



Report on Construction Industry Health and Safety Data

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Executive This report identifies what health and safety information is currently collected in New Zealand; the methods of collection; and how it is analysed.

The context for the report is the recognition that construction is a dangerous industry to work in. In New Zealand, the construction industry has a fatal injury rate almost triple for the average for all sectors, and in 2008 made the largest contribution to work-related fatalities. The industry is also responsible for a significant proportion of work-related diseases.

This report contributes to:

- a) The recently developed Construction Sector Action Plan (2010-13, Department of Labour), which intends to reduce work-related injuries and fatalities in the construction sector;
- b) The work of the Construction Safety Council (CSC), whose initiatives during the first year of its operation will be fundamental to the execution of the Construction Sector Action Plan. These initiatives are backed by the CSC strategy ('Unify the Direction', December 2009), which expresses the importance of having comprehensive and reliable data so that 'key Insights' into construction health and safety may be identified and communicated across the industry.

Part 1 considers the legislation and legislated responsibilities that influence the collection of data on workplace health and safety. It is argued that data collection is likely to be constrained by the current legislation that defines health and safety according to 'harm' and 'hazard', and by the division of responsibilities for health and

safety between employers and principals and government. New Zealand's emphasis upon rehabilitation means that the injury claims processed by the ACC form the primary source of official statistics on workplace health and safety.

Part 2 considers what information is collected by the Accident Compensation Corporation; the Department of Labour; Statistics New Zealand; and employers and principals. Restrictions on data collection and analysis mean that it can be difficult to form a precise view of workplace injury and disease. Such restrictions include information on injuries that are not covered by the ACC, and the use of coding that cannot identify particular types of injury or the industry sector where the injury occurred. It is also noted that the absence of clear and legislated requirements as to what information should be kept, and how it should be presented, has encouraged workplaces to develop their own individual approaches to health and safety data collection.

Part 3 asks to what extent agencies work together on the collection, analysis and understanding of health and safety data. It is concluded that there currently exist a number of significant problems and barriers, but that there is a new determination to overcome them.

Recommendations

- General Practitioners need better information on which diseases should be notified to the DoL
- Insite data needs to be more routinely integrated with other datasets (such as labour market information)
- NODS information should also be integrated more routinely into other datasets
- Information on dangerous materials (e.g. carcinogenic materials) should be better recorded
- The DoL should more regularly draw on Ministry of Health information on the prevalence of disease and work-related personal injury
- In addition, a 'one-stop-shop' could be developed of information relevant to understanding and enhancing health and safety in the construction industry. The Health and Safety Executive (UK) has such a repository:
www.hse.gov.uk/index.htm.

Further improvements could be made with regard to the health and safety records held by industry (employers and principals):

- More explicit and enforceable guidance from the DoL to industry on what records to keep, and what should be reported on
- The DoL to monitor the consistency of record keeping across industry, including small businesses.

Next steps

- 1) Work with the DoL to ensure there is clear guidance to medical practitioners on which diseases should be notified
- 2) Work with the ACC to investigate what information it collects on construction injuries that do not result in a claims payout
- 3) Consider establishing a register of carcinogenic materials (and registers of other materials injurious to health)
- 4) Work with the DoL to consider how NODS and Insite information can be integrated with other datasets to develop, and communicate, a more comprehensive view of workplace hazards and injury
- 5) Work with the DoL to consider the establishment of a 'one stop shop' for health and safety information for the construction industry
- 6) Consider whether the IRIS system is worth using, replicating or emulating within the construction industry; and if so, the development steps that would be required.

Context of this report

The Construction Safety Council (CSC) supports the Construction Sector Action Plan (2010-13) and the specific aim of reducing accidents and work-related personal injuries in the construction sector. A number of initiatives have been identified for the first year of operation of the CSC, which are also fundamental to the execution of the Action Plan. Those initiatives are:

1. Analyse data to determine common Health and Safety risks
2. Eliminate non-compliant behaviour
3. Endorse individual training that meets agreed standards
4. Reward compliant Health and Safety systems.

Each of these initiatives has a multi-year time horizon, broken down into discrete projects.

The aim of Initiative 1 is to develop benchmarks so that government, the industry and individual companies can quickly and effectively benchmark their Health and Safety performance against other sectors and industries, both nationally and internationally. This initiative has the following deliverables:

- Identify those organisations that collect Health and Safety data
- Hold workshop(s) to agree what data should be collected and how it should be shared
- Develop an implementation plan to undertake the above
- Communicate information about the establishment of the Health and Safety data set.

This report has been prepared on behalf of the Construction Safety Council in response to the first of the above deliverables.

Purpose

This report also responds to the CSC strategy ('Unify the Direction', December 2009). In the CSC strategy, 'visibility of risk' is one of several crucial prerequisites for a health and safety system that can reduce injuries and raise the overall health and safety of the construction industry. The strategy states that risk visibility tends to be compromised by a number of factors, including companies' unwillingness to share information on risks and a general lack of awareness of the consequences of risk-taking.

Recognising the importance of risk visibility to its strategic goals, the CSC will encourage the development of processes to enable 'key insights' into construction health and safety to be identified from industry-driven research and communicated formally across the industry. The CSC also aims to establish a process for combining industry learnings with data collected by the Accident Compensation Corporation (ACC) and other agencies, and to communicate relevant information back to industry.

It is evident that these processes would need to be based on health and safety data that is relevant, up to date, and accurate. However, during the development of the CSC strategy, concerns were expressed with regard to the reliability and accessibility of the data that is currently available.

To clarify these concerns and form a clearer picture of the data that is currently available, this report asks:

- what health and safety information is collected;
- what methods of collection are employed; and
- what analysis is done.

Method

The research for this report has involved web research and discussions with health and safety managers in the construction sector. Discussions were also held with policy advisors and analysts working in the Accident Compensation Corporation, the Department of Labour, and Statistics New Zealand.

Introduction

All advanced economies collect information on workplace health and safety. This is essential to understanding and preventing work-related accidents and disease, and to ensuring that individual workers maintain their wellbeing and earning potential. It is also fundamental to ensuring a productive and sustainable workforce.

Across the world, the construction industry is recognised as one of the most dangerous to workers, both in terms of accidents and disease. Longitudinal studies into patterns of ill-health amongst construction workers have highlighted a prevalence of cardiovascular disease, lung disease, and musculoskeletal disorders:

'Construction is a hazardous occupation. For almost all key risks—chemicals, dusts, manual handling, physical hazards, and psychosocial hazards—exposures are routine and excessive.' (Murie, 2007)

According to the Construction Sector Action Plan (May 2011), the New Zealand construction industry has a fatal injury rate almost triple for the average for all sectors, and in 2008 made the largest contribution to work-related fatalities. Since 2002, the industry has had a fatal incidence rate that has almost quadrupled, and 'the line is trending upwards'. In addition, musculoskeletal and lung diseases, and diseases related to vibration, are prevalent amongst New Zealand construction workers (mesothelioma alone is estimated to be responsible for around 45 deaths per year).

These facts indicate the far-reaching effects of construction injuries and disease - upon construction workers, their families, and the economy as a whole. It is also apparent that any effort to analyse and reduce the incidence of construction injuries and disease must be supported by reliable and comprehensive data.

Part 1: What influences the collection of workplace Health and Safety data?

Legislation

In New Zealand, the primary legislation governing workplace health and safety, and which has a fundamental influence upon the data collected, is the Health and Safety in Employment Act 1992 (HSE Act). This legislation does not attempt to describe what workplace health and safety looks like, or how it can be identified (unlike, for example,

the definition of 'occupational health' given by the World Health Organization (1995) and the health and safety legislation of Queensland, (1995)). Instead, the HSE Act defines workplace health and safety according to what might *threaten* it, or the 'harms' and 'hazards':

harm—

- *(a) means illness, injury, or both*
- *(b) includes physical or mental harm caused by work-related stress*

hazard—

- *(a) means an activity, arrangement, circumstance, event, occurrence, phenomenon, process, situation, or substance (whether arising or caused within or outside a place of work) that is an actual or potential cause or source of harm; and*
- *(b) includes—*
 - *(i) a situation where a person's behaviour may be an actual or potential cause or source of harm to the person or another person; and*
 - *(ii) without limitation, a situation described in subparagraph (i) resulting from physical or mental fatigue, drugs, alcohol, traumatic shock, or another temporary condition that affects a person's behaviour*

It can be argued that, with this focus upon the definition of threats to health and safety, the breadth and variety of interpretations of what might constitute workplace health and safety are inevitably reduced. As a consequence, this focus can constrain what data is regarded as relevant to the maintenance of safe working environments.

Further constraints upon data collection derive from legislated responsibilities for health and safety; the regulatory environment that supports those responsibilities; the design, capacity and operation of data collection systems; and the prevailing political, business, social and economic drivers.

Legislated responsibilities

Probably the most significant influence upon the collection of health and safety data in New Zealand is the way that responsibility for health and safety is shared between employers, government and the Accident Compensation Corporation (ACC).

Under the HSE Act, employers and principals have the primary responsibility for maintaining workplace health and safety, whereas government has the role of monitoring, inspection, and enforcement of the requirements of the Act. The Accident Compensation Act (2001) gives the ACC responsibilities for minimising the incidence and impact of injury in the community; promoting measures to reduce the incidence and severity of personal injury; rehabilitating the injured; and collecting, coordinating and analysing injury-related information.

This division of responsibilities, and New Zealand's distinctive emphasis upon rehabilitation, mean that the injury claims processed by the ACC form the primary source of official statistics on health and safety in the workplace. Additional data is collected by the Department of Labour for monitoring, education and enforcement purposes. Statistics relating to patterns of illness are developed by the Ministry of Health, and further information (such as the detail of individual workplaces' health and safety arrangements) is held by employers and principals.

Part 2: The agencies responsible for the collection and analysis of health and safety data

Accident Compensation Corporation (ACC)

The ACC receives data from every individual's application for compensation. The raw data on each application includes basic information about the claimant and the injury (such as the age, sex and ethnicity of the claimant); the location, industry and description of the accident or process that caused harm; and the effect of the injury on the claimant's ability to work. Claims are also classified according to the relevant Business Industry Description (a description and an associated 'BIC' code allocated according to the main activity the business is involved in) and the Classification Unit Description (representing the group of businesses from the same sector that have a

similar risk of workplace injury). Businesses are further described according to their ANZSIC code.

The potential inaccuracies in this coding have contributed to the widely-held perception that the statistics developed by the ACC are normally able to provide only a partial view of workplace injuries and their consequences. The problems of coding are compounded by differing perceptions of where people work:

'people may say they work in construction but are actually office workers' (ACC representative).

To assess which claims will be accepted for compensation, the ACC uses the definition of 'personal injury' as given in the Accident Compensation Act 2001. This term is defined under a number of categories including death due to a physical injury; physical injury; mental injury due to physical injury; work-related mental injury; and hearing loss that is caused by personal injury. Excluded, however, are the diagnosis of pain without evidence of actual damage to the body from the injury; and stress, illness and age-related injuries unless they stem from a work injury (this last exclusion has been the subject of recent legal challenges). Also excluded from ACC entitlements are injuries that result only in incapacity during the first week, and those where the individual does not take more than one week off work and the provider of medical treatment is reimbursed directly. The treatment costs incurred by public hospitals are also excluded from ACC statistics.

Such restrictions, which arise from the role and focus of the ACC, mean that a proportion of all injuries will either not result in a claim at all, or will be rejected following application to the ACC. They also mean that there is a degree of uncertainty when people file claims with the ACC, which may contribute to the under-reporting of injury; this is especially the case for the more difficult-to-assess areas such as illnesses that are not clearly work-related and may require investigation. Further under-reporting is likely to occur where there is poor or unavailable advice about ACC within the workplace; it is also possible (although this cannot yet be assessed) that experience-based rating may incentivise under-reporting.

Where claims are accepted and recorded in the ACC statistics, the way in which injuries are defined and coded can still make it difficult to form a view of particular injuries in relation to other data (such as age, industry, and consequence):

'The injury coding used by ACC is very wide in its categories and of limited use in differentiating the severity of the injury. For example, the injury code of 'Soft Tissue Injury' covers injuries ranging from strained muscles to dislocated discs to paraplegia and tetraplegia.' (ACC website)

A further limitation of ACC data is the lack of information on the *causes* of illness and injury. To obtain a view of causation, ACC data must be supplemented by information from other agencies – in particular the records of 'serious harm' that are collated by the Department of Labour.

Department of Labour

The Department of Labour (DoL) has the main responsibility for government's monitoring, inspection, and enforcement of the HSE Act. The DoL mainly draws from information supplied by the ACC, but also uses information from a variety of other sources.

Notifiable work

Employers are required to notify the DoL of certain types of work that are defined in the Health and Safety in Employment Regulations (1995). These include working with asbestos, commercial logging, and construction work where workers could fall 5 metres or more, or where explosives are used or stored, or where construction workers breathe air or gas that has been compressed or is under pressure.

Notifications of 'serious harm'

When there is an incident of 'serious harm', employers are required to notify the DoL directly. 'Serious harm' is defined in the HSE Act; it covers a range of injuries and illnesses including cancer, permanent loss of bodily function, and communicable diseases. The DoL responds to such notifications by sending health and safety inspectors to the workplace.

Notifiable Occupational Disease System (NODS)

This is a voluntary system that allows employers, employees and medical practitioners to report a health-related condition that is suspected to arise from work. It has been perceived that NODS reporting has certain limitations as a method of reporting and analysing patterns of occupational disease; key problems include poor diagnosis and under-reporting of occupational diseases, the absence of a register of carcinogenic materials, and the difficulty of integrating the NODS information with other data sets. It has also been observed that:

'NODS notifications tend to contribute to the prevention of the recurrence of harm through the identification of learnings from individual cases rather than aggregated data.'
(NOHSAC, 2005)

It has also been observed that many General Practitioners are not fully aware of which diseases they should notify - hence under-reporting is likely. Indeed the view has been expressed that, when it comes to disease, the Department of Labour appears to have considerably less information than for injuries and fatalities attributable to injury.

Insite

'Insite' is a DoL internal system and not available to the public. The function of Insite is to record and track the observations of health and safety inspectors, both when they are sent out to report on incidents of 'serious harm' and when, perhaps in regular visits to workplaces, they notice the presence of significant hazards. This data is mainly qualitative however statistics can be drawn from some of the data fields.

Currently, Insite information is not integrated into labour market data, hence although Insite provides actual numbers of those injured or killed, it is not possible from this data to state what *proportion* of the workforce has been affected. On the other hand, and with the inclusion of ACC data provided via Statistics New Zealand, the DoL succeeded in defining 'proportion' in tables presented in the recently developed Construction Sector Action Plan (2010-13).

University research

A regular compilation of statistical information on occupational health has been published by researchers at the University of Otago (Gulliver et al, 2010). The responsibility for this publication has recently been taken over by Statistics New Zealand. This information has formed the basis of advice to government departments and ministers.

Other sources of data

Statistics New Zealand

On the basis of data received from the ACC, Statistics NZ produce publicly available statistics on injury claims and some work-related fatalities. They report on (for example) fatal injuries at work; fatal and non-fatal diseases linked to occupation; injuries and disease relating to occupation and type/size of business.

Ministry of Health

The Ministry of Health produces a wide variety of reports that investigate the prevalence of disease across the population and which sometimes make reference to particular industries. One such report (Notifiable and other diseases in New Zealand, Annual Report 2010) analyses the prevalence of non-infectious yet notifiable conditions such as lead absorption. The data for this report is derived from the notifications made to the Ministry of Health by medical practitioners and laboratories, and the data that is used to calculate the rates of disease are obtained from Statistics New Zealand. This report, which is limited to a particular set of diseases, refers to those industries that have already been defined as having 'high risk of exposure'.

Employers and Principals

According to the HSE Act, employers and principals have the major responsibility for maintaining health and safety in the workplace. This brings certain reporting requirements, such as the maintenance of a register of 'accidents and serious harm', in which the employer records the particulars of every accident that has harmed or might have harmed any employee or person at the place of work.

In an interview with a health and safety manager, it was observed that, in response to this legislation, workplaces have developed their own individual ways of reporting:

'ACC requirements are not very clear, there is little detail. And if you look at the HSE Act, it is not prescriptive either – the emphasis is mainly on performance, and industry is left to do its own thing.'

Although there are examples of health and safety managers attempting to share data and bring uniformity to their processes and reporting, it was also observed that competition between organisations can make them reluctant to give information away, or to reduce the cost of health and safety:

'In a tendering market, health and safety is not a level playing field ... people try to find a smarter or cheaper way of doing things.'

It was also stated that subcontractors, in particular, may fail to comply with reporting requirements, and that larger companies tend to follow the rules more carefully than smaller companies. It can be added that New Zealand has many small companies with no dedicated health and safety manager, and a lack of detailed or accurate knowledge of how information on health and safety should be recorded and reported.

However, a health and safety manager stated that safety may not directly correlate to the size of the company, or the systems that are in place:

'having all the right systems does not necessarily mean that you are safer.'

Just as workplaces differ in their response to the HSE legislation and DoL requirements, many have developed their own individual approaches to training for health and safety:

'The legislation only says that the employer is required to provide training. There is nothing prescriptive. Training is usually done in-house and, very often, records of the training are not kept.'

'Many small companies have not gone beyond the earliest stages of health and safety education.'

Part 3: Collaboration and data sharing

A common observation is that the three departments that are most involved in the collection of data on health and safety, namely the DoL, the ACC and the Ministry of Health, do not often work together. Perhaps the most comprehensive criticism of current data collection methods and the way that data is shared between agencies is contained in a report to the Minister of Labour (The Surveillance of Occupational Disease and Injury in New Zealand, 2009). This report discusses the barriers to effective surveillance of occupational disease and injury:

'the various [disease surveillance] systems are disparate, with little coordination between them. Crucially, nobody has been appointed as the responsible person for doing this coordination at DoL. At Statistics New Zealand, the Injury Information Manager has started to address this issue for occupational injury. However, quite different skills, systems, and methods are required for occupational disease.'

According to this report, databases on hazard and exposure 'collect minimal information' on what contributes to risk, and this 'limits the current potential for conducting robust analysis of incidence, prevalence, distribution, and trends of occupational disease and injury.' The report also details 'fundamental conflicts in purpose' that can create barriers to cross-departmental working, and substantial knowledge gaps that arise from gaps in the coverage and accuracy of existing data sets, and a lack of knowledge in some General Practitioners, employers and employees of occupational disease risk factors and reporting requirements.

In addition, 'ethical and privacy issues' present potential barriers to detailed analysis and linkage of different datasets, and

'For work-related chronic diseases ... problems of incomplete coverage are significant, with only a tiny fraction of cases being identified through ACC claims.'

It is to be hoped that this situation will change in the near future, with the reorganisation of DoL services around the primary sectors, and the development of the National Occupational Health Plan. This Plan (the development is being led by the DoL) will cover all sectors of industry and will include both injuries and disease. The Plan and the recommended actions are likely to require considerable additional cross-departmental work, collaboration, and the sharing of data. Both the Plan, and other new initiatives such as the Harm Reduction project (to reduce falls from height) and the Construction Sector Action Plan, also require a sharpening of data collection and better flow of information between agencies. It is also possible that other agencies might be brought into the 'data mix', such as the Coronial Services of New Zealand, which records data on deaths investigated by coroners.

A recent report, "The State of Workplace Health and Safety in New Zealand" (DoL 2011) is the first in a series (to be produced annually) to help the integration of data and to monitor progress towards the Workplace Health and Safety Strategy's vision of 'healthy people in safe and productive workplaces'. This report, which brings together key New Zealand workplace health and safety statistics in a 'snapshot', admits that agencies have not comprehensively assessed the impact of work-related diseases, and that under-reporting makes the tracking of disease difficult. To combat this, the tracking of data on certain diseases has been revised, and a new model for surveillance of occupational cancer, respiratory diseases and dermatitis will be developed by December 2011.

The individuals interviewed for this report are optimistic. Despite anticipating the difficulties and delays that will be involved in better interdepartmental working and data flow, many now believe that there is a new interest and impetus across government departments for accurate and relevant data on health and safety in the workplace:

'things are looking up ... there is an increased emphasis on collecting the right data and looking at relevant research.'

Conclusion

A comprehensive view of accidents and work-related personal injuries in the construction industry is constrained by a variety of factors. These include the use of codes that are too broad to identify particular types of injury; exclusions applied by the ACC to determine which claims can or cannot be accepted; and a lack of standardisation in the way that employers collect and report on health and safety information. The findings also indicate that no single agency is tasked with having an overall view. Although agencies are able to work together to gain such a view, this tends to be the exception rather than the rule, and normally requires a specific mandate and dedicated resourcing.

Co-operation between agencies is clearly desirable in order to bring together the data that is located in separate agencies and subject to different analyses. But even where agencies do work together to pool their information, questions may still be raised regarding the reliability and completeness of that data. For example, ACC data is routinely used by the Department of Labour and Statistics New Zealand in the development of their own reports. However, this data is still limited by the filters originally laid upon it by the ACC; this suggests that the mere pooling of data by agencies, whilst possibly bringing a more rounded and comprehensive view of health and safety, is not likely to result in a view that is any more accurate or less partial.

It is also apparent that the data supplied by government agencies must be supplemented by better data collection and reporting by industry. It is probable that, if industry's health and safety data collection were better standardised and enforced, then health and safety reporting would be more comprehensive and accurate. But the factors that might militate against this – such as the concerns of small companies with regard to their competitive advantage – could make such measures both difficult and expensive.

The following table summarises the main points made in this report regarding agencies' data collection.

Collection agency	What is collected	Issues, constraints
ACC	Data from individual claims	<ul style="list-style-type: none">• Limited definition of personal injury• Injuries excluded that result in incapacity of less than 1 week• Injuries excluded where medical provider reimbursed directly

		<ul style="list-style-type: none"> • Treatment costs of public hospitals excluded • Definitions and coding do not always allow for analysis of injury types • ACC not interested in the causes of injury
Department of Labour	<p>Use ACC claims data and:</p> <ul style="list-style-type: none"> • Employers' notifications of 'notifiable work' • Notification by employers of 'serious harm' • NODS: notification of health-related conditions arising from work • Insite: DoL internal system. Records observations of health and safety inspectors 	<ul style="list-style-type: none"> • Have the role of monitoring, inspection, enforcement of the HSE Act. Use ACC data, hence subject to its limitations. • Under-reporting: some GPs are not aware of which diseases should be notified. • Insite information is mainly qualitative; not integrated into labour market data. • No register of carcinogenic materials. • Difficult to integrate NODS information into other data sets. • DoL has considerably less information on disease than on injuries.
Universities	Use original research and data from agencies	
Statistics New Zealand	Use ACC claims data to report on workplace injuries and fatalities	<ul style="list-style-type: none"> • Use ACC data, hence subject to its limitations
Ministry of Health	<p>Produce reports on disease across the population and may refer to some industries</p> <ul style="list-style-type: none"> • Use data on notifiable conditions from medical practitioners and laboratories; data to calculate rates of disease obtained from Stats NZ <p>Can refer to 'high risk of exposure' industries</p>	
Employers and principals	larger employers are more likely to collect data than small employers	<ul style="list-style-type: none"> • Have the major responsibility for workplace H&S • Reporting is not standardised • Competition pressures can mean 'cutting corners' and reluctance to share data between workplaces

Recommendations

The health and safety information that is most widely used by government agencies is derived from ACC claims information. As this report has indicated, ACC data is not sufficiently comprehensive or reliable to enable an accurate view to be gained of construction industry health and safety. Without amendment of the legislated responsibilities of the ACC (which leads to the emphasis upon rehabilitation and a lack of interest in the causes of injury and disease) the enhancement of data collection or analysis by the ACC is unlikely to occur, and difficult to address.

However, there is scope for addressing some of the weaknesses in Department of Labour data collection systems:

- General Practitioners need better information on which diseases should be notified to the DoL
- Insite data needs to be more routinely integrated with other datasets (such as labour market information)
- NODS information should also be integrated more routinely into other datasets
- Information on dangerous materials (e.g. carcinogenic materials) should be better recorded
- The DoL should more regularly draw on Ministry of Health information on the prevalence of disease and work-related personal injury
- In addition, a 'one-stop-shop' could be developed of information relevant to understanding and enhancing health and safety in the construction industry.

The Health and Safety Executive (UK) has such a repository:

www.hse.gov.uk/index.htm.

Further improvements could be made with regard to the health and safety records held by industry (employers and principals):

- More explicit and enforceable guidance from the DoL to industry on what records to keep, and what should be reported on
- The DoL to monitor the consistency of record keeping across industry, including small businesses.

To address the problem of businesses cutting the resources dedicated to health and safety in order to gain a competitive edge, health and safety requirements (such as robust reporting) could be integrated into procurement policies and government contracts, and made enforceable upon sub-contractors. It should be recognised, however, that arguments in favour of such requirements may impact upon perceived productivity and the cost of procurement.

Other measures that might be taken by the construction industry could include the development of an industry-wide reporting system (such as IRIS, the Incident Reporting Information System of the New Zealand Forest Owners' Association) to enable better overall monitoring and the sharing of data between workplaces.

Next steps

- 1) Work with the DoL to ensure there is clear guidance to medical practitioners on which diseases should be notified
- 2) Work with the ACC to investigate what information it collects on construction injuries that do not result in a claims payout
- 3) Work with the DoL to consider establishing a register of carcinogenic materials (and registers of other materials injurious to health)
- 4) Work with the DoL to consider how NODS and Insite information can be integrated with other datasets to develop, and communicate, a more comprehensive view of workplace hazards and injury
- 5) Work with the DoL to consider the establishment of a 'one stop shop' for health and safety information for the construction industry
- 6) Consider whether the IRIS system is worth using, replicating or emulating within the construction industry; and if so, the development steps that would be required.

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