipality or county. At their OHS provider, the manager and professionals; nurses, ergonomists, psychologists and physicians, were interviewed. The interviews were analysed using qualitative methods, including content analysis and discourse analysis.

Results:
The studies show large differences between these different public organisations in degree and organisation of worker participation in procurement, planning and deploying OHS. Despite clear regulations and clear legal rights for participation and collective agreements that include specific regulation of joint OHSM/OHS strategy, only a minority of the studied organisations have well implemented structures for a social dialogue on OHS. However, organisations with well-developed and organised structures for worker participation tend to use OHS more as a resource in preventive OHSM and less restricted to only curative services to employees with impaired health. Some OHS's claim that systematic dialogue with workers is a prerequisite for the possibilities to get adequate knowledge of current work environment risks and for the OHS to act fast and make good prioritisations of their services. However, due to restrictions in agreements, economic models or organizational structures, such dialogues with workers and/or safety representatives were hard to maintain.
- **Procurement of OHS.** Municipalities and counties that did not have their own in-house OHS unit (about half of the interviewed cases) can contract an OHS on the open market. A new agreement usually has to be negotiated every 3–4 years, following the Public Procurement Act, which also regulates how the procurement shall be conducted legally. The agreement then becomes the framework for cooperation. The contract is negotiated at the top of each public organization and in most— but not all— cases one or more of the employees' safety representatives were included in the process. However, the procurement is rarely grounded in an analysis of OHSM-needs and in most cases with limited influence from either managers or safety reps from lower levels of the organization, i.e. from those that know these OHSM-needs. Quality demands in the procurement are then limited to ensuring access to certain professional competences from the OHS, such as a number of consulting hours from physicians etc. There were a few exceptions, where procurement were the result of a thorough process where local needs had been investigated and considered, as well as the need for expert support to help strengthen local OHSM. That meant that local OHSM, including worker participation, in these cases had influence on decisions on how to procure OHS-support and for what. About half of the studied organizations had their own in-house OHS. Still, these built-in OHS's in most ways worked under the same premises as contracted OHS (see Schmidt, forthcoming), in other words, as in-house on demand consultants. Overall, workers, and their representatives, had very little influence over budget decisions, and OHS-support was to a large extent restricted by economic considerations. Hence this expert-support was not open to be used "when needed" as the law prescribes. Worker influence on the use of OHS was then limited by the dominance of economic arguments over OHSM arguments.

- **Influence through OHSM structures.** The need for expert support is supposed to be negotiated as part of the OHSM, where workers and safety reps have important roles in defining how OHS shall be utilized, what OHS shall contribute with, and so forth. This includes e.g. OHS support to identify problems and their causes, to assure the quality of the performance of OHSM, and to develop or carry out risk assessments, and so forth. If these requirements are complied with, the independent role of OHS can then be secured by establishing contacts with both managers and workers/reps throughout the organization, which ensures a process where both social partners participate in defining the problems and what measures should be taken against them. However, in most cases the relation with OHS is instead mediated by the HR-department and not directly by the managers and safety reps in the organizations' OHSM. These HR-departments were found to have other priorities than the mandatory prevention in the organization's OHSM. The HR-people focused more on individual issues of rehabilitation, curative services and wellness activities. These actions of the HR-department are not discussed in any structures for worker participation, since HR is solely a staff-resource for the employer. Strong and well developed structures for OHSM, on the other hand, led to increased influence by line managers and safety reps over how the OHS-support was deployed, which in turn led to a use of OHS that was more adapted to workplace needs to improve preventive actions.

- **Direct contact.** Most of the studied cases of public organizations have in their respective OHS-contracts included some possibility for workers to take direct contact with OHS, in some cases without the need to inform their manager of the first contact/s. This enables workers to initiate work-related issues or problems with OHS experts, without mediation from (i.e. a filter by) managers or HR-departments. From such direct dialogue with workers, OHS's staff can maintain their information on workplace issues from the workers' perspective, which they can use in their expert analysis of the situation. If OHS's find it necessary, they can refer such worker initiated issues back to the managers and the workplace, to discuss what measures shall be taken. However, in our findings, such individual contacts – despite being initiated by workers – in most cases resulted in measures and activities aimed more at the individual's behavior and health, and less at reducing health risks at the workplace. Only if several individuals from the same part of the organization contacted the OHS with the same problems, this OHS contacted management for further investigation and/or suggesting preventive measures. Overall however, direct contact thus rarely led to activities from OHS aimed at the workplace. This can, at least to some extent, be explained by a misinterpretation of the role of OHS, by the OHS themselves as well as by managers and workers, considering OHS as an actor for individual (and mostly curative) treatment, and not as a resource for OHSM.
**Discussion:**
The use of OHS as an expert resource in OHS management is strategically important for the prevention of work-related ill-health and accidents. Our results from the public employers indicate the necessity and benefits of worker participation in the organization's use of OHS. Our results also demonstrate how a good dialogue between employer, employees and OHS is a key factor for establishing effective use of expert knowledge and support. The effectiveness of worker participation, however, turned out to be limited by a number of factors. One important factor is that OHS is mostly seen as management/manager support resource. This does not have to be a problem, if the OHS actors – including participating workers and their safety reps – have a significant role in defining the aims and scope of OHS support. However, this is rarely the case and hence workers mostly have a limited access to expert support from OHS to find, investigate or abate work environment risks. This can be interpreted as, at least partially, a result from a weaker position by unions and safety representatives. The OHSs – external as well as in-house – are economic dependent of the employers. This further limits the access of workers to the OHS's expert support. The organization of the relations between OHS and customer organization in most cases means a relation between OHS and managers and HR-departments and only to a limited extent one between OHS and workers. This reality thus questions the independent and neutral role of OHS. Instead of neutrality in regard to the social partners within the customer organizations, several OHS claims that their independence stems from their scientific and methodological objectivity. That argument, however valid it might be, is not in line with what is prescribed in the Work Environment Act or with the principle behind worker participation in OHS management.

Even though our studied public organizations formally have an extensive dialogue between managers and workers/safety reps on OHS issues, our conclusion is still that the fundamental knowledge process between workers and OHS about work, workplace and risks, is limited, despite that it is seen as an integral part of the work environment law and regulations.

**Keywords:** Worker participation, occupational health and safety management, occupational health services, expert support.

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