
by

Susann Camus

M.A. (English), University of Toronto, 1983
B.A. (Hons., English), University of Ottawa, 1981

Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of Master’s in Public Health

in the

Master of Public Health Program
Faculty of Health Sciences

© Susann Camus 2013
SIMON FRASER UNIVERSITY
Fall 2013

All rights reserved.
However, in accordance with the Copyright Act of Canada, this work may be reproduced, without authorization, under the conditions for “Fair Dealing.” Therefore, limited reproduction of this work for the purposes of private study, research, criticism, review and news reporting is likely to be in accordance with the law, particularly if cited appropriately.
Approval

Name: Susann Camus

Degree: Master of Public Health


Examiner Committee: Chair: Dr. Malcolm Steinberg
Clinical Assistant Professor
Public Health Practice Program Director

John Calvert, Ph.D.
Senior Supervisor
Associate Professor

Tim Takaro, M.D.
Supervisor
Professor

George Astrakianakis, Ph.D.
External Examiner
Associate Professor
School of Population and Public Health
Faculty of Medicine
University of British Columbia

Date Defended/Approved: November 21, 2013
Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the non-exclusive, royalty-free right to include a digital copy of this thesis, project or extended essay[s] and associated supplemental files ("Work") (title[s] below) in Summit, the Institutional Research Repository at SFU. SFU may also make copies of the Work for purposes of a scholarly or research nature; for users of the SFU Library; or in response to a request from another library, or educational institution, on SFU’s own behalf or for one of its users. Distribution may be in any form.

The author has further agreed that SFU may keep more than one copy of the Work for purposes of back-up and security; and that SFU may, without changing the content, translate, if technically possible, the Work to any medium or format for the purpose of preserving the Work and facilitating the exercise of SFU’s rights under this licence.

It is understood that copying, publication, or public performance of the Work for commercial purposes shall not be allowed without the author’s written permission.

While granting the above uses to SFU, the author retains copyright ownership and moral rights in the Work, and may deal with the copyright in the Work in any way consistent with the terms of this licence, including the right to change the Work for subsequent purposes, including editing and publishing the Work in whole or in part, and licensing the content to other parties as the author may desire.

The author represents and warrants that he/she has the right to grant the rights contained in this licence and that the Work does not, to the best of the author’s knowledge, infringe upon anyone’s copyright. The author has obtained written copyright permission, where required, for the use of any third-party copyrighted material contained in the Work. The author represents and warrants that the Work is his/her own original work and that he/she has not previously assigned or relinquished the rights conferred in this licence.

Simon Fraser University Library
Burnaby, British Columbia, Canada

revised Fall 2013
Ethics Statement

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

a. human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

b. advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

c. as a co-investigator, collaborator or research assistant in a research project approved in advance,

or

d. as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Simon Fraser University Library
Burnaby, British Columbia, Canada

update Spring 2010
Abstract

This thesis analyzes the conditions giving rise to the Occupational Health and Safety Agency for Healthcare (OHSAH), its mandate, what it accomplished, why it was dismantled, and how its legacy can be preserved. Policy decisions contributing to the agency’s establishment and closure are explored from the perspective of stakeholders/key informants. A quantitative analysis compares injury and lost work time rates among healthcare workers with other industrial sectors and considers the costs associated with time loss from work as the result of slips, trips, falls, musculoskeletal and other injuries, and injury-related insurance claims. The competing interests and unequal distribution of power among healthcare employers and healthcare workers are described. OHSAH’s limited success in mobilizing supporters is discussed. Fundamental misperceptions and missteps are identified that contributed to OHSAH’s inability to secure champions to ensure the agency’s continued operation in the face of limited financial resources. Finally, this paper makes recommendations to further OHSAH’s legacy.

Key Words: Occupational Health and Safety Agency for Healthcare; OHSAH; healthcare workers; occupational health and safety; British Columbia
Dedication

This thesis is dedicated to my husband and best friend, Bob Corns, for his unconditional support, patience, and practical assistance, and to our other family member, little Finnegan, for staying up late with me on many nights while I worked on this thesis.
Acknowledgements

I would like to thank the health and safety professionals in BC’s health authorities, unions representing healthcare workers, representatives from WorkSafeBC, government officials, and academics who agreed to be interviewed for this thesis, which would not have been possible without their assistance.

I would also like to thank my senior supervisor, Dr. John Calvert, for his tremendous support and guidance during the research and writing phases of this dissertation. Thank you to Dr. Tim Takaro, Dr. George Astrakianakis, and Dr. Malcolm Steinberg for their input. Thank you to Michel Joffres for his encouragement and support when I started in the MPH and five years later, when I completed the thesis. Thanks to Laurie Goldsmith for introducing me to the fascinating world of health policy and encouraging me to embark on a thesis. Thank you to WorkSafeBC staff in Statistical Services and Research Services. Thanks to Michelle Purdon for expert guidance on the literature review and to Bonnie Gallup for assistance with transcribing interviews. Thank you to Ed Mills, Evan Wood, Diane Finegood, Susan Chunick, Cathy Weir, and Donna Ralph for supporting my education in health policy and public health. Thanks to my friend, Dr. Tsetsen Tugsmandal, for sharing this journey with me.

Any errors in this thesis are the responsibility of the author.
# Table of Contents

Approval ................................................................. ii
Partial Copyright Licence ............................................ iii
Ethics Statement ....................................................... iv
Abstract ....................................................................... vi
Dedication .................................................................... vii
Acknowledgements ..................................................... viii
Table of Contents ....................................................... vii
List of Tables ........................................................... xi
List of Figures .......................................................... xi
List of Acronyms ...................................................... xii

## Chapter 1. Introduction ............................................. 1
Objectives of this Paper ................................................. 1
Opening of a Policy Window .......................................... 3
A Cost-Neutral Agency ................................................ 4
How OHSAH Was Funded ............................................. 5
An International Model for Occupational Health and Safety .... 6
Government Accolades for OHSAH ................................. 7
The Decline of OHSAH ............................................... 8

## Chapter 2. Methods .................................................. 12
Literature Search and Review of the Literature .................. 12
Results of the Literature Search .................................... 13
Key Informant Interviews: Questions Asked ....................... 15
Mixed Methods Approach ............................................. 16
Self as Instrument ....................................................... 17
An Inductive Approach ................................................ 18
Political Contests ....................................................... 18
A Deductive Approach ................................................ 22

## Chapter 3. Occupational Health and Safety in Canada .......... 24
Workers as Commodities ............................................ 24
Workers’ Compensation for On-The-Job Injury or Death ........ 25
Occupational Health and Safety Legislation in British Columbia 25
Employers’ Liability Act, 1891 ....................................... 25
BC Workmen’s Compensation Act, 1902 ......................... 26
Royal Commission, 1912, Leading to “The Historic Compromise,” 1917 27
Creation of the Workmen’s Compensation Board of British Columbia, 1916 28
Royal Commission, Workmen’s Compensation Board, 1942 ........ 29
Commission of Inquiry, Workmen’s Compensation Act (1962-1965) .... 30
A New Workmen’s Compensation Act, 1968 ....................... 31
Renaming the Act, 1974 ............................................. 31
Deficits and Cutbacks, 1976 .......................................... 31
List of Tables

Table 1. Political Contest - Support for Establishing OHSAH ........................................ 18
Table 2. Political Contest - Who Benefits from Ceiling Lifts? ........................................ 20
Table 3. Political Contest: Who is OHSAH’s Customer in the Health Authority? ........ 21

List of Figures

Figure 1. OHSASH Timeline, 1998 - 2010 ................................................................. 2
Figure 2. Number of Short-Term Disability Claims per 100 person-years of WCB-covered Employment; Excludes Bill 63 ................................................... 35
Figure 3. WorkSafeBC Total Claims by Year and by Class, 1996 - 1999 .................. 37
Figure 4. WorkSafeBC Total Number of Claims by Year, 1996 - 1999 ..................... 38
Figure 5. WorkSafeBC Proportion of Claims by Year and by Class, 1996 - 1999 .... 39
Figure 6. Proportions of Days Lost in 1997 in Class 6 Industries, Subclass 0626 .... 41
Figure 7. Proportion of Claims for Strains in 1997 in Class 6 Industries, Subclass 0626 ................................................................. 41
Figure 8. Proportions of Overall Total Claim Costs Charged by 1997 by Subclass ............................................................................. 42
Figure 9. Claim Costs in 2013$, Service Sector, 1996 - 2011 ................................. 59
Figure 10. Days Lost in Year, Service Sector, 1996 - 2011 .................................. 60
Figure 11. Costs in 2013$ for Short Term Disability Claims, Service Sector, 1996 – 2011 ............................................................................. 61
Figure 12. Costs in 2013$ for Long Term Disability Claims, Service Sector, 1996-2011 ............................................................................. 62
### List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCGEU</td>
<td>BC Government and Service Employers’ Union</td>
</tr>
<tr>
<td>BCNU</td>
<td>BC Nurses Union</td>
</tr>
<tr>
<td>Bill 29</td>
<td>Health and Social Services Delivery Act</td>
</tr>
<tr>
<td>BoD</td>
<td>Board of Directors</td>
</tr>
<tr>
<td>BoG</td>
<td>Board of Governors</td>
</tr>
<tr>
<td>CCF</td>
<td>Canadian Commonwealth Federation</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CIHR</td>
<td>Canadian Institutes of Health Research</td>
</tr>
<tr>
<td>CHSRF</td>
<td>Canadian Health Services Research Foundation</td>
</tr>
<tr>
<td>Hansard</td>
<td>Hansard - Official Report of Debates of the Legislative Assembly</td>
</tr>
<tr>
<td>HEABC</td>
<td>Health Employers Association of British Columbia</td>
</tr>
<tr>
<td>HEU</td>
<td>Hospital Employees’ Union</td>
</tr>
<tr>
<td>HSSCA</td>
<td>Health Services and Support Community Association</td>
</tr>
<tr>
<td>HSSFA</td>
<td>Health Services and Support Facilities Association</td>
</tr>
<tr>
<td>H&amp;S</td>
<td>Health and Safety</td>
</tr>
<tr>
<td>KT</td>
<td>Knowledge Translation</td>
</tr>
<tr>
<td>MSDS</td>
<td>Material Safety Data Sheet</td>
</tr>
<tr>
<td>MSKIs</td>
<td>Musculoskeletal Injuries</td>
</tr>
<tr>
<td>NDP</td>
<td>New Democratic Party</td>
</tr>
<tr>
<td>NIDMR</td>
<td>National Institute of Disability Management and Research</td>
</tr>
<tr>
<td>NIOSH</td>
<td>National Institute for Occupational Safety &amp; Health</td>
</tr>
<tr>
<td>OHS</td>
<td>Occupational Health and Safety</td>
</tr>
<tr>
<td>OHSAH</td>
<td>Occupational Health and Safety Agency for Healthcare</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PEARs</td>
<td>Prevention and Early Active Return-to-work Safety</td>
</tr>
<tr>
<td>PIC.net</td>
<td>Provincial Infection Control Network</td>
</tr>
<tr>
<td>PICO</td>
<td>Patient-Intervention-Comparison-Outcome</td>
</tr>
<tr>
<td>PHSA</td>
<td>Provincial Health Services Health Authority</td>
</tr>
<tr>
<td>The Accord</td>
<td>Public Sector Accord on Occupational Health and Safety</td>
</tr>
<tr>
<td>WCB</td>
<td>Workers’ Compensation Board of British Columbia</td>
</tr>
<tr>
<td>WHITE™</td>
<td>Workplace Health Indicator Tracking and Evaluation</td>
</tr>
<tr>
<td>WorkSafeBC</td>
<td>Workers’ Compensation Board of British Columbia</td>
</tr>
</tbody>
</table>
Chapter 1.

Introduction

When most people think of dangerous occupations, they think of work on construction sites, in underground mines, and on offshore oil rigs. They don’t think of healthcare workers, even though work-related injuries and lost-work-time rates among nurses and nursing aides in acute care, long-term care, and community settings have rivaled those of construction workers and miners. This thesis analyzes the rise and fall of the Occupational Health and Safety Agency for Healthcare (OHSAH), created by the Government of British Columbia in 1998 in response to the high injury and lost work-time rates among healthcare workers and dismantled in 2010 as a budgetary decision.

Objectives of this Paper

The objectives of this paper are to understand the conditions giving rise to OHSAH, the agency’s mandate, what it accomplished, why it was shut down, and how its legacy can be preserved. This paper theorizes that both the creation and closure of OHSAH were policy decisions influenced by a complex combination of factors. These include:

1) High injury and lost work-time rates among healthcare workers, which contributed to high insurance claims and rates;
2) Competing interests of healthcare employers and healthcare workers;
3) Unequal distribution of power among these two broad communities and their constituents;
4) Varying successes of these communities in mobilizing their supporters;
5) Misperceptions among academics specializing in healthcare delivery, managers in healthcare organizations, and employee representatives for healthcare workers; and,
6) Government’s need to distribute limited financial resources in a way that would not be perceived as favouring one constituency over another in the healthcare sector or in British Columbia at large.

This paper analyzes the conditions leading up to the creation of OHSAH and compares injury rates and lost work-time in the healthcare sector prior to and following the establishment and closing of the agency. The content of the Accord creating OHSAH is scrutinized based on what it says and does not say, as well as its use of language and numbers. Funding mechanisms for the agency are described. The degree to which the agency was able to influence unions and health authorities is also considered. Key informants identify what they see as OHSAH’s greatest challenges and accomplishments. Recommendations are made for furthering the agency’s legacy.

Figure 1. OHSAH Timeline, 1998 - 2010

![OHSAH Timeline, 1998 - 2010](image)
Opening of a Policy Window

Policies change when policy makers recognize a problem exists, there is a solution, and political conditions are conducive to change (Kingdon, 1995). The election in British Columbia of a New Democratic Party (NDP) provincial government in 1991 and its re-election for a second term in 1996 provided a window of opportunity for organized labour to influence a pro-union government that had campaigned on a promise of equitable distribution of wealth and resources (Heard, nd). Aware that collective agreements among public health sectors were scheduled to expire in 1998, the provincial government set out to negotiate 32 public sector accords with unions and employers representing more than 250,000 public sector workers (Calvert, 2000). The government was also intent on demonstrating to the business sector that an NDP government could govern without enacting policies that would scare away investors or generate large tax increases for small businesses.

Policy and economic constraints limited the government’s ability to fund or support large wage increases. Consequently, the government invited healthcare unions and employers to identify non-monetary policy issues outside of the bargaining table that were major sources of concern for both parties and propose cost-neutral solutions. Both parties identified the health and safety of healthcare workers as extremely important. This consensus paved the way for enactment of an Accord in May 1998 to create the Occupational Health and Safety Agency for Healthcare (OHSAH) in British Columbia (Government of British Columbia, 1998) (see Appendix A.)

OHSAH was established as a collaborative agency that would take health and safety issues off the bargaining table. These issues would be jointly resolved by union representatives and employer representatives working in partnership through OHSAH (Hansard, 2004). The agency would develop programs and guidelines to promote prevention of accidents and the achievement of safe work practices, safe workloads, and safe early return to work. The agency was also tasked with identifying measures to evaluate new health and safety programs and innovations.

The Accord to create OHSAH was made possible by a confluence of events:

1) Election of a government perceived as sympathetic to unionized workers;
2) Very high injury rates among healthcare workers, especially nurses and nursing aides in acute and intermediate care settings;
3) Demands from nursing unions for government and employers to take action to lower these rates;
4) Healthcare organizations’ preference to minimize the presence of health and safety issues at the bargaining table; and,
5) A government committed to finding creative, cost-neutral solutions. The government’s intention was to fund OHSAH through monies saved from reduced work-loss and disability claims arising from lower accident and injury rates, improved safe return to work programs, and lower insurance rates for the health authorities.

**A Cost-Neutral Agency**

Organizations pay insurance premiums to the Workers’ Compensation Board of British Columbia (informally known as WorkSafeBC) based on workers’ assessable earnings (WorkSafeBC, 2013d). Industries with higher numbers of injuries to workers pay higher insurance premiums. For example, the base rate paid by health authorities to ensure acute care workers in 2013 was $1.31 per $100 of assessable payroll, compared to $1.09 in 2012, and $0.91 in 2011. By comparison, the base rate for workers in oil or gas drilling was $1.95 in 2013 and $2.28 in 2012 per $100 of assessable payroll,

Premiums pay for the cost of work-related injuries and diseases. WorkSafeBC uses the following formula to calculate insurance premiums (WorkSafeBC, 2013d):

\[
\text{premium} = \frac{(\text{base rate} \pm \text{experience rating adjustment}) \times \text{assessable earnings}}{100}
\]

Employers in industries with comparable claim costs pay a similar base rate, which is based on every $100 of payroll. Rates for organizations with good safety records may be discounted by up to 50 percent, while unsafe workplaces may be assessed fines up to 100% of their base rate (WorkSafeBC, 2013d). Experience rating is a means of adjusting compensation premiums to reflect injury costs (WorkSafeBC, 2013b).
How OHSAH Was Funded

OHSAH was perceived as a means of addressing workers’ safety issues without incurring significant cost to the provincial treasury. The government gave OHSAH an $11 million advance over three years, to be repaid at a later, unspecified date from anticipated savings. The payment was made as part of the collective bargaining process, outside of the Collective Agreement. The government had no intention of enshrining funding in the Collective Agreement (J. Calvert, personal communication, October 18, 2013).

The Health Services and Support Facilities Association (HSSFA), particularly the Hospital Employees’ Union (HEU), led the initiative to create OHSAH. At that time, HEU represented approximately 50,000 provincial workers employed in hospitals, community and residential care (Hospital Employees’ Union, 2013). Injury rates and occupational health and safety (OHS) issues affected HEU healthcare support workers, including nursing aides, more than nurses in acute care. The NDP government was voted out of office in 2001. HEU reached a negotiated settlement with the outgoing NDP government to secure funding for OHSAH until the agreement expired in 2004. However, within a year of coming into office, the Liberals used their majority status to pass Bill 29: Health and Social Services Delivery Improvement Act (Bill 29) (Minister of Skills Development and Labour, 2002). In effect, the Liberals unilaterally rewrote the Collective Agreement with HEU. In brief, Bill 29 granted health authorities broad rights to contract out and redistribute work carried out by unionized employees. Bill 29 contributed to the layoff and loss of more than 8,000 healthcare workers and union members, mostly from HEU. Key informants representing workers have suggested the Liberal passed Bill 29 to demonstrate their power to unions, to send a message of support to employers, and to penalize HEU for supporting the NDP.

In 2007, the Supreme Court of Canada declared provisions of Bill 29 to be illegal, prompting settlements with the unions. Stating that the provincial government violated the collective bargaining process, the Court gave the government 12 months to renegotiate with HEU (Supreme Court of Canada, 2007), (Sandborn, 2007).

Key informants report that HEU continued to display commitment to a bipartite approach to resolving OHS issues despite losing 14% of their members and the
accompanying dues. HEU’s efforts to get funding for OHSASH into the Collective Agreement in 2004 were unsuccessful. The government imposed a compensation plan and passed legislation ordering unions back to work. The government also decided that responsibility for funding OHSASH would be shifted from HEU to the BC Nurses Union (BCNU). “The effect was that the strongest union that had negotiated the founding of the Agency was no longer being dealt with,” commented a key informant who was actively involved with OHSASH in its early years. A former NDP government official and key informant suggested that the Liberal government did not have a sense of ownership in OHSASH and shifting OHSASH from HEU to BCNU was a reflection of this in part.

In 2006 funding for OHSASH was taken out of the collective bargaining process on the basis that the agency was now mature and did not need the protection that a signed contract – the Collective Agreement – would provide. The government allocated $10 million to OHSASH over five years. Aware that funding needed to be secured for 2011, OHSASH employee representatives approached the Ministry of Health in 2009 asking about continued funding, but did not receive a response. In March 2010, they were advised OHSASH would not be funded beyond 2010. The new Executive Director of OHSASH, just weeks into her position, was advised there were no more funds despite having thought she had months to make OHSASH research more applied and more responsive to the needs of the health authorities. Employer representatives suggest that employee representatives felt they "had been had" as a result of the decision not to fund OHSASH beyond 2010, that trust was “broken,” and it would take “years” to rebuild the relationship.

An International Model for Occupational Health and Safety

In its heyday, OHSASH was perceived internationally as a model for OHS (D. Keen, personal communication, September 4, 2009). OHSASH was credited with a dramatic decrease in injury rates among healthcare workers from 1999 – 2002 (Shamian, 2007). The evaluation of an innovative ceiling lift sling to lift patients with limited mobility out of bed and reduce occupational injury (Alamgir et al., 2009) confirmed the value of installing ceiling lifts in regional health facilities. Many key informants hailed the Workplace Health Indicator Tracking and Evaluation (WHITE™) database for centralizing information on healthcare workers’ injuries and case
management (Gilligan & Alamgir, 2008) as a crowning legacy. OHSAH was also credited with building research capacity through university and healthcare collaborations (Spiegel et al., 2009) and establishing a provincial centre of excellence in OHS.

OHSAH’s founding director, Dr. Annalee Yassi, was an internationally recognized occupational health physician and university academic. In her academic role, she received millions of dollars in grants from the Canadian Institutes of Health Research (CIHR) that funded research carried out by graduate students and new researchers at OHSAH. During and following her tenure at OHSAH, she was instrumental in transferring knowledge of OHSAH’s structure and purpose to national and international health organizations.

**Government Accolades for OHSAH**

In *Hansard – Official Report of Debates of the Legislative Assembly*, then-Minister of Health, the Hon. Colin Hansen, described how Workers’ Compensation Board insurance rates for healthcare workers decreased for the first time in many years (Hansard, 2004). He stated that OHSAH “continues to play a very important role in terms of workplace safety” (page 9261). Asked if the province had any proposals to strengthen occupational safety in upcoming bargaining rounds, the Minister noted that OHSAH was established to take health and safety issues off the bargaining table, to be resolved cooperatively with input from employers and unions. “We see the good work of OHSAH continuing to try to address these workplace issues,” he stated (page 1120).

The Chief Administrative Officer for the Ministry of Health, B. de Faye, called OHSAH a “critical partner” for health care at the Select Standing Committee on Public Accounts in 2008 (Hansard, 2008) (page 1300). De Faye highlighted the collaborative nature of OHSAH and the “very important conferences” organized by the agency’s executive director (page 1300). OHSAH was also awarded the Inaugural Knowledge Translation-in-Practice Award in 2004 from the Canadian Institutes of Health Research (CIHR) in recognition of its topnotch research and knowledge translation.
The Decline of OHS AH

Key informants representing employers, employees, and OHS AH described the agency’s early years as genuinely collaborative. However, the agency’s structure, advisory nature, the weak economy, the reorganization from 52 to five regional and one provincial health authority in 2001 (BC Ministry of Health, 2013) and the ensuing competition for scarce public funds combined to bring about OHS AH’s demise. The agency did not have binding powers. Its advisory nature meant that recommendations brought forward by health and safety experts on committees could be modified or rejected by employers or unions if the recommendations did not fit with their agendas. The amalgamation of 52 health authorities into five regional and one provincial health authority strengthened the regional health authorities, increasing their budgets, staff, and ability to influence health policy. Their scope also increased and key informants have suggested that health authorities may have believed that OHS AH research funds should distributed directly to the health authorities to build their research capacity. By comparison, healthcare unions had very limited research and staffing resources to allocate to OHS research capacity building.

OHS AH was created by a labour-friendly government in 1998. That administration was voted out of office in 2001. In 2002, the Liberal government passed legislation that had the effect of causing great upheaval to the key signatories to the Accord that created OHS AH. The union champion for OHS AH, the Hospital Employees’ Union, lost 14% of its members following passage of Bill 29 by a pro-business government that did not feel strongly invested in OHS AH. The Health Employers’ Association and BC Nurses’ Association also jostled continuously with the provincial government over provisions in Bill 29 and their effect on union members.

OHS AH lacked the authority to go into workplaces and had no authority to implement best practices. At best, it could recommend actions and serve as a knowledge broker by sharing evidence on best practices derived from research carried out by OHS AH staff with academic ties. One key informant, a university-trained health and safety professional with more than two decades of OHS experience, described the frustration of drafting documents and then having non-expert collaborators revise the content to the point where the document became meaningless.
The strong link between OHS/A and the academy had its advantages. OHS/A staff with PhDs and university affiliations were able to secure millions of dollars in additional funds from grant agencies for occupational health and safety research. The product of their research benefited healthcare employers and workers because it provided evidence for changes in practice that, if implemented, would reduce injury and worker lost time rates. This also benefited the researchers themselves by contributing to their advancement/standing in the academic world.

Good research, whether undertaken by an academic in a university or a healthcare professional in a health authority, requires rigor. It takes time to do literature reviews, identify research questions, draft proposals, secure funding, obtain ethics approval, conduct research, analyze findings, share results, implement and measure their impact. This time-consuming process does not dovetail with operational requirements in the health authorities. A health authority executive reported that the need for quick fixes and the inability to obtain them from research carried out by OHS/A was a source of tension for the health authority. He also described “a constant need to educate new graduates and academics.” He felt that OHS/A should be taking direction from OHS professionals with healthcare workplace experience. This tension may have contributed to decreased support for the agency from healthcare organizations when support was most needed.

Paradoxically, many healthcare organizations are slow to implement practice changes based on evidence-based or evidence-informed research. For example, physician Ignaz Semmelweis demonstrated in the 1840s that good hand hygiene could significantly reduce maternal mortality from septicaemia in obstetric wards (Gordis, 2009). To this day, noncompliance with hand hygiene best practices remains an issue for hospitals. More recently, Hack et al. have observed that although recording initial oncology consultations to give to patients has been proven to improve patient information recall, reduce anxiety, and increase patient satisfaction with care provided, translation of this knowledge into practice remains slow (2011). Twenty to 25 percent of patient care provided is either not needed or harmful (Graham et al., 2006). For studies published between 1945 and 1999 on cirrhosis and hepatitis in adults, by 2000 only 60% of the conclusions remained valid. Nineteen percent were obsolete and 21 percent were proven false (Graham et al., 2006). The incremental pace of change in healthcare
organizations is a well-recognized source of concern for healthcare academics and for government.

Although OHSAH was intended to be self-sustaining, the Liberal provincial government quietly closed the agency 11 years after it opened. There was no governmental press release to announce the agency’s closure (E. Yearwood-Lee, personal correspondence, December 15, 2011). Rather, OHSAH employees were informed the agency would close. The agency was wound down over a period of months. A short statement was placed on the OHSAH website to inform readers that OHSAH had ceased to exist as of October 31, 2010 due to budgetary measures. The website was subsequently shut down. A longer statement remains accessible on the BC Nurses Union (BCNU) website (British Columbia Nurses' Union, June 24, 2010) (see Appendix B). BCNU calls OHSAH’s work “outstanding,” stating that the collaboration among health authorities, unions, WorkSafeBC, and university researchers produced “tremendous success” (June 24, 2010). The author of the statement laments the loss of “this valuable organization which has worked tirelessly to prioritize health workers’ need for healthy workplaces” (June 24, 2010).

The story behind the story to close OHSAH remains unclear to this author and to most of the players. Legally binding nondisclosure agreements prevented several key informants from commenting on the changes in OHSAH leadership, changes in governance, and the decision to close the agency. A request for information on OHSAH governance was made in 2013 to the BC Ministry of Health and the Public Service Agency under the Freedom of Information and Protection of Privacy Act. The request was for a copy of the job description for the Executive Director position, the positions of Chief Scientific and Medical Officer and Financial & Administrative Director, and minutes of any meetings or memos about OHSAH that provide information regarding the Executive Director position being replaced by these two positions and later restored to one position. The request was rejected:

The BCPSA holds no responsive records. OHSAH was not affiliated with the BCPSA or the Ministry of Health, but rather was a non-profit organization made up of health care employers and unions which received funding from the provincial government before it became defunct in 2010. The Provincial Health Safety Authority has also advised that they hold no records that respond to this request.
Your file with the BCPSA is now closed.
(Sarrazin, 2013, private correspondence).

Several key informants suggest the decision to not fund OHSAH beyond 2010 had been made months in advance of the announcement to OHSAH staff. The final executive director accepted the position as a secondment from a health authority in December 2009, thinking that she had months to prove to key stakeholders that OHSAH could provide valuable services to occupational health and safety professionals in health authorities. Less than a month into her new role, she was advised OHSAH would not receive more funding. Instead of rebuilding the agency, she was tasked with shutting it down.

A stakeholder attending a Board meeting recalls a discussion on recruiting for a new executive director.

Somebody said, ‘Well, you know there’s the Institute of Work and Health in Ontario.’ Somebody said, ‘Well, we don’t have a guarantee of funding past x date, so it wouldn’t be kosher, basically, to recruit somebody from back east. Then funding runs out and that’s it,’ and I am sitting there listening, is that right, oh oh!
Chapter 2.

Methods

The research methods used to gather data for this thesis include a literature search, qualitative enquiries based on interviews with key informants who had a major stake in OHSAH, and a quantitative analysis of injury and lost time rates among healthcare workers prior to and during the agency’s lifespan. I also conducted a policy analysis that examines the political and economic environment that created a window of opportunity for government, health authorities, and unions to co-sign the Accord to create OHSAH. In addition, I identified how these conflicting interests ultimately made it possible for the provincial government to close down the agency with minimal resistance. Finally, I submitted a Freedom of Information request to the Ministry of Health requesting information on OHSAH governance.

As a starting point, I conducted a literature search using the Patient-Intervention-Comparison-Outcome (PICO) approach in an effort to identify articles on OHSAH’s closure (see Appendix C). In addition, I used a mixed methods approach that draws on qualitative as well as quantitative theory. The qualitative approach was inductive as I sought to understand the reasons behinds the stated reason for the agency’s closure, drawing on content provided by key informants during detailed, semi-structured interviews (Neuman, 2006). I used a quantitative approach to analyze statistics from WorkSafeBC as they related to injury, lost time rates, and premiums paid by employers to WorkSafeBC to cover the cost of on-the-job accident claims resulting in injury or loss time.

Literature Search and Review of the Literature

A literature search was undertaken to identify articles written about OHSAH and its demise. The search included articles written in English on OHSAH from 1998-2011,
with emphasis on the Agency’s final year of operation. Key terms were: “OHS AH, “Occupational Health & Safety Agency for Healthcare” of British Columbia, “Public Sector Accord on Occupational Health and Safety,” “OHS AH + bipartite,” “OHS AH effectiveness,” “OHS AH funding terminated,” “OHS AH abolished,” and “OHS AH disbanded.” Partners to the signing of the Accord were identified as subsets: British Columbia Nursing Union or BCNU, Hospital Employers’ Union (HEU), Health Employers Association of British Columbia (HEABC), Government of British Columbia, “Healthcare workers in BC,” as were stakeholders with a strong interest in OHS AH: Annalee Yassi, Gary Moser, Catherine Fast, Dave Keen, George Heyman, Tony Pennikett, and John Calvert. Information sources searched included journals, databases, grey literature, systematic reviews, government websites, government documents, and policy institutes such as the Canadian Health Services Research Foundation (CHSRF).

The PICO approach was used to identify the patients or subjects (OHS AH, BC healthcare unions representing healthcare workers, healthcare employers, the provincial government, individual leaders), the intervention (why OHS AH was established and subsequently dismantled), alternatives to OHS AH (e.g. WorkSafeBC, Canadian Centre for Occupational Health and Safety), and the desired outcome of fewer injuries and lost days of employment among healthcare workers. Medline, CINAHL and Ovid EBM Reviews were searched. The Government of British Columbia website and, specifically, the Ministry of Health Services website, was searched, as were back copies of Hansard, the journal of the legislative assembly.

Results of the Literature Search

No research articles on OHS AH’s dismantling were found at the time the search was undertaken in 2011, although numerous OHS articles were identified, including many written by the founding executive director of OHS AH, Dr. Yassi, as well as other OHS AH executives and associates. With the exception of an article published in mid-2012 and co-authored by Dr. Yassi, no direct references had been made to the closure of OHS AH at the time of the writing of this chapter in late 2012, possibly because of the time lag between when articles are written and when they are published (Spiegel et al., 2012). A short note on the OHS AH website advised that the agency was closed due to budgetary measures. The sentence directed viewers to the Provincial Health Services
Agency (PHSA) website. The PHSA website temporarily posted two sentences on its website: “On October 1, 2010, PHSA began supporting the following provincial programs previously maintained by the Occupational Health and Safety Agency for Healthcare (OHS AH) in BC, as that organization has ceased operations due to discontinued funding. On this site, you can access or find more information on the programs below....” (www.phsa.ca, accessed on December 14, 2011). This sentence was subsequently removed and it became very challenging to find OHS AH materials. However, technology upgrades have subsequently made it easier to find these resources on the PHSA website.

The fullest description of the government’s decision to close OHS AH comes from a notice on the British Columbia Nurses Union (BCNU) website dated June 24, 2010 and still available to the public (see below):

**Occupational Health and Safety Agency funding ends June 24, 2010**

The Occupational Health and Safety Agency (OHS AH) was conceived in early 1998 in an accord between management and union representatives. OHS AH partners included health authorities, unions, WorkSafeBC, and university researchers. This organizational collaboration has achieved remarkable success. OHS AH’s mandate was to reduce workplace injuries and illness in healthcare workers and to return injured workers back to the job quickly and safely. From 1998 - 2005 both ‘injury rate’ and ‘days lost’ showed a steady decline.

The Provincial Ministry of Health Services has ended funding to OHS AH, and as a result the agency will cease operations in the coming months. Core programs that will continue to be provided within B.C.’s healthcare system are; White.net, MSDS and OHS Connect. There is a commitment to completing the important work of the Provincial Violence Prevention Steering Committee (PVPSC), which will include the completion of the Provincial Violence Prevention Training Curriculum.

OHS AH will no longer be providing support to the Provincial Musculoskeletal Injury Prevention (MSIP) and Biohazardous Exposures Steering Committees.

Thank-you to all BCNU members who participated in both regional and provincial roles.

The work of OHS AH has been outstanding, affecting the health and safety of health care workers throughout B.C.
BCNU regrets the loss of this valuable organization which has worked tirelessly to prioritize health workers' need for healthy workplaces.

(BCNU website, June 24, 2010)

The provincial government itself did not issue a press release advising that OHSAH would be dismantled; nor was the agency’s impending closure debated in the Legislature (private correspondence with the Reference Librarian from the BC Legislature, December 2011), even though parliamentary committees had previously expressed strong support for the agency. More recently, the dismantling of OHSAH is referred to in an article co-written by Dr. Yassi (Spiegel et al., 2012).

Key Informant Interviews: Questions Asked

In-depth, confidential interviews were undertaken with 16 key informants selected through a mix of purposeful and snowball sampling. Key informants include former OHSAH leaders, government representatives, health authority and OHS safety leaders and experts, healthcare academics, and bargaining sector representatives. Key informants were provided with a written list of questions along with a subject consent form approved by Simon Fraser University’s Department of Research Ethics (See Appendix D, Semi-Structured Interview Guide to the Rise and Fall of the Occupational Health and Safety Agency for Healthcare (OHSAH) of British Columbia, and Appendix E, Subject Consent Form). These questions formed the basis for the interviews, although some informants chose to speak more broadly. Interviews averaged 90 minutes. Interviews were conducted in Burnaby, New Westminster, Surrey, Sydney, and Vancouver. Interviews with stakeholders outside of British Columbia were conducted by telephone. The questions are as follows:

1. During what period did you work at OHSAH (if applicable) and what was your role?

2. Was there something particular about the political and labour environments that presented a window of opportunity for a policy decision supporting the creation of an occupational health and safety agency specifically for healthcare workers? What were the political and labour conditions leading up to OHSAH’s establishment in 1999?

3. Why was a bipartite structure used and how did this structure influence how decisions were made?
4. OHSAH did not have binding powers. How did the organization’s advisory nature influence the degree to which unions and employers implemented recommendations and guidelines arising from OHSAH?

5. Please describe what you see as OHSAH’s two most important contributions to occupational health and safety in BC.

6. Why do you think OHSAH became a candidate for dismantling? What were the consequences of dismantling OHSAH? What steps have been taken to ensure the preservation of OHSAH’s legacy?

I requested interviews with individuals from government, healthcare organizations, and unions who had directly been involved in negotiations leading up to the creation of OHSAH. Some informants pointed me in the direction of others whom they believed could also provide insights into OHSAH. I interviewed OHS specialists from healthcare organizations, bargaining units, and academics who had been employed by OHSAH. Informants were promised that their names would not be identified in the thesis. This promise was made in order to be able to obtain candid descriptions and impressions of OHSAH from a variety of sources, including individuals who continue to be public figures.

Responses were transcribed and, where requested, reviewed by the key informant for accuracy. Responses were anonymized to protect the identity of participants. Responses were analyzed with an eye to discerning emerging themes as well as conflicting interpretations of events leading to OHSAH’s closure.

**Mixed Methods Approach**

This is a mixed methods retrospective study that integrates qualitative and quantitative methods (Leech & Onwuegbuzie, 2009). The nature of this thesis requires that informants’ accounts of their experience with OHSAH be balanced with quantitative observations since it is the numbers that were the impetus for the establishment of OHSAH.

I used a mixed methods approach because there are two key themes explored in this thesis: 1) the story of OHSAH as an organization, with an emphasis on the competing interests; and, 2) the numbers that on the one hand gave rise to OHSAH (i.e. injury, disability and lost work-time rates) and the numbers as they reflect the financial
costs of injuries. A qualitative approach, reflected in one-on-one interviews with key informants, provides the basis for understanding the perspectives each brought to OHSAP. A quantitative approach considers injuries and lost work-time rates, as well as insurance rates paid by health organizations as a reflection of injury and lost work-time rates.

Self as Instrument

I became aware of OHSAP in late 2009 while working as a research-team-building strategist with a provincial health authority that was committed to developing the research capacity of its staff. I asked one of OHSAP’s directors to partner with a workplace team on a research grant application aimed at decreasing injuries and lost work-time rates among nurses in a hospital with high injury rates. The OHSAP director very willingly provided statistical expertise for the submission. A few months later, I learned that OHSAP had been dismantled and staff had dispersed across North America. As a graduate student, I was interested in understanding the reasons why OHSAP was dismantled. This interest subsequently became the basis for a formal thesis proposal. I am also a certified human resources practitioner who has contributed to governance policy in private and public organizations. As I plunged into the interviews, I was surprised to learn that committee members participated in strategic decision making to the point where they would vote on proposals they themselves had developed. There was no arm’s length between operational and strategic decision making. Finally, I now work as a quality improvement consultant in a health authority. I draw on evidence-based research and quality principles to inform the actions I take and decisions I make. These principles include the notion of setting aims that are time specific, measurable and define the population of interest, establishing evaluation measures, involving frontline workers, and taking concrete steps to sustain improvements (Institute for Healthcare Improvement, 2011). These experiences informed both my exploration of the rise of OHSAP and my analysis of why it was dismantled.
An Inductive Approach

The short, vague statement on the website that cited budgetary reasons made me curious about the story behind the decision because OHSAH’s annual budget of a few million dollars is a relatively small portion of the total dollars the government allocates for health care. I used an inductive approach to gain an understanding of why OHSAH was dismantled. An inductive approach is a bottom-up approach that begins with specific observations that reveal patterns (Neuman, 2006). I did not have any preconceived notions or know what I would find. I listened with an open mind to key informants’ observations as to why they thought the Ministry of Health Services decided to dismantle OHSAH, what were the agency’s achievements, how could its legacy be preserved, whether OHSAH should be reconstituted and if so, what form that would take. I did not reach a point of theoretical saturation.

Rather, several key themes emerged, reflecting OHSAH’s complex nature and the complex web of relationships among its stakeholders. I believe that these divergent perspectives reflect the conflicting interests of those who had a stake in OHSAH and are the result of continuing misperceptions between what OHSAH was and what competing interests would have liked it to be. These disparate themes can be explained in part by applying Wilson’s theory of competing policy interests (Wilson, 1974) and Stone’s matrix (Stone, 2002) involving fundamental conflicts between the market and the polis (public), with the market representing employers/government and the polis representing OHSAH.

Political Contests

Table 1. Political Contest - Support for Establishing OHSAH

<table>
<thead>
<tr>
<th>Costs</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diffused</td>
</tr>
<tr>
<td>Diffused Effects</td>
<td>Annual funding of OHSAH</td>
</tr>
<tr>
<td>Concentrated Effects</td>
<td></td>
</tr>
</tbody>
</table>

This table, based on Stone’s matrix of political contests, shows two dimensions of policy effects: costs vs. benefits and concentrated vs. diffuse effects. Diffuse benefits
are distributed across the board, but the broad level of diffusion means the benefits are small. In contrast, concentrated benefits are distributed to a specific interest and of benefit to that interest. Equal matches are between two sets of concentrated benefits and between two sets of diffused interests. Governments typically distribute diffuse benefits unless they are either unduly influenced by a specific interest or have a particular motive for engaging that interest. In this instance, the funding that the government provided to OHSAH is a diffuse benefit, spread across all the unions and health authorities. There are two concentrated interests, employers and unions.

The window of interest that provided the opportunity for the creation of OHSAH represents an alliance of two powerful, concentrated interests, healthcare employers (represented by the Health Employers Association of British Columbia - HEABC) and employees (represented by the Health Services and Support Facilities Association – HSSFA – and the Health Services and Support Community Association - HSSCA). The concentrated interests are themselves representative of powerful subgroups, namely the regional health authorities and the unions. Although the government that created OHSAH is commonly described as labour friendly, it is highly conceivable that a government commonly described as pro-business would have also taken advantage of this window of opportunity for the following reasons:

1) A desire to reduce insurance claims, compensation costs, and lost work time resulting from healthcare workers’ on-the-job injuries;
2) The understanding that an investment of less than $2 million annually is a low price to pay for securing labour support in the healthcare sector.

The hiring of an academic who remained an academic while filling the role of founding executive director introduced a third interest, the university, into the matrix. The unintended consequence of this hiring was the creation of a conflict between OHSAH and the academy and OHSAH and the health employers over who decides on what OHSAH should focus on and who owns the results of the research. The executive director identified healthcare employees at large as her customers.
In looking at competing interests, consider the costs and benefits attached to ceiling lifts. An OHSAN evaluation of ceiling lifts demonstrated the lifts reduced musculoskeletal injuries (MSKIs) in nurses who used them, lowering injury and loss time rates for nurses transferring patients out of bed. In this context, every nurse potentially benefits because of reduced musculoskeletal injuries. This is a concentrated benefit because it applies to a specific occupational group. Benefits to all patients are diffuse because every patient benefits because reductions in nursing staff injuries mean fewer nurses off the job as the result of MSKIs. If financial and human resources were
equitably distributed across and within the health authorities, the above interpretation of diffuse benefits would apply. If this were the case, government would benefit because it would be perceived as investing in the health sector to improve patient care. Government would also be perceived as caring about employee welfare by unions, business would support the purchase of equipment, and taxpayers would applaud the benefits to everyone.

However, resources in and across health authorities were and continue to be unevenly distributed. OHSAH’s evaluation demonstrated the effectiveness of ceiling lifts in preventing injury to healthcare workers and patients. Concentrated interests who benefited from the research carried out on ceiling lifts include sites equipped with lifts, unionized employees who used the lifts to move their patients, patients who were lifted, and academics who evaluated the lift initiative. The upfront cost associated with purchasing the lift, installation fee, training fee, and maintenance costs restricted the number of lifts that could be purchased. While it would be helpful for all hospitals to have lifts, older hospital units that house four patients in tight quarters do not have the space to use the lifts. It would also be helpful for homecare nurses to be able to use ceiling lifts for their patients in the community, but this is unlikely to happen unless the patient has the financial means to purchase their own lift and the space to install it. The healthcare workers whose workplaces are equipped with lifts benefit from reduced strain on their arms, shoulders and backs, and reduced musculoskeletal injuries as a result. The patients who are transferred from their beds in the lifts also benefit. Academics also benefit from being able to publish their research demonstrating the effectiveness of ceiling lifts.

Table 3. Political Contest: Who is OHSAH’s Customer in the Health Authority?

<table>
<thead>
<tr>
<th>Costs</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Diffused</td>
</tr>
<tr>
<td></td>
<td>Concentrated</td>
</tr>
<tr>
<td>Diffused Effects</td>
<td>All employees</td>
</tr>
<tr>
<td></td>
<td>Health &amp; safety professionals in health authorities</td>
</tr>
<tr>
<td></td>
<td>Union executives</td>
</tr>
<tr>
<td></td>
<td>Government</td>
</tr>
<tr>
<td></td>
<td>Employer executives</td>
</tr>
<tr>
<td>Concentrated Effects</td>
<td></td>
</tr>
</tbody>
</table>

21
Employer key informants believe that health and safety (H&S) professionals within their organizations, not employees at large, should have been OHSASH's primary customer. Had this been the case, these H&S professionals would have provided direction to OHSASH on research and training initiatives and would have been a concentrated interest whose influence dictated whether benefits would be distributed broadly across the health authorities and internal units or concentrated in specific authorities and departments. While it is likely that OHSASH would have had stronger champions in the health authorities if it had mobilized support from H&S professionals in the health authorities, doing so would have undercut the agency’s bipartite foundation. By being aligned with H&S professionals who report up the line, OHSASH would have been perceived as supporting employers over employees.

Instead, OHSASH chose to identify all employees as its customers. In the months following the government’s passage of Bill 29, HEU mobilized its members and mounted very strong campaigns to win public support. Other unions were less effective in mobilizing support for OHSASH. If OHSASH had been successful in knowledge transfer at the level of the individual union member and had consequently mobilized healthcare unions to lobby on its behalf, the agency might still exist.

A Deductive Approach

WorkSafeBC publishes annual statistical reports on occupational injuries and disease by accident type and occupation in British Columbia. These reports are categorized by type of disease, the exposure giving rise to the disease, the worker’s age, gender, and occupation. I reviewed records from 1987-2011, dates chosen to show health and safety conditions in hospitals prior to, during, and following the creation of OHSASH. Statistical summaries include numbers of claims, days lost from work, and costs (long-term disability, short-term disability, and survivor benefits). Healthcare and rehabilitation costs are excluded (WorkSafeBC, 2011). Reports are also published on fees paid by employers to WorkSafeBC to cover the cost of on-the-job accident claims resulting in injury or loss time. I compared injury and work-time-lost rates for the 10 years preceding the creation of OHSASH, using Excel to generate charts.
Deductive reasoning begins with a theoretical proposition that outlines the logical connections among concepts and then moves toward the concrete (Neuman, p. 59). I used deductive reasoning to examine injury and lost time rates among healthcare workers leading up to the establishment of OHSAH, over the course of its existence, and following its closure. I hypothesized that the establishment and funding of a provincial occupational health and safety agency for healthcare workers, and the agreement by healthcare employers and employees to work collaboratively to reduce injuries and lost work time, among other factors, would logically result in a decrease in injuries and lost work time.

Triangulation is a means of taking different measures of a situation in order to get a more complete and accurate picture (Neuman, p. 149). Taken together, the qualitative and quantitative approaches used in this thesis provide a rich, in-depth analysis of the conditions giving rise to OHSAH and the circumstances under which it operated.
Chapter 3.

Occupational Health and Safety in Canada

Any consideration of OHSAN’s origins and accomplishments needs to be placed in the larger context of occupational health and safety. Following is a brief overview that describes the rise of market forces. The emphasis on profit and productivity without regard to workers’ health and safety gave birth to the unionist movement and to reforms in workplace health and safety. Steps leading to the ‘historic compromise’ between market forces and what Stone refers to as the polis or public good (in this instance represented by owners and workers, respectively) are described. Findings from Royal Commissions on Labour are summarized and legislation to create the current Workers’ Compensation Board, informally known as WorkSafeBC, is examined.

The mandate of WorkSafeBC is also closely scrutinized. Types of accidents, claims paid by WorkSafeBC and work days lost for short and long-term disability are analyzed by industry. Accidents, claims, and lost time for healthcare workers are compared to accidents, claims, and lost time for workers in mining and construction, among other sectors, in the years leading up to the creation of OHSAN in 1998.

Workers as Commodities

In the United Kingdom as well as in North America, the Industrial Revolution heralded massive industrial development and productivity increases arising from the use of steam power, mechanization of work processes, and emphasis on large-scale factory production in the 18th and 19th centuries. The rise of market forces, represented by the business entrepreneur, and the emergence of urban factories using steam power, signaled a profound movement of agrarian workers into urban centres to seek work in factories. Workers used mechanized processes to produce goods as quickly and cheaply as possible, often in abominable conditions. Workers during this era were
perceived as commodities, with minimal consideration given to their welfare (Perry & Hu, 2010). Workplace safety was largely absent. Employees were exposed to physical hazards such as thick dust, high heat, loud sounds and dangerous machinery. They were also exposed to chemical hazards such as gases, toxins, and fumes. Exposures, combined with long work hours, contributed to unsafe workplaces. The lack of protective equipment and long hours standing at machines fueled high injury and fatality rates. The concept of preventing injury by controlling hazards and promoting healthy workplaces was largely unknown at this time (Frumkin, 2010).

**Workers’ Compensation for On-The-Job Injury or Death**

Despite the high fatality and injury rates, workers and their families in the 18\(^{th}\) and 19\(^{th}\) centuries had limited recourse to compensation for work injuries. Under the Common Law legal framework, workers in the United Kingdom and English Canada were ineligible for compensation if they were partly responsible for their injuries (principle of contributory negligence), if their fellow employees were partly responsible (principle of fellow servant), or if they knew their jobs were hazardous when they were hired (principle of assumption of risk) (Guyton, 1999). Workers’ only recourse was to bring a civil suit or tort against their employer. Very few workers had the financial means to file private suits. Historical accounts from British Columbia suggest that even when cases against employers were successful, awards were reduced or overturned by presiding judges whose political beliefs were more closely aligned with the views of employers (Chaklader, 1998).

**Occupational Health and Safety Legislation in British Columbia**

**Employers’ Liability Act, 1891**

The British Columbia government passed the Employers’ Liability Act in 1891 in recognition of the need to assist injured workers (Government of British Columbia, 1891). It was the first legislation of its kind in Canada. The Employers’ Liability Act had many restrictions. It was limited to railway workers and manual labourers. In addition,
employers were identified as being liable only for accidents caused by their negligence. The Act was, however, significant in restricting employers’ ability to cite the ‘fellow-servant’ justification for unsafe working conditions. In addition, it prohibited employers from absolving themselves of responsibility from workplace accidents on the basis of equipment being defective.

The legislation opened the door for more successful civil cases settled in favour of the worker. In a landmark ruling in 1894, the courts rejected the principle of assumption of risk. Two years later, the courts limited employers’ ability to evoke the principle of contributory negligence (Karsten, 2002). The growing influence of trade unions in British Columbian politics enabled the Legislature to pass a new act in 1902 based on the British Workmen’s Compensation Act.

**BC Workmen’s Compensation Act, 1902**

A mining explosion in Nanaimo in 1887 that killed 148 coal miners provided the impetus for two Nanaimo Members of the BC Legislative Assembly to propose, in 1902, the first Workman’s Compensation Act in Canada (Friends of the Morden Mine, 2007). The physical dangers of mining were compounded by English-speaking supervisors with limited mining experience and a preference for hiring undocumented Chinese labourers who were paid half the wages of their Canadian counterparts and subjected to discriminatory practices. The frequency of mining accidents, high fatality rates, and cost to miners, their survivors, and mine operators, prompted all interested parties to recognize the need to change mining practices.

The BC Workmen’s Compensation Act provided injured workers in the railway, factory, mine, engineering, and construction sectors with a set scale of compensation and an arbitration system for injuries sustained at work. These were sectors with high injury rates (Chaklader, 1998). The legislation provided no-fault compensation for injuries arising from and during work, unless the worker was grossly negligent. It set out payment rates, wait time to become eligible for benefits, and compensation to dependents whose wage earner was killed on the job. It also provided a means for arbitration of disagreements between employers and employees. However, it excluded large groups of workers, including loggers, among those most at risk for workplace accidents, and healthcare workers. It also failed to decrease the number of civil suits
being filed by injured workers. Finally, it was not successful in reducing unsafe work conditions.

**Royal Commission, 1912, Leading to “The Historic Compromise,” 1917**

Employer and worker witnesses to the Royal Commission established in 1912 were polarized on many occupational health and safety issues. For instance, they could not agree on compensation for injured workers. However, they were able to agree that a safe workplace could be mutually beneficial. Workers welcomed improvements in physical working conditions. Workers welcomed the emphasis on a safe workplace. Employers appreciated the opportunity to reduce the risk for potentially large judgments being imposed on them by courts finding in favour of the worker. British Columbia’s draft legislation covered workers in many trades and natural resource sectors, including lumber, logging, mining, milling, manufacturing, canning, and ship building and bricklaying (Chaklader, 1998). However, the legislation excluded workers in many sectors and jobs, such as government employees (including nurses), fishermen, longshoremen, clerical workers, and casual employees.

The BC legislation was based on regulations from Washington, Oregon, and Ontario. For example, Article II, Section 35 of the Washington State Constitution, adopted in 1889, called for workers in hazardous industries to be protected, with penalties imposed as a means of enforcing the law (Washington State Department of Labor & Industries, 2011). Washington passed the Worker Compensation Act in 1911. The Employer’s Liability Law, passed by the State of Oregon in 1910, made it mandatory for employers in hazardous industries to provide a place of safe employment and removed employers’ three defenses against unsafe work practices: assumption of risk, contributory negligence, and negligence of a fellow workers (OSHA, nd). Oregon followed this law with the creation of the Workmen’s Compensation Act in 1913, with its emphasis on preventing injuries rather than paying workers compensation for being injured. In Ontario, the *Final Report on Laws Relating to the Liability of Employers* (the Meredith Commission) proposed the historic compromise (Meredith, 1913). The compromise refers to workers giving up the right to sue their employers for damages in favour of a government-administered insurance plan for injured workers and their families (Parson, Harper, McKelvie, Stoney, & Jardine, 1914). This is an underlying
principle of workers’ compensation – that industry should bear the cost of its accidents as part of the cost of doing business.

A major source of friction between employers and workers in BC was the intent to have the Workmen’s Compensation Board (WCB) consist of one person, a commissioner who would be appointed by the Lieutenant-Governor in Council (Coneybeer, 1990). A strong reaction from BC’s trade unions prompted the establishment in 1915 of the Pineo Select Committee (Pineo & Robertson, 1916). The committee included employer and worker representatives. Its mandate was to protect employers against personal injury claims and provide workers with better compensation. Recommendations included the establishment of a publicly administered compensation plan to remunerate injured employees while also protecting employers against civil suits. Union representatives agreed to employers’ demands for a medical aid fund for injured workers that would be paid for by workers at a fixed rate of one cent a day, with employers covering the shortfall if workers were hospitalized or needed more than first aid. A three-day wait period before becoming eligible for compensation from work-related injuries was set. This agreement between employers, the BC Federation of Labour, and the Railway Brotherhoods was one of the first major instances in British Columbia of employers and workers meeting collaboratively to seek solutions to issues of mutual interest. It was also the first time in North America that employees had full medical coverage for work-related injuries. All recommendations from the Select Committee were accepted and included in the legislation creating the Workman’s Compensation Board of British Columbia.

**Creation of the Workmen’s Compensation Board of British Columbia, 1916**

The Workmen’s Compensation Board of British Columbia was created in 1916 in response to dangerous working conditions in British Columbia’s largest industries at the time – coal mining, fishing, and lumber. Vancouver Island’s coal mines were considered “by far the most dangerous in the world” (Government of British Columbia, 1903). The Board was to provide a means for compensating workers injured on the job and to regulate, inspect and assess occupational health and safety (OHS) in provincial workplaces. At the time, the Act was considered the most progressive in North America and served as a model for legislation in other jurisdictions. The Board had three
commissioners, a labour representative, an employers’ representative, and an impartial Chair (Coneybeer, 1990).

Within a decade, complaints from employers and workers, as well as media coverage of high profile cases, prompted the government to review the structure and work of the Board. No changes were made at the time. During the 1930s, employers argued that the cost of levies was too high, while employee representatives lobbied for more benefits. In 1938, benefits for injured workers and their widows were increased, in an effort to placate a stronger labour presence in the British Columbia legislature in the form of the Canadian Commonwealth Federation (CCF) (Blake, 1985). The effort was unsuccessful, as CCF members continued to press for reforms to the Workmen’s Compensation Act. As a consequence, the government announced the creation of a Royal Commission in 1941 led by Gordon McGregor Sloan.

Royal Commission, Workmen’s Compensation Board, 1942

Labour representatives advocated universal workers’ compensation coverage for all workers, rather than by select occupational group. Not surprisingly, employer representatives argued that the cost to provide all employees with coverage would be exorbitant. Sloan supported employers’ representations on the basis that no other jurisdiction in North America provided universal coverage for workers. He retained the three-day wait period. He rejected a request to create a medical appeal board. His recommendations were approved in 1943. In an effort to forestall calls from the CCF for a new royal commission, in 1946 the government eliminated the tariff workers paid for medical aid. The CCF continued to bombard the legislature with resolutions, including blanket coverage for all workers, elimination of a waiting period to qualify for benefits, and coverage for chiropractic treatment (Sloan, 1942).

This Royal Commission is significant because it marks the first time that different industries agreed in advance of the hearings to work together, in this instance to prevent the passage of a recommendation to allow universal coverage. Further, the method employers used to influence OHS policy in British Columbia was also a first – they were guided by legal experts, rather than relying on their own often limited knowledge. As a result, Sloan may have been more heavily influenced by employers, whose witnesses included 18 lawyers accustomed to presenting formal arguments in legal settings (Sloan,
By contrast, Sloan observed that many workers making representations (i.e. labour representatives) to the Commission were not aware of how the Workmen’s Compensation Board operated or how a Royal Commission was conducted. Representations from labour did not form a cohesive whole. Instead, each advocated for its members’ narrow interests.

The unions do not appear to have given consideration to representing a united front to the Royal Commission and mobilizing to achieve a common goal. This individualistic approach is a reflection of the competing interests of their members, limited resources and limited expertise in making quasi legal representations. As a consequence, the interests of workers from different sectors were not as well represented as the interests of employers at this Royal Commission.

The end of World War II heralded massive changes to the workforce, prompted by massive economic growth, the return from overseas of large numbers of soldiers to the workplace, the displacement of women from jobs they held during the war, and the growth in militant unionism. In response a second Royal Commission, also led by Justice Sloan, was convened in 1949 (Chaklader, 1998). Many physicians came forward to testify voluntarily in support of injured workers. Sloan’s recommendations included establishment of increasing widows’ pensions, dependant children’s allowances, and minimum and maximum payments for injured workers. He rejected blanket coverage of all workers in favour of sector by sector coverage. Within two years, his recommendations had been fully enacted. Another set of amendments was passed in 1955. These included providing optional coverage for fishermen, a previously excluded sector. Further amendments enacted in 1959 extended coverage to some industrial groups not previously covered.

**Commission of Inquiry, Workmen’s Compensation Act (1962-1965)**

Labour had focused on obtaining workers’ compensation coverage for all BC employees. However, with many basic concerns addressed, labour shifted its focus to the workings of the Board and its Chair. A third Royal Commission was called in 1962, with much of the three years of hearings focused on the Board’s operations (Tysoe, 1966). The recommendations from the Commissioner (Chief Justice DesBrisay, followed
by Justice Tysoe after his predecessor’s death in 1963) included indexing benefits and allowances to the cost of living.

**A New Workmen’s Compensation Act, 1968**

Rather than amend Workmen’s Compensation legislation, the Social Credit government opted to rewrite the Act. In early 1968, a new Act incorporating Justice Tysoe’s recommendations was introduced and passed in the Legislature. The accident claim reporting structure was simplified, coverage was extended to volunteer workers, and responsibility was placed on the WCB to disprove a claim rather than forcing the injured party to prove a claim.

The Social Credit government was defeated in 1972. With a majority government, the NDP enacted a series of changes to the WCB. Appeals of WCB decisions would be heard by external boards appointed by the government.

**Renaming the Act, 1974**

The official name of the Workmen’s Compensation Act was changed to “Workers’ Compensation Act” in 1974 to reflect the growing importance of female workers. Pensions for dependants of deceased workers were increased, employee and union representatives were given a mandate to accompany Workers’ Compensation inspectors as they inspected job sites, and penalties were increased for employers operating unsafe workplaces. In 1975, workers became eligible for pensions for partial functional disability from work-related accidents (e.g. loss of a thumb).

**Deficits and Cutbacks, 1976**

By 1975, the deficit in WCB reserve funds was $85.6 million. The Social Credit Party regained power in 1975, having campaigned on a commitment to reduce government waste as exemplified by spending at the WCB. Operational and actuarial reviews were very critical of the WCB’s forecasting estimates (Chaklader, 1998). A recommendation to create a Board of Governors (BoG) to curb the power of the Chairman of the WCB was implemented. A new Chair was appointed with a mandate to
reduce costs. Staffing cuts led to waits of up to two years for decisions on coverage for injured workers.

For its part, the BC Federation of Labour conducted parallel public hearings into workers' compensation. The Federation called for the creation of a Royal Commission, public review of Board decisions, and the right to be consulted about candidates for the position of Chairman of the Board.

**The Munroe Committee, 1988**

In 1988, the Ministry of Labour appointed Donald Munroe to chair a committee examining the structure of the Workers’ Compensation Board (WCB), policies it enacted, and statutes under which it was governed (Munroe, 2000). The committee recommended replacing the three-commissioner management structure with a 13-person BoG to increase executive accountability. The BoG would be composed of five representatives from labour, five representatives from employers, two governors representing the public interest, and the Chair of the BoG. The governors would make policy, oversee appeals and administration of the WCB (Munroe, 2000). The BoG would appoint the President/CEO, who would be responsible for implementing BoG policy and administering the WCB.

In response to Munroe's recommendations, the WCB was restructured in 1989. Policy and appeal functions were separated. The CEO and chair of the appeals process were non-voting members of the BoG.

**Bill 63: Universal Coverage in BC, 1993**

Amendments to the Workers Compensation Act in 1993 provided for compulsory coverage for all BC employers and workers, except federal government agencies and industries with federal jurisdiction (e.g. telecommunications, shipping) who are covered by the Canada Labour Code.

In 1996, the government commissioned a review of the BoG’s structure after hearing of conflicts between BoG employer and labour representatives. The review determined that BoG representatives were voting along membership lines rather than
working collaboratively for the greater good (O’Callaghan & Korbin, 1995). As a consequence, the Lieutenant Governor dissolved the BoG, replacing it with a Panel of Administrators. The government subsequently announced the creation of a Royal Commission, the first in three decades, to review the statutory framework, mandate, structure, organization, governance and administration of the WCB in 1996 (Gill, Exell, & Stoney, 1999). The final report of the Royal Commission highlighted an urgent need to reform service delivery and ensure the fair and equitable distribution of benefits to injured workers:

The reasons for the board’s service failure are complex and multi-faceted. Put briefly and in the context of the current decade, they relate to severe shortcomings in leadership, lack of defined goals, poor performance evaluation and deficient accountability structures and processes. These shortcomings have been exacerbated by the lamentable state of stakeholder relations in the workers’ compensation arena, in particular those between industry and organized labour. (Gill et al., 1999)

Recommendations included: a clear, legislated mandate defining services and service levels to be provided; a system of responsible governance; a high-quality claims adjudication process; an independent and timely appeal process; and a performance evaluation system to monitor and assess cost effectiveness, prevention, rehabilitation, and compensation systems.

**Core Services Reviews**

In the face of cost over runs and a weakening economy, the provincial government established two core service reviews of the WCB: 1) a law and policy review examining governance and 2) a service delivery review.

The purpose of the law and policy review was to determine if the WCB should continue to provide current levels and ranges of coverage, and to align specific components with other Canadian jurisdictions (Winter, 2002). As a result of the review, a Board of Directors (BoD) replaced the Panel of Administrators in 2003 as the governing body of the WCB. The Board included a Chair, a worker representative, an employer representative, a health and safety professional, an actuary, and two representatives from the public. The appeals process was simplified and streamlined, with the review
confirming the Royal Commission recommendation that external appeals be handled by an independent body. Adjustments were also made to workers’ benefits.

The service review focused on whether services to workers and employers were provided in a fair, clear, and timely manner. Recommendations from the review included implementing a service quality program, improving staff training and feedback, identifying and reporting public outcome measures related to injury rates, claims timelines, outcomes for permanent injuries, client satisfaction, administration costs, assessment levels, and adopting practice guidelines for disability management from the National Institute of Disability Management and Research (NIDMR) in BC (Hunt, 2002).

In 2005, the WCB changed its working name to WorkSafeBC to reflect the organization’s focus on prevention, customer service, and return to work. (The legal name remains Workers’ Compensation Board of British Columbia.)

About WorkSafeBC

WorkSafeBC is a provincial agency with a mandate to promote workplace health and safety in British Columbia (WorkSafeBC, 2013a). The agency emphasizes education and awareness to promote safety at work. It offers safety training, provides safety toolkits that organizations can adapt and adopt, has “how to” publications on a myriad of topics, and sponsors research competitions aimed at fostering innovative safety approaches in the workplace, among other foci.

The agency works with both employers and workers to reduce work-related injuries and fatalities through consultation and enforcement of the Workers’ Compensation Act, including Occupational Health and Safety Regulations, legal requirements that workplaces under the jurisdiction of WorkSafeBC must meet. WorkSafeBC also works with organizations and workers to provide return to work rehabilitation services, healthcare benefits, and related services. The agency produces an annual report, annual statistics on occupational injuries by accident type and occupation, occupational disease, and numbers and costs of claims. Although the agency prefers to use education to secure compliance, it has the authority to fine employers who fail to comply with its health and safety directives.
The vision and mission of WorkSafeBC emphasize the organization’s focus on workers. The vision is for British Columbians to be free from workplace injury, disease, and death. The mission includes championing safe and healthy workplaces, delivering outstanding service to workers and employers, saving lives, preventing injury and disability, and providing excellent medical and rehabilitative care to workers, all while maintaining cost-effective and sustainable services.

**Work-Related Claims**

WorkSafeBC publishes annual statistical reports on key compensation indicators — claims accepted for fatal benefits, health-care costs, short-term disability costs (includes health care and rehabilitation costs), long-term disability costs, and survivor benefits for industries it covers. It also produces charts showing trends in statistical indicators over a 10 year period (Workers’ Compensation Board of British Columbia, 1997).

**Figure 2. Number of Short-Term Disability Claims per 100 person-years of WCB-covered Employment; Excludes Bill 63**

(Data source: (Workers’ Compensation Board of British Columbia, 1997))
For example, Figure 2, *Number of Short-Term Disability Claims per 100 person-years of WCB-covered Employment; Excludes Bill 63*, shows an overall decrease in injury rates over six years, from 1990 to 1996, for job classes covered by WorkSafeBC. There is a slight increase in 1997. Injury rate refers to the number of short-term disability claims per 100 person years of employment that WCB covers, equivalent to work by 100 full-time employees.

WorkSafeBC divides industries into the following general classes:

Class 1 – Forest-products industries
Class 4 – Mining; quarrying; manufacturing of dams, rock, lime, clay, or cement products
Class 6 – Light manufacturing, service and trade industries
Class 7 – Heavy manufacturing, construction
Class 8 – Power and gas utilities, communications, motor-vehicle transportation, air transportation
Class 9 – Water transportation, wharf operations, fishing, and fish-packing
Class 12 – Canadian Northern Railways, Air Canada, Via Rail Canada, Northern Alberta Railway Company
Class 13 – The Crown in right of the Province and any permanent board or commission of the Crown in right of the Province
Class 14 – Municipal corporations and agencies
Class 18 – Burlington Northern Inc.
Class 19 – Federal government
Class 31 – Medical, dental offices
Class 33 – Financial institutions; business services
Class 38 – Federal Government Job Creation
(Data from *Workers' Compensation Board of British Columbia, 1999*)

Classes are subsequently divided into Subclasses. For example, Class 1, Forest Products Industries, covers workers in logging, pulp and paper mills, sawmills, plywood mills, and shakes and shingles. Class 4 covers miners and quarry workers. Class 6 includes light manufacturing, services and trades. Subclass 626 includes Hospitals, First

Figure 3. WorkSafeBC Total Claims by Year and by Class, 1996 - 1999

(Data source: Claim Costs, Workers’ Compensation Board of British Columbia, 1999)

An examination of total claims by class between 1996 and 1999 refutes the popular perception that workers with jobs in heavy manufacturing and construction and logging are most at risk of injury, disability, or death in British Columbia. Figure 3, above, shows WorkSafeBC total claims by year and by class between 1996 to 1999. Five classes are observed to have the highest number of total claims in this period: Class 1,
Forest-Products Industries (logging and pulp and paper mills); Class 6, Light Manufacturing, Service, and Trade (including textile manufacturing, food product manufacturing, hospitals & related, hotels and restaurants); Class 7, Heavy Manufacturing and Construction (construction trades, building construction, and heavy manufacturing); Class 8, Power and Gas, Communications and Transportation; and Class 14, Municipalities and Schoolboards. All other classes, including Class 4, representing Mining, Quarrying and Related Industries, are grouped into a single category.

Between 1996 and 1999, total claims for industries in Class 6, Light Manufacturing, Service and Trade, including healthcare workers, were more than double the number of claims for industries in Class 7, Heavy Manufacturing and Construction, and more than three times the number of claims in Class 1, Forest-Products Industries. Claims in Class 6 were ten times the number of claims in Classes 1 and 7 and about four times the number of claims in sectors grouped into a single category. Claims in Class 6 industries increased for three consecutive years, peaking at 65,677 claims in 1998 and dropping to 63,910 claims in 1999, slightly above the 1997 figures.

**Figure 4. WorkSafeBC Total Number of Claims by Year, 1996 - 1999**

(Data source: Claim Costs, Workers’ Compensation Board of British Columbia, 1999)
The peak in 1997 is apparent in Figure 4, WorkSafeBC Total Number of Claims by Year, 1996-1999, where the increase in claims in Class 6 caused the total claims to increase from 1996 to 1997, after which the trend shows a steady drop in claims between 1997 and 1998, followed by a sharper drop in claims between 1998 and 1999.

Another way to consider these numbers is by looking at claims as a percent of total claims. In Figure 5, WorkSafeBC Proportion of Claims by Year and by Class, claims for Classes 1, 6, 7, 8, and 14 are measured as a percent.

**Figure 5. WorkSafeBC Proportion of Claims by Year and by Class, 1996 - 1999**

(Data source: Claim Costs, Workers' Compensation Board of British Columbia, 1999)

All but claims for Class 6 industries fall below the 25% mark, meaning that each of these classes accounts for less than 25 percent of annual claims. Class 6 claims stand alone in the upper range, accounting for 42.2%, 43.0%, 45.5%, and 46.7% of all work claims for the years 1996, 1997, 1998, and 1999, respectively. Consistent with Figure 2, claims for Class 6 industries as shown in Figure 3 are shown to increase,

Stone suggests that policy problems can be defined by measuring their magnitude. The sizeable increase in injuries, disability, and lost work time on the part of healthcare workers points to problems with work practices in healthcare settings and the need for a policy solution. Increases in work days lost, wages lost, and strains in the hospitals and related subclass account for the increase in claims paid by WorkSafeBC in 1997. WorkSafeBC paid out $34,957,000 for claims for work days lost in Hospitals and Related in 1997. By far the largest type of claims from Hospitals and Related were the 4,130 strains reported. By comparison, the next two highest sources for strains in this subclass were hotels and restaurants, reporting 1,410 strains, and miscellaneous manufacturing, reporting 1,120 strains.

Figure 6, Proportions of Days Lost in 1997 in Class 6 Industries, Subclass 0626, shows the Hospitals and Related class experiencing almost the same proportion of days lost to injury (36%) as 16 combined industries (35%). This comparison shows the magnitude of the problem in Hospitals and Related.

With 271,339 work days lost in Hospitals and Related, this subclass accounts for triple the number of days lost in Hotels and Restaurants, the next highest subclass in the sector, as shown in Figure 7, Proportion of Claims for Strains in 1997 in Class 6 Industries, Subclass 0626.
Figure 6. Proportions of Days Lost in 1997 in Class 6 Industries, Subclass 0626

(Data source: Days lost, Workers' Compensation Board of British Columbia, 1997)

Figure 7. Proportion of Claims for Strains in 1997 in Class 6 Industries, Subclass 0626

(Data source: Claims for Strains, Workers' Compensation Board of British Columbia, 1997)
The high number and cost of Hospitals and Related claims places this subclass among sectors generally considered the most dangerous, such as Logging, Heavy Manufacturing, Sawmills, and Building Construction (see Figure 8). For example, 14% of the total costs of claims in 1997 were allocated to Hospitals and Related. Thus, hospital claims are half as high as claims in 1997 for Logging, generally acknowledged to be a hazardous industry. The Logging, Heavy Manufacturing, Sawmills, and Building Construction subclass are male dominated and known for strenuous physical work environments, hazardous machinery, and the need for workers to be physically fit and very strong. By contrast, Hospitals and Related are predominantly female environments.

**Figure 8.  Proportions of Overall Total Claim Costs Charged by 1997 by Subclass**

(Data source: Claim Costs, Table A-2, Workers’ Compensation Board of British Columbia, 1997)

**Why Injury Rates and Claims Concern Workers and Employers**

The increase in injuries and claims among healthcare workers was of concern to employers for operational and financial reasons. Health employers pay an experience rating to WorkSafeBC based on injury, disability, and fatality rates among their employees. Experienced ratings increase as claims increase. In the 1990s and 2000s (and continuing to the present), healthcare employers had been told by government to
reduce spending. This was particularly difficulty to do when there were high employee injury rates since injured employees needed to be replaced so that patient care is not compromised. Thus, although healthcare was primarily focused on the patient and not the caregiver, the well-being of the caregiver influenced the delivery of quality patient care. A shortage of well nurses had a detrimental impact on patient care and contributed to more injuries as nurses took whatever shortcuts they could to carry out their increased workload (Hayes & al., 2006).

Increased injuries also contributed to difficulties in recruiting and retaining nurses. While a shortage of qualified nurses was already recognized as a challenge for healthcare organizations, new nurses' growing awareness that their chosen field ranked among the most dangerous workplaces in the province would have been a disincentive to working as a nurse in British Columbia in 1997, exacerbating staffing shortages and placing an even greater burden on uninjured nurses that in turn would potentially increase their risk of injury and subsequent time loss from work. Moreover, the effect of large numbers of nurses leaving their occupation would have a significant impact on the unions to which they paid dues.

Unions representing nurses and other healthcare workers were also concerned about the increase in injuries and claims among their own because of the impact injuries and inability to work have on the injured person's quality of life, financial security, and mental and physical health (Torgerson, 2007). Injured workers who have exhausted their sick bank, vacation time, and all other paid leave risk financial hardship that could prompt them to leave healthcare for a less stressful work environment. Psychosocial impacts for injured healthcare workers are also well documented, with physical disability contributing to mental health disability. Further, mental health disability is a leading cause of workplace absenteeism (Harder, Hawley, & Stewart, 2011) and contributes to insurance claims.

The increase in hospital and related claims in 1997 was a source of concern for government, employers, employees, and the employee groups with which they were affiliated. It was also a concern for the NDP government, which depended on support from unionized employees to remain in power. The provincial government's challenge was to find a way to balance the need for fiscally responsible policies with policies that were perceived by the unions to be supportive of workers. The creation of OHSAH was a
means to address the interests of healthcare unions, healthcare employers, and interested third parties.
Chapter 4.

The Public Sector Accord on Occupational Health and Safety

The Accord process was designed to identify policy changes that would improve the likelihood of achieving agreement at the bargaining table without costing the government additional money. It was explicitly excluded from having a financial mandate to avoid creating two negotiation streams that both involved compensation issues. The presence of two negotiating streams (e.g. renewal of Collective Agreements and creation of OHSAH) would have been confusing to the collective bargaining process, possibly making it harder to arrive at settlements. The Accord asked both the employer and unions to bring forward their policy proposals to indicate their priorities. The Accord provided a means to mobilize competing interests by uniting them around a shared goal of reducing healthcare costs to employers, employees, and the public by reducing injuries and insurance claims in the healthcare sector.

The Public Sector Accord on Occupational Health and Safety (the Accord) was signed on May 23, 1998 by representatives from unions (Chris Allnut, Business Manager for the Health Services and Support Facilities Association and George Heyman, Business Manager for the Health Services and Support Community Association), employers (Greg Walsh, of the Health Employers Association of BC), and the provincial government (Tony Penikett, Deputy Minister with the Government of British Columbia) (Government of British Columbia, 1998).

In 1995, the Health Sector Labour Relations Commission ("Dorsey Commission") recommended reducing the number of healthcare bargaining units from 888 to 10. It also recommended that the number of healthcare unions be reduced from 19 to seven. (Ministry of Jobs, 1996). The Hospital Employees’ Union (HEU) became the dominant union in the health facilities sector, while the BC Government and Service Employers’ Union (BCGEU) became the dominant union in the community sector.
Accord Signatories

Key unions representing healthcare workers are: HEU, BCGEU, and the BC Nursing Union (BCNU). HEU and the BCNU represent most of the province’s healthcare workers. HEU currently represents more than 43,000 workers in acute care, residential care, community group homes, outpatient clinics and labs, community social services, and First Nations health agencies (Hospital Employees' Union, 2013). Among the healthcare unions, HEU played a leadership role in advocating for the creation of a centralized health and safety agency for healthcare workers and its ongoing funding. HEU was successful in 2001 in securing a negotiated settlement with the outgoing NDP government to fund OHSAS through the course of the Collective Agreement, which expired in 2004. Despite losing 7,500 members as the result of the Liberal government’s unilateral rewriting of the Collective Agreement with HEU in 2002, HEU continued to lobby on behalf of care aides and other healthcare workers it represented, until being told by the government that the BCNU would become the union responsible for negotiating funding for OHSAS.

BCGEU currently has approximately 65,000 members in 550 bargaining units across British Columbia. Members are employed in direct government services and in a wide range of sectors, These include community health workers providing nursing care, personal care, housekeeping, dietary and rehabilitation services in psychiatric hospitals and residential care, community social services, child care, community colleges, casinos, hotels, and highways maintenance (BC Government and Service Employees' Union, 2013). Leading up to the creation of OHSAS, BCGEU executives were particularly concerned over health and safety issues facing community health workers – lifting patients in homes and beds not designed to facilitate easy movement and dealing with the expectations of family members.

BCNU currently has about 40,000 members, including registered nurses, registered psychiatric nurses, and, since 2012, licensed practical nurses, and allied healthcare employees (British Columbia Nurses' Union, 2013). Key issues for BCNU executives were the high levels of musculoskeletal injuries, slips, trips and falls sustained by nurses in acute care settings, the threat of bloodborne disease from needlestick injuries, and the rise in violent incidents directed at nurses.
The Health Employers Association of BC (HEABC) represents more than 260 publicly funded healthcare employers at the bargaining table. HEABC members include the provincial health authorities, nonprofit care providers, and denominational and proprietary care providers (Health Employers Association of BC, 2012). There were 52 health regions and more than 500 employers making decisions affecting the lives of healthcare workers in BC prior to the signing of the Accord. The Accord was seen as a way to create a centralized agency that would facilitate the sharing of evidence based research and healthcare best practices among the regions while simplifying industrial relations.

The Accord does not define which individual disciplines are included because the focus is on the benefit to workers as a group rather than to individual workers. This exclusion is significant because it has the effect of allowing unionized healthcare workers in an array of settings, from hospitals and acute-care facilities, to residential institutions, to homecare, to cooperate in the implementation and evaluation of policies, programs, and innovations in health care originating from OHSAH. The Accord does, however, exclude non-unionized healthcare employees. In doing so, the authors are situating the Accord as a document informed by union-management negotiations leading up to the bargaining table.

A Language of Collaboration and Inclusion

The language of the Accord emphasizes the importance of collaboration and group interests over individual interests. For example, the Preamble uses “share,” and “… all have,” while the signatory page is introduced with the phrase “We agree to….” The second paragraph continues in the same vein: “The parties further agree that….” The objectives of the Accord emphasize a collaborative approach through the use of phrases such as “facilitate cooperation between unions and employers” and “share information and experience.” Section III, "Parties to the Accord", describes a commitment to working cooperatively. Section IV, “Establishment of a Health Care Occupational Health and Safety Agency,” speaks to “equal representation” from unions and employers with a neutral chair selected by the unions and employers and the agency’s working with “all members” of the healthcare community. This inclusive language emphasizes the establishment of a community of interests among healthcare
employers and employees and the sharing of a common goal aimed at reducing and preventing injuries and lost work-time among healthcare workers.

The Addendum to the Accord uses language that more clearly describes OHSAH’s role. Promotion of best practices and conducting necessary research is recognized as being enhanced through a joint effort on the part of unions, employers, and the agency. The creation of OHSAH is described as a “government-funded approach” to identifying and implementing strategies to strengthen safe work environments, healthy workforces and quality patient care. OHSAH is referred to as a “jointly run agency” (by unions and employers) with the purpose of developing and evaluating program objectives relating to prevention programs and compliance with Workers’ Compensation Board requirement. Finally, OHSAH is also given the mandate to promote the adoption of practices, programs or models that provide equal or greater protection to workers than existing practices, programs or models.

The references to “economic incentive and social responsibility” in paragraph 3 of the Preamble are twinned to emphasize the collaboration of two traditionally competing interests – unions and employers – brought together by the third partner in OHSAH, the government of BC. The provincial government perceived the Accord as a means of facilitating the obtaining of settlements at the bargaining table.

Two additional stakeholders are subsequently identified, patients and the public at large. The purpose of mentioning these two interests is to demonstrate that OHSAH has a focus that transcends collective agreements between healthcare workers and employers. In effect, that focus is much broader in nature and would appeal both to healthcare employers, who emphasize better patient care in their vision and mission statements, and to healthcare workers, most of whom chose to become nurses of healthcare providers because of a desire to provide best possible care to their patients.

The Value of Every Injured Worker

In the policy world, numbers are used to create urgency and to categorize people as belonging to one group or another (Hayes & al., 2006). The second paragraph of the Accord cites the number of short-term disability claims among healthcare workers in
1996 as 4,591 and as 23,756 in the five years between 1992 and 1996. Five percent of workers are estimated to be on long-term disability at any one time, with over 200,000 lost days of work annually. These are very specific numbers. In keeping with good statistical practice, a statistician might have rounded the numbers up to 4,600 and 23,800, respectively. However, the author of the Accord has chosen not to round. In making this decision, the author is emphasizing the value of every healthcare worker.

While the language of the Accord speaks of collaboration, the Preamble appears slightly weighted in favour of the worker. References to workers and unions come first in every paragraph of the Accord. Although a reference needs to be made to a subject, whether it is a worker, employer or government representative, having the first reference be to workers is a means of emphasizing to them that the government highly values their participation. Finally, and perhaps most importantly, workers are accorded the first reference because the nature of this Accord is aimed at education and training for healthcare workers in order to avoid injury and occupational disease. In the third paragraph of the Accord, injuries and disease are described first as exacting a toll on workers “and their families,” followed by a reference to the impact on the employer and workplace: “while resulting in significant additional costs for treatment, recovery and income replacement.” The reference to workers’ families further highlights the government’s emphasis on the value it places on the worker.

The third paragraph also uses language that is directed at employers. The structure of the first sentence explicitly states that unions, employers, and government all have an economic incentive and social responsibility to foster safety and reduce injuries. Employers’ economic incentives to reduce injuries come in the form of reduced insurance premiums paid to WorkSafe BC and reduced operating costs that are a consequence of not having to replace injured workers. Healthcare workers do not have the same economic incentive to reduce injuries, although those who are recent hires and have suffered on-the-job injuries requiring long-term rehabilitation may struggle financially once they have used up their sick benefits. However, as members of the polis, represented by the unions, unionized workers have relationships with their peers and are expected to sacrifice for the common good (Stone, 2002).
Clear Objectives, Unclear Roles and Responsibilities

The Accord uses broad, inclusive language to describe OHSAH. The overarching message is clear, but who is responsible for what is less clear. Specifics are provided in the form of numbers – numbers of injured workers and numbers of dollars to fund the agency’s start-up. Motherhood statements about improving safe work environments abound, but are low on specifics. The advantage of this approach is that it provided the representatives to OHSAH with a blank slate upon which they could build their own vision of a health and safety organization that they would direct. The disadvantage is that the lack of guidelines had the potential to create an imbalance by enabling the parties to unequally influence how OHSAH would operate and what would be its focus. The lack of specifics also had the potential to create conflict among members as the result of role confusion. Some members might have felt that their roles were being duplicated or overshadowed.

The objectives of the Accord are clearly set out in bullet form. However, nowhere is it stated who is responsible for carrying out each objective. Although all of the objectives are worthy goals, the lack of attribution of responsibility for achieving them could stoke conflict among the different interests because each interest could make a reasonable case for ‘owning’ part or all of the objective. Several examples of unclear roles and responsibilities for accomplishment of the objectives are provided below:

1) The first objective focuses on promoting healthy workforces, safe workloads, and safer work practices. Clearly, this objective is directed at employers because they are the interest who promotes a healthy workforce by ensuring employees have the tools and training they need to perform their tasks, and the rest periods required to prevent slips and strains. At the same time, there is a responsibility on the part of the employee to take responsibility for her or his own health needs, even though this can be very difficult when a work unit is short staffed.

Since an employer determines an employee’s workload, this objective is clearly directed at the employer. However, workplace standards for setting workloads, either in terms of hours worked and tasks assigned or in terms of weights lifted, have been set as the result of studies undertaken by researchers, who identified what constitutes a safe
workload. Thus researchers from OHSAN might feel they have a stake in owning this objective because of the research underlying the standard.

Employers may provide guidelines for safe workloads but not provide the required level of staffing or the appropriate tools or training to ensure that the guidelines can be followed. As a result, an employee may not follow a best work practice. Further, nurses are trained to practice critical thinking, which includes analyzing situations, reasoning, knowing and applying standards of care (Scheffer & Rubenfield, 2000). As a result of practicing critical thinking, a nurse may decide not to follow a directive that she or he believes is unsafe or not in the patient’s interest. While it is easy to blame the nurse if an injury results, a systems approach that aims to correct the underlying factors contributing to the unsafe work practice would foster greater compliance with safe practices (Wakefield, 2008). The issue is in the workplace; however, it is researchers who have identified the need for a systems approach and provided healthcare organizations with training materials to implement system-wide changes to ensure safe workloads.

2) The reference to reducing the incidence of accidents and occupational diseases (second objective) is clearly targeted at employers since accidents take place in their work environment. However, researchers at OHSAN may see this objective as part of their domain since the objective speaks to the need to reduce occupational disease. This reduction might be achieved by researching the timing, amount and pathway of exposure, developing interventions to prevent symptoms of an occupational disease, and transferring this knowledge to employers and employees in the workplace. Employers, employees, and researchers all have roles to play in ensuring safe workloads. What is not clear is where one responsibility begins and one ends.

3) The objective of facilitation of cooperation between unions and employers on health and safety issues and the adoption of best practices across the sector is clearly targeted at employers since it is employers who identify workers’ training needs and decide whether to address these needs by either developing training programs to meet their workers’ needs or sending workers to training provided by outside parties. It is also the employer who decides whether a worker can be granted time away from work to take the training. While it is workers who apply a best practice, the decision to adopt a best practice is made by the employer. Further, successful implementation of that best
practice will only occur if the employer has put in place the conditions or culture that makes it desirable for workers to follow the best practice. At the same time, frontline staff are often very aware of workplace hazards and can choose to bring these to the attention of their supervisor for resolution.

Best practices originate from research. Their uptake may be encouraged or impeded by employers and/or by workers for any number of reasons. For example, induced hypothermia applied upon the patients’ arrival at hospital has been proven to improve heart attack patients’ survival with good neurological outcomes (Dainty et al., 2011). However, only 26% of emergency physicians and 26% of hospitals follow this practice. Reasons they cite for not adopting this practice included: staffing shortages (20%), overwork (20%), and perceptions of poor prognosis (25%). The overarching reason, however, was the absence of a clinical protocol for therapeutic hypothermia (Dainty et al., 2011).

Many generic health and safety goals are the responsibility of OHS departments in healthcare organizations and OHSAH. These include: promotion of a safe and healthy work environment; reduction in incidence of accidents and occupational exposures; provision of education and training to workers; facilitation of cooperation between unions and employees on health and safety issues; and safe early return to work. Although one could argue that everyone has this mandate, the lack of clear roles and responsibilities for OHS could result in jurisdictional disputes between OHSAH and OHS departments.

By contrast, the sectoral-wide nature of other objectives listed in the Accord suggests a provincial agency may be more suited to promoting broad goals. For example, OHSAH would have been ideally suited to serving as an information clearing house on OHS, to further the goal to “share information and experience across the sector,” as stated in section II, Objectives of the Accord.

While employers can and do share information, their overriding objective is to meet operating needs by providing services to their clients, the patients. They recognize that providing best patient services is conditional on having healthy, well educated, highly motivated and highly engaged staff to deliver these services. Since the employers’ focus is more on immediate operational needs than longer-term aspirations, the objective of sharing information and experience across the sector appears to be more
applicable to OHSAH than to its partners, even though the Accord does not spell out if the objectives are aimed at OHSAH, employers, or employees.

Likewise the goal of researching innovative health and safety solutions sounds as if it had been written with a provincial agency in mind, rather than a health authority or nursing home. Since OHSAH would not be burdened by the operational requirement of providing healthcare services to patients, it would have the time to carry out the research and share the findings with the signatories to the Accord.

The proliferation of data makes it extremely challenging for even the most dedicated workers of healthcare practitioners to remain current on developments in their fields. For example, a clinician in general medicine would need enough time to read 19 articles every day of the year to remain abreast of emerging research (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). Healthcare organizations’ ability to do research or to implement research findings is constrained by operational requirements and by workers’ research skills. This challenge remains even in health authorities such as Fraser Health, where healthcare workers are encouraged to develop research capacity and are encouraged to enroll in graduate programs of study. By contrast, OHSAH staff would have the time to do the research and to disseminate the findings to union and employer representatives.

Funding Constraints

Funding mechanisms to enable OHSAH to carry out its mandate are described in section V of the Accord. The intent was for OHSAH to be self-financing and cost-neutral. The hope was that improved health and safety practices in the workplace would translate into lower injury and loss time rates. This would result in lower insurance premiums. In addition, a strengthened return to work program would make it possible for injured workers to return to work sooner rather than later. WorkSafeBC’s role in financing OHSAH was described in section V as follows: “Resources will be generated from a variety of different sources, including...lower WCB assessment rating and the implementation of new WCB worksafe programs. The Agency will directly negotiate these arrangements with the Workers’ Compensation Board” (Government of British Columbia, 1998). WorkSafeBC was not a signatory to the Accord but did support the
research undertaken by OHSAH by providing numerous grants for research initiatives, as well as highlighting OHSAH publications. There is no reference on WorkSafeBC’s website to the decision to close OHSAH and to the actual closure, likely because WorkSafeBC itself is a government agency and would not have found it appropriate to comment publicly on government’s decision to close another public agency.

Recognizing that it would take time for OHSAH to become self-sustaining, the Ministry of Health allocated start-up funds for the first three years: $5 million in FY 1998-1998, $4 million in FY 1999-2000 and $2 million in FY 2000-2001. A million dollar annual limit was placed on operating expenditures. OHSAH was allowed to carry forward unexpended funds. No mechanism was described for ensuring funding beyond 2001. Although OHSAH was the product of negotiations between employers’ and workers’ representatives, and at least initially had support from the government, neither the employers’ nor the workers’ representatives called for funding for the agency to be enshrined in the Collective Agreement. The Accord process was carried out in parallel to the Collective Agreement process, with the understanding that there were no funds available for a new agency. Start-up funds were advanced to the Agency. The lack of a mechanism to ensure continued funding mean that OHSAH would be dependent on the good graces of the employer, the unions, and the government for its continued existence. This made OHSAH an easy target for cost cutting.

Accountability

Section IV of the Accord assigns OHSAH responsibility for developing a methodology for evaluating outcomes, establishing program goals, including measurable outcomes, and applying the methodology to audit outcomes. Section V of the Accord stipulated that OHSAH would audit its programs to document expenditures and identify savings achieved. There is no mention of OHSAH being subject to external audits or to performance reviews by the government, employers’ organizations, or healthcare unions.

As a matter of good accounting practice, external accountants audit most community organizations’ books annually. Internal auditors screen expenditures in larger organizations. Federal Crown corporations are inspected by the Auditor General to
determine if taxpayers’ dollars are being well spent. In academic institutions, services and operations of faculties are audited or evaluated to ensure they meet accreditation standards. OHSASH was responsible both for evaluating programs and for evaluating its own effectiveness in evaluating programs. Although internationally recognized for its innovations in occupational health and safety, the agency would have benefited from a mechanism for independent evaluation of its own work.

An independent audit that demonstrated sterling results could have mobilized support from different stakeholders to petition the government to continue to fund OHSASH or to pressure union or employer representatives to request that the agency’s funding be enshrined in the Collective Agreement. Conversely, a less than stellar result could have prompted the agency to change its practices so that future audits would be more favourable.

Making the agency responsible for auditing its own programs and identifying savings achieved placed the agency in a potential conflict with employers and unions. OHSASH’s primary role, based on the Addendum to the Accord, was to promote better health and safety practices in the healthcare workplace. For its part, OHSASH needed to show savings from reduced workplace injuries and loss time. OHSASH was in a position to assess or evaluate the effectiveness of workplace health and safety innovations, but not to implement these. Since this was the purview of the employer, it would have been very difficult for OHSASH to claim responsibility for these savings without alienating its employer partner. At best, OHSASH could state that its contributions enabled employers and unions to reduce workplace injuries and time loss. However, a statement of this kind would not have been sufficient to ensure the agency’s continuing beyond its start-up phase.
Chapter 5.

Economic Analysis

An economic analysis is a systematic examination that compares at least two alternatives methods for achieving a specific objective. It considers opportunity costs and benefits to the community and provides decision makers with financial data for making decisions on how to allocate scarce resources (BusinessDictionary.com, 2013). In 2001, British Columbia’s Minister of Skills, Training and Labour commissioned a review of WorkSafeBC to contain rising costs associated with compensating workers injured on the job (Winter, 2002). The review was in response to reports that the agency ended its 2001 fiscal year with a deficit of $286.8 million. Further, projections based on maintaining the status quo estimated WorkSafeBC would have an overall deficit (unfunded liability) of approximately $1 billion by 2005. The high number of workplace injuries and claims paid to injured and disabled workers contributed to the deficit. While reductions in operating expenses and long-term compensation practices have reduced the scope of the deficit, ongoing attention to reducing costs is required in order to sustain this publicly funded workplace injury compensation program.

Since OHSASH was set up to reduce healthcare injuries and associated compensation costs, the question arises as to whether OHSASH was effective in decreasing healthcare workers’ injuries and attendant costs. While a detailed economic analysis is outside the scope of this thesis, it is worth highlighting several key initiatives undertaken by OHSASH to reduce healthcare injuries and claims.

Ceiling Lifts

A cost-benefit analysis of the use of ceiling lifts to reduce musculoskeletal injury (MSKI) when transferring patients demonstrated a significant decrease in compensation claims on the part of nurses who use ceiling lifts in place of manually lifting or
transferring their patients out of bed (Alamgir, Yu, et al., 2008). The study took place at three extended care facilities run by Providence Health. Between 2000 and the end of 2005, $1,081,410 was spent to purchase and install 1,000 lifts (cost includes training to use them, as well as maintenance costs). The payback period was estimated to range from 6.2-6.3 years, based on direct claim cost savings, and 2.06-3.20 years when indirect savings were also considered. The Ministry of Health Services and WorkSafeBC allocated $15 million in 2001-2002 to purchase mechanical lifts and electric beds (Yassi, Ostry, Spiegel, Walsh, & de Boer, 2002). OHSAN and its research partners – provincial researchers, healthcare unions and employers, WorkSafeBC and insurance representatives from the carrier for long-term disability healthcare claims – established a partnership credited with saving $51 million in prevented insurance costs from 2002-2004 (Yassi, Tomlin, Sidebottom, Rideout, & DeBoer, 2004).

Although this research provided evidence for reducing MSKI and claim costs in healthcare workers, the number of ceiling lifts installed throughout the health authorities remains limited. The opportunity cost incurred by the health authorities is the cost of injuries that could have been prevented through widespread use of ceiling lifts in acute and residential care facilities, but were not prevented due to limited investment in ceiling lifts.

**WHITE™ Database**

BC’s health authorities use the Workplace Health Indicator Tracking and Evaluation (WHITE™) Database to identify and prevent healthcare injuries and provide clinical interventions to reduce disability and time loss (PHSA, 2013), (Gilligan & Alamgir, 2008). Data can be extracted to analyze injury by occupation, by work status, and a host of other variables (Alamgir, Yu, Chavoshi & Ngan, 2008). The WHITE Database centralizes and consolidates injury and illness information across the province, replacing a mix of paper and electronic systems. It is the only electronic health and safety database of its kind in North America. It has been suggested that some in OHSAN were concerned that the WHITE™ database was absorbing a disproportionate amount of the agency’s resources (G. Astrakianakis, personal communication, November 21, 2013) in large part because of the difficulty of standardizing documentation from multiple sources.
and originating in multiple formats. These obstacles made it difficult for academics to retrieve the information they were seeking from WHITE. In turn, these roadblocks may have made academics less eager to seek information from the database.

**PEARS**

The Prevention and Early Active Return-to-work Safely (PEARS) program was developed as a collaborative effort among OHSAS researchers and union and employer representatives to prevent injuries and, when they did occur, to provide early interventions to prevent long-term disability. Although supported by employees, limited implementation of PEARS took place across the health authorities due to health authorities weighing the opportunity costs associated with full implementation. They agreed with the overall concept, but a key employer informant reports that the health authority found the return in investment in PEARS insufficient to merit implementation of all program elements. PEARS was popular among employees, but the health authority’s evaluation of the program did not show any difference in time loss due to injury or chronic pain, levels of employee engagement, or intent to resign. The program was subsequently modified. Disability management staff work one-on-one with employees struggling at work with health issues or concerns to find accommodations.

**Injury Indicators and Claims, 1998-2011**

WorkSafe BC tracks a number of indicators for many sectors of the working population, including days lost, overall costs, costs for short-term disability, costs for long-term disability, costs for health-care-only claims, and survivor benefits. Health Care and Social Assistance are grouped together in the Service Sector. The Service Sector also includes Hospitals and Related (a separate subset until 1999, when it was grouped with Health Care), Accommodation, Food & Leisure Services, Business Services, Professional, Scientific and Technical Services, Other Services, Education, Utilities and Related, and Hotels and Restaurants. I pooled and graphed Service Sector data from 1996-2011 (latest available at the time this information was reviewed) in Figures 9, 10, and 11. The gap in Figures 9, 11 and 12 exists because of the change in 1999 in reporting claim costs.
Claim costs for Health Care & Social Assistance claims, adjusted for inflation based on 2013 dollar values, rose from approximately $82,435,122 in 2000 to $83,826,076 in 2001. Dollar values were adjusted based on monthly index data (Bank of Canada, 2013). A steep decline over the next two years followed, with overall costs decreasing to $73,292,903 in 2002 and $56,825,186 in 2003. The rate of ascent increased sharply from 2003 to 2004, to $65,187,745. Three years of small decreases follow. There is a small increase from $58,775,701 in 2007 to $60,504,394 in 2008, a slight decrease in 2009, and a larger increase in 2010, to $63,185,620. There is a more pronounced increase in 2011, to $66,414,305. It is conceivable that the sharp decrease from 2001 to 2003 is at least partially attributable to the establishment of OHSAAH, its regular bipartite discussions with employers and employee representatives, and the interventions that resulted from this dialogue. It is also conceivable that the spike in claim costs from 2003 to 2004 may be related to increased costs arising from the effect of staff shortages exacerbated by the passage of Bill 29 in 2002. Bill 29 gave employers the right to contract out jobs previously filled by 7,500 healthcare workers from the Hospital Employees’ Union, including workers who had been on the job for a considerable period of time and were familiar with the hazards present in their workplace. The hiring of contract employees, likely younger and less experienced than
the HEU workers, would have contributed to increased injury rates because younger workers, especially males, are at highest risk for injury. The fact that not all contract workers in health authorities receive site orientation and safety training would further increase the likelihood of injuries. While nurses continued to perform the duties required of them, it is highly possible that some may have taken shortcuts in an effort to complete all their tasks, and these shortcuts may have contributed to their being injured on the job.

**Figure 10. Days Lost in Year, Service Sector, 1996 - 2011**

![Days Lost in Year](image)

(Data source: WorkSafeBC Statistics, 1996-2011)

Days lost in the health care subsector increased steeply from approximately 250,000 days in 1996 to 450,00 days in1998. The rate of days lost decreased slightly in 2000, beginning a sharp descent that saw the number of days lost in 2003 comparable to days lost in 1996. While it is not possible to separate out the contributions of health and safety professionals in the workplace and the impact of union-based educational campaigns from contributions made by OHSAN to decrease days lost to injury in the health care sector, OHSAN may well have contributed to this decrease as a result of increased healthcare worker engagement arising from the health authorities, unions, and researchers from OHSAN being fully engaged in a bipartite process aimed at preventing healthcare injuries and time loss from work. The sharp rise in days lost began in 2003
and continued to 2005, dipping in 2006, and then increased and dipped. The increases and dips in days lost may be a reflection of the adverse impact on nurses of the passage of Bill 29. Decreases in health authority operating costs would have decreased, but been partly offset by increases in premiums paid by health authorities in response to increased injury rates and increases in the need to backfill positions held by injured nurses.

**Figure 11. Costs in 2013$ for Short Term Disability Claims, Service Sector, 1996 – 2011**

![Chart showing costs in 2013$ for Short Term Disability Claims, Service Sector, 1996 – 2011](image)

(Data source: WorkSafeBC Statistics, 1996-2011)

The steep drop in short-term disability costs for the health care and social assistance sector from 2000 to 2003, from $64,999,721 to $29,578,231, is a reflection of health authority attempts to reduce short-term disability claims by promoting safe work practices and emphasizing early return to work. Although it is not possible to attribute this steep drop in short-term disability claims to OHSAAH, it is highly conceivable that the high degree of bipartite collaboration in promoting safe work practices (e.g. preventing musculoskeletal injuries through implementation of a ‘no lift’ policy that included motorized beds and ceiling lists), as well as emphasis on early return to work, played a
substantial role (Yassi et al., 2004). Short-term disability claims increased steeply from $29,578,231 in 2003 to $35,655,558 in 2004, gradually from 2004 to 2005, dipping to $34,259,650 in 2006, and then steadily increasing to $48,202,411 in 2011. Increased claims from 2003 to 2004 may well be a reflection of inadequate staffing levels and work overload, and of more demands being placed on aging workers. The increase from 2006 to 2011 may in part be explained by the health authorities’ decision to discontinue the PEARS initiative as it was originally conceived, or any number of factors.

**Figure 12. Costs in 2013$ for Long Term Disability Claims, Services Sector, 1996-2011**

![Chart showing costs in 2013$ for long term disability claims, Services Sector, 1996-2011](chart)

(Data source: WorkSafeBC Statistics, 1996-2011)

The years 2000 to 2004 marked a sharp rise in long-term care disability costs in the health care and social assistance subsector, from $12,879,666 in 2000, to $17,609,377 in 2001, $18,692,968 in 2002, $21,761,948 in 2003, to $24,311,432 in 2004. Costs in long-term disability claims declined steeply from $24,311,432 in 2004 to $20,795,618 in 2005. Although not as pronounced, costs for long-term disability claims in this services subsector continued to decrease from 2005 to 2010, rising from $13,532,469 in 2010 to $15,066,795 in 2011. The sharp rise in disability costs from 2000 - 2001 set off alarm bells at the provincial level (Winter, 2002) and may have contributed
to passage of Bill 29. The author advances this hypothesis knowing that since salaries and benefits are a health authority’s largest expenditure, a reduction in employees will reduce operating costs. A reduction in employees from a group with disproportionately high short-term disability rates would further reduce operating costs. The reduction in long-term disability claims over a six year period beginning in 2004 and ending in 2010 suggests the implementation of targeted strategies to reduce long-term disability claims costs that may include initiatives to prevent short-term claimants from making long-term claims. This is consistent with the aims of PEARs in terms of early intervention designed to return employer to their work as soon as possible. It is also highly conceivable that there was a shift in costs to non-unionized workers, whose long-term disability insurance coverage benefits are presumably less than those for unionized employees.

**Limitations of this Analysis**

It is not possible to separate out the contributions of health and safety professionals in the workplace and the impact of union-based educational campaigns from contributions made by OHSAH to decrease injury rates and claim costs. To attribute the decreased injury rates and claim costs seen up to 2004 exclusively to OHSAH would do a disservice to the health and safety and disability management professionals in the health authorities who work directly with healthcare employees to understand why injuries occur, how they can be prevented, and how to provide guidance and resources to injured workers to lower the frequency of long-term disability claims. Conversely, OHSAH’s work has informed the installation of ceiling lifts and other interventions that, if they had been fully implemented, had very promising potential to decrease injuries and time loss claims by substantial amounts over the course of OHSAH’S lifespan. While tempting to ascribe shifts in claim costs to specific events, a statistician would be wary of inferring statistical validity to so few data points and over such a short period of time.

The close linkages between the University of British Columbia (UBC), OHSAH and WorkSafeBC make it difficult to tease out which organization was responsible for which research contributions. For example, the 2003 Severe Acute Respiratory Syndrome (SARS) outbreak and resulting deaths in Toronto of acute care staff drew attention to the need for healthcare workers to be particularly vigilant about respiratory
exposures. In response, OHS AH developed a training program to reduce respiratory infections among healthcare workers. The Exposure Control Plan is an online module for Joint Occupational Health & Safety Committee members tasked with developing or reviewing exposure plans (Innes, Astrakianakis, & Stoffman, 2010). An exposure plan is a document created in response to a specific workplace risk. It documents the specific controls to minimize or eliminate exposures, including chemical exposures, blood borne diseases, and contact diseases. The authors were BC based and the plan was a collaboration among representatives from WorkSafeBC, BCNU, the Provincial Infection Control Network, Vancouver Coastal Health Authority, Vancouver Island Health Authority, OHS AH and UBC.

An observational study performed in 11 hospitals in 2011 found that healthcare workers’ adherence to personal protective equipment could be improved, particularly when working with pediatric respiratory patients (Mitchell & al., 2013). Researchers were from across Canada, including BC. Additional research in 2011 by BC researchers from UBC and Fraser Health Authority and funded by WorkSafeBC highlighted the inadequacy of control measures to prevent healthcare workers from absorbing antineoplastic drugs (used to treat cancer) through their hands touching work surfaces contaminated with these drugs (Hon, Chua, Danyluk, & Astrakianakis, Aug 2013). These two recent publications identified routes of exposure. This knowledge provides researchers with the opportunity to implement interventions to control these exposures and reduce healthcare workers’ risk of becoming ill from these exposures and missing work as a result.

Finally, many additional factors outside the purview of OHS AH, UBC, and health and safety professionals in the health authorities may have contributed to increasing and decreasing healthcare sector injury rates and claim costs. Further research is needed in this regard.
Chapter 6.

What the Key Informants Had to Say

In-depth, confidential interviews averaging 1.5 hours apiece were undertaken with 15 key informants selected through a mix of purposeful and snowball sampling. Key informants included former leaders from OHSAN, WorkSafeBC, and the Government of British Columbia, health authority health and safety leaders, healthcare academics, bargaining sector leaders and health and safety professionals within the bargaining sectors. Questions were asked to ascertain the key informant’s role with reference to OHSAN. Questions to secure insights into OHSAN include:

1) Was there a window of opportunity that made the establishment of OHSAN a possibility?
2) Why was a bipartite structure used and how did it influence decision making?
3) Did OHSAN’s advisory nature influence implementation practices?
4) What were OHSAN’s two most important contributions to occupational health and safety in BC?
5) Why did OHSAN become a candidate for dismantling?
6) How can OHSAN’s legacy be preserved?
7) Should OHSAN or its equivalent be reconstituted?

Responses to each question are followed by a brief analysis. The analysis is written in italics to clearly distinguish it from key informants’ comments. To protect privacy, key informants’ responses have been anonymized.
A Window of Opportunity to Improve Healthcare Occupational Health & Safety

Key informants confirmed that the election of the NDP in 1996 for a second term provided a window of opportunity for workers to influence government policy. The government invited unions and employers to identify nonmonetary policy issues outside of the bargaining table that were major sources of contention and to propose cost-neutral solutions. In May 1998 three parties signed the Accord to create the Occupational Health and Safety Agency for Healthcare (OHSAH) in British Columbia: the unions, represented by the Health Services and Support Facilities Association (HSSFA) and the Health Services and Support Community Association (HSSCA), the employers, represented by the Health Employers Association of British Columbia (HEABC), and the government.

EA, an employer’s representative to OHSAH, called the agency “a child of collective bargaining,” whose creation was prompted by high injury rates among healthcare workers and successful Hospital Employees’ Union (HEU) media campaigns that outlined the hazards and risks of working in healthcare. “OHSAH was an attempt to get health and safety off of the bargaining table and out of labour relations. It really does not belong in bargaining and from a safety practitioner’s prospective, labour relations is not the place for resolving health and safety issues. This was an attempt by the parties to have a place to always refer these issues, to have a vehicle to park issues so others could look at the issue, not the bargaining committees,” he explained.

Heading into 1996, HEU members were highly skeptical about employers’ interest in protecting workers’ health. “There were a number of anecdotes which really poisoned relationships, where OHS employees of employers appeared to have done things that broke confidentiality, were harmful to employees, and were not very professional,” said UA, a former HSSFA leader. Although the collective agreement had good OHS language prior to 1998, this did not seem to be changing patterns of behaviours on the part of employees or employers.

The concept of OHSAH was first raised at the Facilities Bargaining Association bargaining table. The suggestion was that it could be modeled on the bipartite Health Care Labour Adjustment Agency, created in 1996 by the province, health employers and
the unions to help with the restructuring and regionalization of health care from 52 to seven regional organizations. “The old route was, you just dump those people off the street and sometimes you rehire them next door and sometimes you don’t. Instead of doing that, there was an agreement on ensuring employment security for healthcare workers as management restructured itself. So that helped lay the groundwork to make things a little less adversarial,” explained UA.

According to a union health and safety representative, government support of OHSAH had less to do with the NDP being in power as with a confluence of factors – increases in injury rates, restructuring of the healthcare sector resulting in everyone in the healthcare sector negotiating at one table, and new regulations from WorkSafeBC on violence prevention and ergonomics – coming together at the same time.

UA, the former union leader, had a different interpretation on why management came to the table: “I think that there was some desire on the part of the employers’ side in 1996 to see if there was an appetite for a more collaborative approach on things because employers were beginning to see that they did not enjoy social license. Their employees didn’t trust them, so they needed the union interest to be there. Any programs that were instituted were instituted in the interests of employees as well as in the interests of employers, which sometimes overlap, but do not always overlap.”

UB, a union health and safety representative, suggested that the unions were not collectively united in their initial support for the establishment of OHSAH. While some unions were tabling proposals for the bargaining table focused on reducing the risk of violence for healthcare workers and reducing MSKI, considerable discussion took place among the unions over whether the creation of OHSAH would take power away from the unions or dilute the power of the Collective Agreement. Discussion also focused on whether the establishment of OHSAH should be enshrined in or outside the Collective Agreement. “It makes sense to have that kind of dialogue,” she said. “Ultimately, we were all in agreement by the time OHSAH was formed. The agreement was initially in the Collective Agreement. It was negotiated.”

**Analysis:** Comments offered by key informants confirm that the two traditional adversaries in healthcare – employers and employees – were united in their desire for a more collaborative relationship focused on reducing healthcare workers’ injuries and
resulting time loss. Key informants confirmed that the conditions that Kingdon describes as being necessary for the opening of a window of opportunity were present.

A Bipartite Structure

The Model for OHSAH

The author initially thought that OHSAH’s bipartite structure was modeled on joint workplace health and safety committees, given the rights and obligations of employers and workers spelled out in the Canada Labour Code and provincial labour codes (Government of Canada, 2013). For instance, the Canada Labour Code stipulates that employers must provide their employees with the information, training, and supervision needed to work safely, including a good understanding of overall work safety procedures, knowing how to use workplace tools and equipment properly, and being aware of potential or actual workplace hazards. BC law requires the establishment of bipartite health and safety committees in workplaces with 20 or more employees (Ostry & Yassi, 2004). These committees are jointly co-chaired by an employer and an employee representative. Members receive training and committees are required to meet at least nine times a year.

Although it shares many commonalities with joint OHS committees, OHSAH was distinct in that it had an independent body or secretariat with a mandate to conduct independent research into best practices in the workplace and identify, implement, and evaluate innovations.

An Interest-Based Approach

Collective bargaining in British Columbia is generally based on who has power. There is a winner and a loser. The relationship is adversarial. Attempts are usually made to mobilize public opinion to support one side over the other. Collaboration is modest at best. The rigidity of traditional collective bargaining encourages an antagonistic attitude that persists beyond the bargaining period and can magnify the effect of differences of interpretation of clauses in the Collective Agreement. “If something is born at the bargaining table, then one or the other side is giving up, or both sides are giving up
something in order to get something. What Labour was giving up was a very lengthy list of health and safety demands in order to get OHSAH. And so the bipartite structure was crucial to its existence," explained a former OHSAH director and academic.

The bipartite aspect provided an opportunity for employers and employees to build a collaboration and establish a structure characterized by a desire to resolve mutually pressing interests. The bipartite aspect was also essential in helping the agency secure resources to conduct the research, training, and evaluation of innovations, and in moving health and safety issues forward, according to a former union leader.

A former OHSAH director and academic was insistent that OHSAH had a tripartite structure, with conflict among parties being a fundamental aspect, along with recognition of this conflict and a structure to encourage parties to work together: “The philosophy of the organization was that it was set up as a tripartite organization that brought together the three traditional parties that meet on the shop floor, so to speak, the state, management, and workers (unions). The insightful inception of this organization was to recognize that this terrain is always contested by those three parties because the state provides notices of oversight, management has particular power and control over any workplace, and workers exist within that space. The insightfulness of setting up an organization that recognized those three parties as being inextricably bound in any attempts to find promotive, preventive and curative responses to the problems of health and safety was very good," suggested OA.

While it is true that the government was a signatory to the Accord that created OHSAH, the government remained in the background, providing operating funds to enable unions and employers to work together to achieve common goals. The core work carried out by OHSAH was informed by the bipartite relationship between employers and employees, and it is in this sense that OHSAH was considered to have a bipartite structure. The decision of the NDP government to remain in the background may have provided taken a step further by the Liberals, who would have been less engaged with the agency, to the point where they had limited interest in funding it.

Another academic and former OHSAH director suggested that OHSAH’s bipartite nature stems from the agency having been conceived at the bargaining table, where
there is a push and pull based on how much the employer is willing to give and how strongly the employees’ side feels about a particular issue. OHSAsH’s bipartite nature was recognition by the signatories that traditional adversarial approaches to collective bargaining were not working in the healthcare sector. A change was needed. With encouragement from the Ministry of Health, management and labour agreed to work together using a consensus-based framework where employers and employees had an equal seat at the decision making table.

One long-time health and safety union expert explained her decision making with OHSAsH this way: “There was a recognition that adversarial approaches weren’t working. There was a recognition that things needed to be resolved through consensus. In my time on committees, you would vote on certain kinds of motions but in terms of actually defining a direction, it was bipartite. It was really about buy-in, support. I can say that when we endorsed a project, we were out telling our members, ‘We’ve endorsed this. We would like you to participate. This is an important study.’”

**Criticism of the Bipartite Approach**

OHSAsH’s bipartite nature had its critics, who complained that the process to reach decisions took too long. Rather than being able to dictate a decision, employers and unions were tasked with holding a dialogue that would see them work through a problem in order to reach a consensus. One health and safety director felt that progress made on issues was too slow to address operational needs in the health authorities. A health and safety union representative suggested that the caucusing typical of traditional collective bargaining continued among employee and employee representatives. “It was like negotiating, with labour sitting on one side and management on the other and separately caucusing. It never moved away from this, so what the employer representatives were thinking or feeling, we didn’t know. We would heard after they’d discussed it what their mind was, but you never really knew how they got to where they were on certain items. That was quite frustrating. They would probably say the same about labour. They wouldn’t know how we came to certain positions either, because there wasn’t that dialogue.”

At the same time, that tension was partly mitigated by the fact that those at the table were health and safety practitioners or people who wrote health and safety
regulations. They spoke a common language and shared an interest in reducing OHS risks in healthcare. This commonness of purpose brought its own set of tensions to bear when health and safety issues were discussed by the Board of Directors, which in its infancy was unlike most Boards. Most Boards provide oversight to their organizations and make decisions at a very high, strategic level. They rarely involve themselves in operational decisions.

In the beginning, health and safety practitioners who worked on advisory committees to OHSAH also sat on the Board of Directors, making decisions on recommendations from their advisory committees. Interestingly, neither union nor management key informants felt there was a conflict of interest occurring as the result of the same individuals voting on the Board to approve proposals they had developed while sitting as committee members. “The employer did not view this as a conflict because we saw OHSAH as a useful vehicle to transfer issues to,” said EA, an employer key informant. He speculated that the unions also did not perceive a conflict because they were “just happy to be involved.”

**Analysis:** The bipartite structure was a key principle leading to the establishment of OHSAH. Although the Accord is careful not to give more authority to one party at the expense of another, it is apparent that key informants representing employers believed they had more power than key informants representing employees. The phrase that unions were “just happy to be involved” could be interpreted as a nonjudgmental explanation or as a patronizing expression. Employers certainly had more resources available to them.

Responses to this question point to the larger issue of governance. The Accord provided a set of principles for OHSAH to follow. However, it was left to the signatories to the Accord to identify how OHSAH would operate, what would be the reporting structures within the agency and beyond, and how decisions would be communicated and to whom. Although it is evident to this reader that the focus was clearly intended to be to improve the health and safety of healthcare workers, how this would be carried out was not described.

In an apparent conflict of interest, health and safety professionals who represented their constituencies on OHSAH committees also represented their
constituencies on the Board, voting on proposals they had drafted and sent to the Board for approval. One health and safety professional who sat on committees and on the Board at the same time explained the dual roles this way: “Many of the Board members, including labour and employer representatives, had direct, almost daily involvement with staff members at OHSAH. “You would be working on projects on committees and then have to take that hat off and put your Board hat on.”

In 2007, a major restructuring of OHSAH saw the role of Executive Director divided into two – Chief Scientific and Medical Officer and Financial & Administrative Director. Changes were also made at the level of the Board of Directors, with vice-presidents from the health employers and the unions attending Board meetings and making decisions. This change in structure followed the departure of the founding Executive Director. Following the agency’s closure in November 2010, its website was taken down and written documentation originating from OHSAH became difficult to locate until 2013. Health and safety material originating with OHSAH was recently restored to the Internet under the auspices of the Provincial Health Services Association.

I have not been able to access minutes from the OHSAH Board of Directors or any written documentation describing governance at OHSAH. Attempts to speak with key informants on this matter were not successful. An application filed under BC’s Freedom of Information legislation to see documentation on OHSAH governance was rejected in September 2013. In rejecting the request, the BC government stated that OHSAH was not affiliated with the BC Public Service or the Ministry of Health but was a non-profit organization. Further, it stated that PHSA does not possess such records (Sarrazin, personal correspondence, September 27, 2013).

**Did OHSAH’s Advisory Nature Influence Implementation Practices?**

As an advisory agency, OHSAH had the ability to recommend implementation of many health and safety innovations, but lacked the power to enforce recommendations.

One key informant compared OHSAH to the National Institute for Occupational Safety & Health (NIOSH) as opposed to the Occupational Safety and Health Administration
NIOSH is part of the U.S. Centers for Disease Control and Prevention. Federally funded, NIOSH has a mandate to conduct research and provide “practical solutions to identified problems” in agriculture, construction, mining, and other traditional industries (Centers for Disease Control and Prevention, 2013). NIOSH researchers produce new scientific knowledge and practical solutions to reduce the risk of work-related injury and death. By contrast, OSHA is part of the U.S. Department of Labor and develops and enforces workplace health and safety regulations. Like NIOSH, OHSAS was a government-funded health and safety agency with a mandate to conduct health and safety research and to advise and recommend the implementation, but not enforce, innovative health and safety practices. OHSAS’s advisory nature was a constraining factor, but there was never an expectation that it could enforce implementation of good practices. The hope was that the evidence from research would demonstrate the value of implementation of good practices and health authorities would act accordingly.

A union health & safety specialist called OHSAS’s lack of power to implement evidence based practices “the piece that was missing.” She contended that if employers wanted something, it would be implemented whether or not labour agreed. However, if labour wanted something and the employer did not, it wouldn’t be implemented. She recalled working on an OHSAS committee where employer and labour representatives sat together in a room for months and finally had agreement on a training course. “Labour had things they wanted. So did the employer. So did the Board. We made sure it was compliant with all parties.” Despite reaching agreement at the OHSAS committee level, that agreement did not matter when it came to implementation. “The employer changed the training to meet its needs, getting what it required,” she said. Two employer key informants have confirmed that they welcomed employee input, but ultimately made decisions based on the needs of the employer.

Employers’ unilateral adaptation of agreed-on materials is in keeping with another union leader’s contention that while the unions would have allowed OHSAS to have some authority to enforce implementation of best practices, the province’s health authorities would not give up the control to make this happen. “They are very territorial. Part of the problem, in my observation, was the refusal of the health authorities to ever get themselves into a position where they had to be transparent about what they were doing so that people could compare between health authorities. Individuals who sat on the Board would also be
gatekeepers back at their health authorities,” she said. OHS AH’s lack of binding powers made it possible for the health authorities to pick and choose implementation of best practices that suited their agendas.

Analysis: Stakeholders representing employers were surprised this question was asked. It was asked because in Canadian employment law, the employee is seen as a vulnerable entity potentially subject to the demands of a more powerful entity, the employer (Supreme Court of Canada, 1989). The author wondered what mechanisms were in place to prevent employers from arbitrarily applying or ignoring work carried out by OHS AH. The responses of key informants suggest that employers implemented OHS AH recommendations when doing so suited their operational needs.

Why OHS AH Became a Candidate for Dismantling

Agencies that are created and funded by government are particularly vulnerable to pressures from competing interests, ideological shifts, and economic downturns. Agencies need to demonstrate to stakeholders that they are best at representing their interests. It is unclear to what degree consultations about shutting down OHS AH took place before the decision to close the agency was announced to its staff in early 2010. Although the government stated it made the decision to close OHS AH as a budgetary decision, a complex interplay of factors likely contributed to that decision. The lack of transparency surrounding the decision to close OHS AH has given rise to numerous conspiracy theories and blaming games that have had the unfortunate consequence of damaging interest-based relationships forged during OHS AH’s heyday. Key informants representing employers, workers, and WorkSafeBC offered their insights on why OHS AH was closed. These include conflict between OHS AH and the health authorities (town vs. gown), competing interests among union representatives, insufficient knowledge translation, conflict over who was OHS AH’s primary customer, and conflict over what is an OHS issue and what is a human resources issue.
Town vs. Gown

In hiring an internationally recognized academic to be its inaugural director, the OHSAH Board of Directors was positioning OHSAH as a hybrid between a sectoral organization representing healthcare and an institute for research in workplace health and safety. The Director’s academic background meant the agency had access to world knowledge from the research literature and from the director’s networks with other OHS academics. OHSAH also benefited from the research grants awarded to the academics on staff and from their ability to hire other academics to work at the agency. In addition, the agency was able to draw on an inexpensive labour pool provided by students working for OHSAH academic directors.

Rather than welcoming these resources, employer key informants criticized OHSAH as “an ivory tower operation” with primary emphasis on generating publications and not on finding solutions to preventing the high injury and lost work time rates that plagued the health authorities. Employer key informants suggested that academics’ knowledge of healthcare was theoretical, not grounded in professional practice within a health authority. The lack of knowledge meant that employers had to show OHSAH academics what ceiling lifts looked like, how they were operated, and how healthcare workers did their jobs. Interviews with some health authority key informants also pointed to an apparent lack of understanding of the activities academic must engage in to progress through the ranks and secure tenure. One former OHSAH director/academic believed health authority researchers lacked the skills required to lead OHS research projects but could play a supporting role in research initiatives led by academics.

Employer and worker key informants were critical of the time it takes to undertake and complete rigorous research. “By the time you do your research, by the time you do your analysis, by the time you submit and go back and forth, several years have passed, and the business has moved on. I think in retrospect what was needed was rigorous evaluation. Not to say there isn’t value in scientific research or published literature, but the timeliness of that is problematic in a business that moves as quickly as this one does. By the time the paper got published, the issue had gone away or it was substantially different,” mused one employer key informant. Worker representatives were sometimes frustrated by the slow pace of academic research, but thought the benefits outweighed the costs.
The focus of research was also a sore point for some employer key informants, who felt that OHSAH researchers chose topics of interest to themselves rather than focusing on concerns articulated by OHS professionals in the health authorities, namely the business of preventing healthcare injuries, limiting short and long-term disability, and lowering claim costs for days lost to injuries and disability. It was “difficult” to get OHSAH to focus on “the nuts and bolts items that needed to be addressed from an operational perspective,” contended a former employee key informant.

Amalgamation of the health authorities from 52 to five regional authorities and one provincial authority created large, powerful health authorities. Three include research capacity building among their strategic goals. One way of strengthening internal research capacity is to redirect funds earmarked for OHSAH to build the research capacity of their health and safety professionals. “It was never quite said in those words, but some of the occupational health people would have rather seen resources allocated for OHSAH divided among the health authorities and earmarked for OHS issues,” suggested a former OHSAH director.

Analysis: The relationship between university academics and healthcare practitioners could have been better. Comments from key informants representing these constituencies suggest a lack of understanding of what academics do and the constraints they face. Conversely, there is a lack of understanding of what healthcare practitioners do and the operational pressures under which they work. These misperceptions likely prevented OHSAH from fully understanding the needs of the health authorities and being able to address those needs. In addition, the misperceptions likely prevented the health authorities from championing OHSAH to frontline workers and to the decision makers whose support was crucial for ensuring the agency’s continued existence.

Competing Interests Among Union Representatives

Although the Health Services and Support Facilities Association and the Health Services and Support Community Association signed the Accord and agreed to work jointly to improve health and safety for healthcare members, union leaders are, at the end of the day, responsible to their members. Union leaders, like politicians, are judged
and elected or not re-elected based on the contributions they make for their constituency members, not on their global contributions. The different unions were united in their concern over members’ high injury rates, but divided over how to tackle these issues. For instance, one union wanted OHSAH to focus research on safety issues for healthcare workers working on their own in community settings to identify solutions to basic needs around lifting patients, managing surroundings and confined spaces (e.g. cramped bedrooms), dealing with the expectations of family members, and knowing how to respond to potentially violent situations (e.g. handling patients with dementia who mistakenly see the healthcare worker as an enemy). Other unions were more interested in health and safety issues specific to bedside nurses in acute care, such as MSKI from moving patients and reducing the risk of bloodborne infections from needlestick injuries from patients with infectious diseases.

HEU became less active in advocating for OHSAH after being overwhelmed by the loss of 7,500 healthcare jobs as the result of the government’s decision to break the Collective Agreement in 2002 and allow the health authorities to contract out positions in order to reduce operating costs. HEU needed to regroup and focus on recruiting contract workers to make up for the loss of 7,500 jobs. Passage of Bill 29 also caused considerable upheaval to the other healthcare unions. Although the unions had varying sizes of membership, their resources were dwarfed by the resources available to the large regional health authorities. As a result of the labour disruptions occurring following Bill 29, the few resources that the unions had were diverted from OHSAH to broader labour relations issues over wages and job security. The health authorities themselves were forced to deal with the impact of adjusting to multiple health reorganizations in a 10-year period. These reorganizations also meant that the health authorities’ attention was diverted from reducing employees’ time loss to on the job injuries and resulting insurance claims, to figuring out how to allocate significant increases in financial resources, meet the expectations of many large competing interests, and manage human resources on a large scale.

Preparing for collective bargaining takes a great deal of time on the part of unions and employers. Unions have limited capacity to contribute to other activities outside of the workplace, even if those activities are seen as having value to members. This constraint was evident at OHSAH committee meetings, where some unions were
represented by multiple representatives and other unions had no presence. It has also been suggested by employee key informants that their Executives who sat on the OHSAH Board of Directors were not always well versed on decisions taken by union members on committees and as a result did not support committee recommendations made by OHS professionals from their own union.

Health authorities, unions and OHSAH have implemented strong campaigns to reduce slips, trips and falls, needlestick injuries and workplace violence, among other threats to healthcare workers. For example, Alamgir et al. described how registered nurses in acute care settings are at highest risk of exposure to human blood and body fluids (BBF) from patients at the bedside (Alamgir, Cvitkovich, Astrakianakis, & Yu, 2008). BC Nurses Union highlighted their lobbying campaign to make safety engineered medical sharps a requirement of the Occupational Health and Safety Regulation (BC Nurses' Union, 2013). OHSAH is acknowledged in these instances. However, frontline healthcare workers who do not read research articles or look closely at references on websites may be less aware of the seminal role played by OHSAH in identifying and reduced hazardous workplace exposures. This is especially true for ceiling lists. Nurses who have used ceiling lists would have appreciated their benefits. However, they may not have been aware of OHSAH’s seminal role in demonstrating the cost effectiveness of these lifts or OHSAH’s role in helping the health authorities secure funds from the province and WorkSafeBC to install ceiling lifts.

For their part, employers welcomed the opportunity to reduce grievances by meeting with employee representatives and seeking solutions to health and safety issues outside the bargaining table. Employer stakeholders stated that they picked and chose what to implement, based on their operational needs and an overarching requirement to trim budgets. Employers’ selective approach to implementing recommendations from OHSAH was frustrating to employee stakeholders and to OHSAH leaders because it emphasized the unequal distribution of power between the unions, OHSAH, and the employer. This frustration, in turn, eroded trust between the parties, making it more difficult to initiate and implement bipartite initiatives.

**Analysis:** Unequal distribution of power can be offset if there is genuine interest on the part of the different interests to engage with each other in an effort to reach mutually beneficial solutions. It appeared that the genuine interest evident in OHSAH’s
formative years dissipated as employers became preoccupied with lowering operating costs and unions entered into collective bargaining knowing they were dealing with a government that appeared more interested in controlling healthcare expenditures than in improving safety and working conditions for healthcare workers.

Insufficient Knowledge Translation

The Canadian Institutes of Health Research (CIHR) defines knowledge translation (KT) as a “dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system” (Canadian Institutes of Health Research, 2013). Effective KT requires the researcher to know the needs of the knowledge user, the individual(s) who will make use of the findings, and engage with them on an ongoing basis. Key informants from OHSAH, employers and employee groups, identified insufficient knowledge translation as a factor contributing to the agency’s closing.

“My sense of the demise is that because it’s something new and different, it requires constant political nurturing. That means being out there with employers, explaining the programs, how it meets their interest, how it’s better than anything else that happened before. The same is true within unions and within the province, so you have to constantly reinforce its value and its importance. I don’t think there was enough of that,” suggested a former union leader.

The Health Sciences Association (PHSA) currently represents more than 17,000 provincial healthcare and community social services professionals in more than 30 disciplines (Health Sciences Association, 2013). Professionals include medical lab technologists, medical imaging technologists, physiotherapists, social workers, occupational therapists, pharmacists, and health records administrators, health librarians, music therapists, orthotists, preschool teachers, psychiatric nurses, and orthotists. The HSA does not have the same high public or political profile as the BC Nurses Union. Multiple requests to the HSA OHS officer to participate in an interview for this thesis went unanswered. The many and differing interests gathered under the HSA help explain why this association was less vocal in its support for OHSAH.
OHSAH at the board level, the program level, and the staff level did not constantly engage with stakeholders to reinforce the agency’s value. “I have serious doubts the CEOs of the health authorities knew the CEO of OHSAH,” surmised a former OHSAH director who says the agency did not provide the service it could have. Some health authority representatives are described as having played both sides of the coin, professing support for OHSAH while working on OHSAH committees, but discounting the agency’s efforts when back at their home base in the health authority. For their part, some union representatives suggested that other union representatives to OHSAH were not sufficiently knowledgeable about health and safety issues to be able to engage meaningfully in initiatives to improve health and safety for their members.

**Analysis:** While OHSAH leaders could have put more effort into promoting their work so that frontline healthcare workers and executives would be aware of the agency’s contributions, employer representatives to OHSAH could and should have promoted the agency within the health authorities. Employer key informants with access to health authority executives could have paved the way for OHSAH leaders to meet with CEOs or communicate with CEOs regarding strategic initiatives to improve the safety of healthcare frontline workers and decrease costs related to injuries and lost work time. Some union key informants championed OHSAH’s efforts to healthcare workers, but the effort was insufficient. As a result, it was not possible to mobilize healthcare workers to forcefully protest the decision to close OHSAH.

**Who Was OHSAH’s Primary Customer?**

The Accord that created OHSAH explicitly described how the agency would be administered (jointly with equal union and employer representation and a neutral chair selected by unions and employers). However, the Accord did not explicitly identify the customer. It has been suggested that OHSAH directors and staff believed that frontline healthcare workers were their primary customer. By contrast, employer key informants believed that OHSAH should have been taking direction from them and working more closely with health and safety professionals in the health authorities.

**Analysis:** It appears there was a fundamental misunderstanding over the identity of OHSAH’s primary customer. It is not known if OHSAH had a constitution or other
governance documentation that clearly articulated the answer to this question. Employer key informants insisted that OHSAs's primary customer was the health and safety professional, not the frontline worker. Unions believed the contrary. This disagreement was never resolved and likely contributed to conflict between OHSAs leadership and employer stakeholders.

Occupational Health & Safety Issue vs. Human Resources

OHSAs was perceived as pro-worker, taking the employee point of view over the employer perspective. Changing political winds in the form of the election of a Liberal government may have spelled the beginning of the end for OHSAs. The agency’s development of the WHITE™ database tracking healthcare employees’ absence from work due to injury and disease, among other variables, was heralded as an invaluable reservoir of knowledge that could be used to support the development of prevention programs. At the same time, considerable conflict ensued over defining what is a human resources issue and what is an occupational health issue. For example, OHSAs’s directors opposed recording who had been vaccinated for influenza and who had not, and giving that information to managers. From the agency’s perspective, that was health information, personal to the employee and his/her physician. From the health authority’s perspective, that was human resources information needed for operational reasons. A similar conflict arose over whether time off from work due to illness or injury falls under the domain of occupational health or human resources.

Conspiracy Theories

It is not known if health authority executives were consulted before the decision was made to close OHSAs. It is conceivable that they were given the option to keep OHSAs open provided they paid for the agency through the funds allocated to them. Commented one health and safety professional: ‘This is another way of saying, ‘There is this much money for health care. If you want to fund OHSAs, something else has to give’.” He noted, however, that there was a provincial infection control network that received about $3 million a year in funding and, in his assessment, was “not overly productive.”
Key informants advised that OHSAN appeared to be entering into a new era more focused on operational needs when the final executive director, a health and safety director from one of the health authorities, was selected to lead OHSAN in late 2009. However, some feel the decision to shut down OHSAN had already been made at that point. Notes one health authority health & safety director: “I think the fix was in anyway. When the Board was recruiting for the position, it was pointed out it would be unfair to recruit from the Institute of Work and Health in Ontario because there was no guarantee of agency funding past a specific date. Getting towards the end of the money, we say ‘Okay, is the funding going forward?’ It’s like, silence from the government. I think the unions felt like they were had.” This informant suggests that government made the decision for financial reasons and did not consider the health and safety perspective.

Another informant stated that the health authorities thought there was a potential for OHSAN to continue and it was on this basis that the last director accepted the position, in the belief that she had a year to refocus the agency on employers’ operational needs. As it turns out, the new director was only given weeks before learning that OHSAN would not receive any more funds.

Two leaders suggested the decision to shut down OHSAN was a conspiracy. One declined to offer further comment, while the second said that “it just seems too convenient that the first time it’s [OHSAN] not in the Collective Agreement and it’s up for renewal for new funding, that the agency is wrapped up and the government pulls its funding.”

By contrast, a former leader of another union suggested that OHSAN’s decline was gradual and there was nothing particular about 2010 that prompted the agency’s closure. A former leader of a safety institute said that the focus on research was overstated, the continuing debate on the nature and focus of OHSAN’s research was a distraction, and that government ultimately did not see the benefits it envisioned when OHSAN was created.

Analysis: It is highly likely that the government’s decision to shut down OHSAN was based on the need to reduce healthcare operating costs. The decision might have been reversed had executives from the health authorities championed the work carried out by OHSAN and had the unions been able to mobilize healthcare workers to support
the agency’s continued existence. Conspiracy theories were created in response to the lack of strong trust-based relationships between employer and employee representatives to OHSAH and the government’s lack of transparency in announcing and explaining its decision to close down the agency.

**OHSAH’s Most Important Contributions**

Key informants credit OHSAH with a host of accomplishments that range from providing a model for joint union – employer problem solving in healthcare, to creating an electronic information management system that is unique in North America. Accomplishments include:

- Demonstrating that a bipartite approach can work, by bringing unions and employers to work together to address healthcare employees’ health and safety issues
- Establishing the WHITE™ database, WHITE.net, a provincial platform containing robust data and information to drive decision-making around health and safety
- Establishing a centre of excellence for healthcare health & safety on which health authorities could draw and which would inspire other jurisdictions
- Creating online occupational health and safety tools and resources.

**Demonstration that a Bipartite Approach Works**

Key informants who worked for health authorities, unions, universities, and/or OHSAH highlighted the agency’s bipartite approach to problem solving. All say that OHSAH demonstrated that a bipartite approach to health and safety was possible and could be successful, notwithstanding the agency’s short-lived history. Several highlighted a joint committee that was developing a provincial violence prevention curriculum as an example of a successful bipartite approach. The committee consisted of OHS directors from the health authorities and OHS leads from the unions. The result was “a very well-functioning group that had very candid conversations” and whose work ultimately led to the implementation of major violence prevention initiatives in the workplace.
Establishment of the Workplace Health Indicator Tracking and Evaluation (WHITE™) Database

BC’s health authorities use the Workplace Health Indicator Tracking and Evaluation (WHITE™) Database to track workplace injury and illness. WHITE™ is a web-based surveillance system that was developed to identify and prevent healthcare injuries and provide clinical interventions to reduce disability and time loss. It has five modules: incident management, claims management, disability management, employee health, healthcare workers’ fit test results and training and education records. The database contains information on healthcare workers’ injuries and illnesses, why these occur, what are their consequences, and the effectiveness of interventions to prevent or reduce their frequency and severity (PHSA, 2013). (WHITE™ Database, accessed on August 11, 2013 at http://www.phsa.ca/HealthProfessionals/Occupational-Health-Safety/White/default.htm). Data can be extracted to analyze injury by occupation, by work status, and a host of other variables (Alamgir, Yu, Chavoshi & Ngan, 2008). The WHITE™ Database centralizes and consolidates injury and illness information across the province, replacing a mix of paper and electronic systems. WHITE has transformed the way health and safety is delivered in BC. It is the only electronic health and safety database of its kind in North America.

Establishment of an OHS Centre of Excellence

Centres of excellence bring together people with expertise in a particular discipline and a commitment to working with one another to achieve a common goal and to share that knowledge. OHSAH brought together a network of OHS specialists from the health authorities, the unions, and academia. The founding director of OHSAH was an academic with internationally recognized expertise in occupational health and safety. One of the strengths of having an academic as the chief executive officer was having an expert contributor to OHS research who, through her professional networks, was knowledgeable about research taking place around the world. This meant that unions and health authorities had the potential to gain access to ground-breaking research as it was emerging. An academic lead also ensured that the agency itself undertook high quality research and published the findings in peer-reviewed journals. The agency, its leader and directors are responsible for a body of scientific literature that has informed
evidence-based healthcare OHS and healthcare decision making in British Columbia and around the globe.

The executive director of workplace health and safety for Fraser Health said that OHSAH was perceived internationally as a model for OHS (D. Keen, personal communication, September 4, 2009). OHSAH was credited with a dramatic decrease in injury rates among healthcare workers from 1999 – 2002 and with inspiring Ontario to install bed lifts (Shamian, 2007). The chief executive officer of a new national non-profit aimed at creating a culture shift to prevent injuries and save lives described contacting OHSAH to gather information on how OHSAH contributed to encouraging an OHS culture focused on preventing on the job injury to healthcare workers (L. Logan, personal communication, November 20, 2013).

Building Evidence-Based Research Capacity

Having an academic lead OHSAH helped the province’s health authorities build their research capacity in health and safety using evidence-based research. “OHSAH helped us apply academic rigor to what we do. OHSAH helped us raise the bar by changing how we think about things, how we approach health and safety in the workplace, and how we collect data,” explained one health authority health & safety director. Said another: “When I started in health and safety, we had what I called, ‘this spray and pray approach to intervention’. We went out and did things because they seemed like a good idea and we hoped that they helped. The legacy of OHSAH, from my perspective, is that we have a much more evidence-based approach. You would no longer think of going out and doing something without evaluating the data, without having an evaluative framework for examining it. There’s rigor and expectations of demonstrating objective indicators and outcomes.”

Creating Occupational Health and Safety Tools and Resources

OHS.net is an electronic health & safety resource library administered by the Provincial Health Services Health Authority (PHSA). It now contains dozens of fact sheets, posters, presentations, guides, reports and handbooks that OHSAH developed in the areas of culture and leadership, disability management, general safety and compliance, mental health and wellness, musculoskeletal injury prevention, occupational
exposures, and violence prevention. When OHSAH was closed down, access to these resources became limited. Now, these resources are more readily accessible on the PHSA OHS.net website under the heading “OHSAH Resources.”

OHSAH also set up a healthcare-focused, web-based Material Safety Data Sheet (MSDS) system that healthcare facilities and workers can search. This is located on the PHSA website, under the “Provincial Occupational Health & Safety Programs.”

**OHSAH’S Legacy and How to Conserve It**

A legacy is a thing handed down by a predecessor (Oxford Dictionaries, 2013). In the context of OHSAH, a legacy is a tool or element that has value to the organization or unit to which it is handed down. In this context, informants identified two broad legacies of interest to all of the stakeholders, as well as several other legacies of interest to specific groups.

**Bipartite Problem Solving**

Although one former union president stated that OHSAH’s closure means that the organization cannot be used as an example to show that a bipartite, joint problem-solving approach works in finding solutions to health and safety issues outside the bargaining table, other union representatives, as well as representatives from employers, academia, and OHSAH, disagreed. They cited the products that OHSAH did create – the WHITE™ Database, a provincial curriculum to deal with violence in the healthcare workplace, and OHSAH’s evaluation of the implementation of ceiling lifts in select healthcare facilities, to name three examples – as confirmation of the success of the bipartite approach.

An academic who conducted research on OHSAH’s behalf pointed to a research study jointly carried out by researchers from OHSAH, UBC, the Ontario-based Institute for Work and Health, Interior Health Authority, Fraser Health Authority and Alberta Services as an example of a collaboration that produced stellar results (G. Astrakianakis, private communication, November 21, 2013). The focus was the development of a tool to evaluate healthcare interventions in BC. The research was funded by WorkSafeBC,
the Workers’ Compensation Board of Nova Scotia, and the Saskatchewan Workers’ Compensation Board (Tompa et al., 2010). A former OHSAH director and academic observed that the Sudden Acute Respiratory Syndrome (SARS) outbreak in British Columbia demonstrated the value of a system-wide collaboration that benefited healthcare workers (M. Steinberg, personal communication, November 21, 2013). In Ontario, 44 healthcare workers and their patients died from SARS as the result of a system failure (Campbell, 2006). The Campbell Report noted that Ontario did not have a provincial centre for infectious disease control, surveillance, and adequate OHS systems and controls to safeguard healthcare workers and patients. By contrast, BC had OHSAH, which provided the foundation for collaborations that brought together academics, public health officials, health authority representatives, and healthcare workers. In essence, the existence of this collaboration helped prevent the kind of systemic deficiencies identified in the Campbell Report.

The WHITE Database™

Four of the region’s health authorities were using the WHITE Database™ as of 2008. All now use it. Information on the database in on the Provincial Health Services Authority database is readily accessible online on the PHSA website, along with contact information for guidance on accessing the database (Provincial Health Services Authority, 2013). Creation of the WHITE database was a source of inspiration for the Occupational Health And Safety Information System (OHASIS) collaboration in South Africa aimed at providing workplace and surveillance data to improve working conditions for South African healthcare workers (Spiegel et al., 2012).

Development of this information system was not without controversy. Some union representatives feared that the database would be used not as a research tool to develop interventions to prevent or reduce injury to healthcare workers but as a database to identify workers with high incidences of absences and dock their pay for being away from work.

Access to information in the database was also a controversial subject. OHS professionals believed that the database should be restricted to OHS staff, with information about an employee’s health not being shared with human resources or the employee’s department. The rationale for this thinking was that employee health records
were considered private and confidential. Employees do not generally have an obligation to tell their managers the reason for a health-related absence. Rather, provision of a note from a physician attesting to the employee requiring time off due to illness or injury (but not specifying the nature or severity of the illness or injury) is sufficient. The WHITE database includes information typically contained in physicians’ patient records, such as records of vaccination. For operational reasons, these records have been shared with managers. Key employee and academic informants expressed concern that the main use of the WHITE database now may be to manage claims, track staff compliance with mandatory vaccination or other operational issues rather than to inform injury prevention initiatives. Key employer informants have not confirmed this concern, but expressed surprise over the low number of researchers who have applied to use the database.

Employer key informants emphasized the strong and multilayered security features built into the WHITE database to protect confidential employee information from being disclosed. Researchers who wish to access the database have to apply to the health authority in question to access data, which is deidentified so that employees’ identifying information is removed prior to data being released (Alamgir, Cvitkovich, et al., 2008). Academic key informants recommended that the WHITE database be moved to an independent body with bipartite control and full access by researchers from across the province and beyond, possibly linking it with Population Data BC. The academics said that removing stewardship of the WHITE database from IT leads in the health authorities to outside the health authorities would send a message that external researchers are encouraged to use the database.

**Giving Occupational Health Professionals a Seat at the Scientific Table**

A key informant has suggested that many infection control and public health practitioners see occupational health as a human resources matter to be addressed as a labour relations issue. As a result, OHS specialists are not always included in science-based decision making, when decisions are made about personal protective equipment. By contrast, OHSAH included OH&S practitioners, and this practice has extended to the Provincial Infection Control Network (PIC.net), where OHS practitioners now sit at the table with their counterparts in public health and infection control.
Emphasis on Primary Prevention and Secondary Prevention

One in three injuries suffered by a healthcare worker is caused by lifting, transferring, or repositioning a patient (WorkSafeBC, 2013c). Ceiling lifts are an example of a bipartite, primary prevention intervention championed by OHSAH. The agency’s cost-benefit analysis showed that ceiling lifts were a cost-effective means of reducing musculoskeletal injury (MSKI) when transferring patients (Alamgir, Yu, et al., 2008). The study took place at three extended care facilities run by Providence Health. Between 2000 and the end of 2005, $1,081,410 was spent to purchase and install 1,000 lifts (cost includes training and maintenance of lifts). The payback period was estimated to range from 6.2-6.3 years based on direct claim cost savings and 2.06-3.20 years when indirect savings were also considered.

The Prevention and Early Active Return-to-Work Safely (PEARS) program was a bipartite initiative that aimed to integrate primary prevention with secondary prevention to reduce musculoskeletal injuries (MSKIs) in healthcare workers. A pilot at Vancouver General Hospital offered PEARS to all employees with MSKIs. Participation was voluntary. The primary preventive aspects included ergonomic assessments to prevent injuries from occurring. Secondary prevention included prompt follow-up in the case of injuries and measures for modifying the workplace and providing the injured employee with access to physiotherapy and other clinical treatment, as well as graduated, modified return-to-work. OHSAH evaluated the effectiveness of the pilot by looking at reduction in time loss injuries for three groups (registered nurses, health sciences professionals, and facility support services workers). Compensation costs were reduced by up to 44 percent for nurses and up to 73% for health science professionals (Davis, Badii, & Yassi, 2004). PEARS helped reinforce the principles of primary and secondary prevention in disability management in health authorities and strengthened the work relationship between specialists in prevention and disability management. Although PEARS was ultimately discontinued, the emphasis on early intervention to facilitate active return to work continues in the health authorities.
Should OHSAH Be Reconstituted?

Key informants would like to see OHSAH reconstituted, but disagree about what shape this should take, where it should be housed, and who should run it. The current period of economic constraint, healthcare cost overruns, and adversarial relationships between unions, between unions and government, and between unions and employers makes establishment of a new entity a highly unlikely proposition. Nonetheless, key informants described how they would like the ‘new and improved’ OHSAH to look and what its focus should be. Suggestions include:

- Academic-led, independent bipartite organization that goes beyond healthcare to include BC’s primary industries. The organization would tackle broader environmental issues related to the range of hazardous substances and exposures, e.g. spills in the environment.
- An independent entity or fostered by WorkSafeBC. The entity would have a mandate to do applied research, to bring the parties together, to identify issues and potential solutions.
- Independent bipartite committee responsive to what the employees are asking for and what employers are asking for.
- Bipartite organization that works in the interest of reducing injuries and illness for workers across BC.
- Committee-run, with a focus on applied research in OHS carried out on a project basis as the need arises. Research would be directed by stakeholders, not by the researcher.
- There would be an emphasis on more knowledge transfer and a way to support and sustain initiatives at the worksite level. Frontline workers would have an easily accessible resource centre.
- A mechanism or venue that will enable and support meaningful collaboration with union partners in creating healthy healthcare workplaces, in decreasing the cost, human and financial, of injury and illness, and support sustainable safe quality patient care.

Analysis: Although OHSAH raised the bar for using evidence-based decision making for health and safety in the healthcare workplace, the health authorities did not feel they had sufficient input into the research directions undertaken by OHSAH academics. Health authority key informants felt that the research needed to be more applied so that it could inform efforts to prevent healthcare workplace injuries and resulting time loss. The length of time to complete research was an issue for both health authorities and unions. Given the fact the OHSAH did not have strong champions to
advocate to government for its continued existence, health authorities would not likely support the creation of a university-based institution to replace OHSAH. Health authorities’ support for a health and safety agency is crucial since health authorities would be a key player and likely funder of this agency.

Stakeholders identified OHSAH’s bipartite nature as a key success factor. Housing OHSAH at an academic institution or within a health authority or union would give undue influence to the host institution. An alternative is for OHSAH to be an independent entity that is affiliated with, but independent of, WorkSafeBC.

If OHSAH had been credited by government and all key stakeholders with making substantial reductions in healthcare workers’ injuries and time loss, a new agency might well have been equipped to provide provincial leadership across sectors. However, the failure of stakeholder champions to come forward and mobilize their constituents to fight the decision to close OHSAH suggests a similar agency would also fail. Further, the fact that there continue to be high numbers of injuries, time loss and short-term disability in the healthcare sector suggests that considerable effort is required to prevent injury and loss time. It therefore is preferable for the new entity to focus its efforts on the healthcare sector as opposed to several or all sectors.

OHSAH did not have a sufficiently strong presence in the health authorities. Unionized frontline workers may not have known that health and safety innovations were the fruit of research carried out by OHSAH. A focus on knowledge translation and the development and dissemination of clearly presented, nontechnical health and safety materials produced in multiple languages (e.g. English, Punjabi, Traditional and Simplified Chinese) that are easily accessible to frontline staff would give OHSAH more presence in the workplace. Ongoing consultation with workplace health and safety professionals would benefit both groups. Health and safety professionals would be able to advise the entity of their specific needs and the entity would work with the health and safety professionals to produce/provide materials to meet those needs. In providing this support, the entity would gain a strong champion in the health authorities and be in a stronger position to influence prevention efforts.

The Vice Presidents of Human Resources (their portfolios include employee health and safety) for the health authorities regularly meet under the rubric of the Health
Human Resources Strategy Committee. It would be helpful for the director of a new entity to be on a first-name basis with the members of this committee and to meet with them on a quarterly or semi-annual basis to understand their specific health and safety needs and to ensure the agency’s work in preventing healthcare injury and time loss is aligned with health and safety strategic initiatives in the health authorities. The same considerations apply to relationships with union executives representing healthcare workers.

Limitations

Responses were anonymized as a means of encouraging key informants, most of whom are public figures, to speak candidly. Although invitations were extended to OHSAAH’s executive directors and interim leaders, legal issues and leaders’ personal preferences limited their participation.
Chapter 7.

Recommendations

An analysis of statistics compiled by WorkSafeBC suggests that OHSAH had limited success in reducing injuries and time loss by healthcare workers to injuries. This suggestion is flawed in three respects: 1) Since OHSAH did not have direct responsibility for reducing healthcare injuries and time loss, continuing increases in healthcare workers' injuries, time loss and related insurance claims cannot be attributed to the agency; 2) OHSAH demonstrated the cost-effectiveness of several interventions (e.g. ceiling lifts); however, the interventions were not implemented or sustained to the point where they would produce lasting reductions in injury rates, time loss, and reduce insurance claims for healthcare workers; and 3) The government's passage of Bill 29 eliminated 7,500 HEU jobs and paved the way for health authorities to hire contract workers who would not have had the same access to safety training as the workers they replaced or the same workplace experience. The positions filled by these contract workers would typically be valued at a lower rate and might be filled by new Canadians whose limited fluency in English placed them at higher risk for on-the-job injuries.

Even OHSAH's critics praised the agency for raising the bar on the use of evidence-based practices to improve safety in healthcare and prevent healthcare workers from injury and disability.

Key informants recommended that a new entity be created. It could take the form of a sectoral health and safety agency or secretariat modeled after sector agencies for high risk industries such as construction or agriculture. The entity could be a joint initiative of WorkSafeBC, British Columbia's regional health authorities, and unions representing healthcare workers. It could be funded by a tax levied on healthcare employers and paid through WorkSafeBC, based on insurance claims. The entity could fund applied research on a topic identified by stakeholders, calling for research proposals from health authority and union representatives in partnership with university-
based researchers. A strong system of governance would include terms of reference for committees, roles and responsibilities for each member of the secretariat, and a constitution for the Board of Directors, with equal representation from health care authorities and unions, as well as representatives from WorkSafeBC and the academy. The customer would be clearly identified for each major initiative. Resources for OHS would be provided in the agreement to ensure that unions have the ability to make a meaningful contribution. The agency could serve as a healthcare knowledge broker on how to prevent work related injuries and time loss.
Chapter 8.

Conclusion

The story of OHSAH cannot be told by numbers alone, although the statistics on numbers of workers injured on the job, days lost to recovery, and insurance claims for short- and long-term disability paint a disturbing picture of a hazardous industry. Likewise, the story of OHSAH cannot be told by words alone, since the words fail to quantify the enormity of the safety challenges facing healthcare employers and workers. The purpose of this thesis was to describe the rise and fall of OHSAH by drawing on the words of key participants from OHSAH, employers’ and employees’ groups and considering what key informants said in relation to what injury and lost time rates showed.

OHSAH was established as a result of the opening of a window of opportunity that included election of a pro-labour government, the mobilization of employer and employee groups united in their search for resolutions to rising injuries, lost time and insurance claims for healthcare workers injured on-the-job injuries. The agency was shut down a little more than a decade later by a pro-business government intent on reducing healthcare deficits.

Although successful in bringing together employer and labour representatives who were genuinely committed to working together in the early years, misunderstandings over the nature of academic research and the requirement of health authorities for quick solutions to pressing problems contributed to town vs. gown tensions. These were exacerbated by employers’ belief that OHS professionals in the authorities were the primary customers, not every healthcare employee. For its part, OHSAH believed its mandate was to provide service to every employee. This conflict was never resolved.

OHSAH undertook rigorous cost evaluations of healthcare innovations that
demonstrated the innovations were cost efficient and effective in reducing injuries to healthcare workers. However, cost constraints prevented the health authorities from fully implementing these innovations. The employers were also selective in implementing OHSAH committee recommendations, doing so when the recommendations met operational needs. The agency had strong champions on the labour side, but implementation of the research into practice (e.g. getting all nurses to use ceiling lifts where the lifts were installed) demonstrated the challenge of introducing changes into the workplace.

The agency’s inability to find champions among health and safety professionals in the health authorities or to mobilize unionized healthcare workers and academics sufficiently enabled the government to close OHSAH quietly without issuing a press release or making an announcement in the Legislative Assembly. The lack of transparency gave rise to conspiracy theories and wholesale speculation over the story behind the story to shut down OHSAH. This speculation contributed to a climate of distrust that continues to this day.

Rising injury and claim rates also persist. Approximately three years have passed since OHSAH was shut down. Health and safety issues remain points of contention during contract negotiations. Although there does not appear to be a window of opportunity to create a new, improved OHSAH, creation of a bipartite sectoral committee under WorkSafeBC but independent from it, is an approach that might be successful. Prior to the establishment of OHSAH, the health services sector had the dubious distinction of being a highly dangerous industry. This distinction remains. It is hoped that adoption of a sectoral framework for a healthcare agency will yield the same gains achieved in farming, forestry and construction and make healthcare a less hazardous workplace.

Although this is the story of OHSAH, some of the lessons learned may be transferable to other sectors or agencies that advocate a bipartite approach to problem solving. These lessons include: Know who your customer is, clearly define roles and responsibilities as well as mechanisms to ensure good governance; build bridges by nurturing relationships and sustaining dialogue with those to whom you provide service and those who may one day be in the position of being able to speak on your behalf to government or other interested parties; and make provision to increase resources for
partners with limited financial and/or human resources. Finally, when efforts yield positive outcomes, distribute praise evenly and communicate positive outcomes widely at the frontline, middle management, senior executive, and ministerial levels.
References


Munroe, D.R. (2000). *Report and Recommendations to the Minister of Labour and Consumer Services by the Advisory Committee on the Structure of the Workers’ Compensation System of British Columbia.* Victoria, BC.


OSHA, Oregon. (nd). *History of Workplace Safety in Oregon.* Salem, OR: Oregon OSHA.


Appendix A.

Public Sector Accord on Occupational Health and Safety

May 23, 1996

PUBLIC SECTOR ACCORD
ON
OCCUPATIONAL HEALTH AND SAFETY

AGREEMENT TO RECOMMEND

We agree to recommend the attached Public Sector Accord on Occupational Health and Safety to our principals.

The parties further agree that no public release of the details of this document will be made without the agreement of the parties.

Health Services and Support Facilities Association

Health Services and Support Community Association

Health Employers Association of B.C.

The Government of British Columbia
PUBLIC SECTOR ACCORD
ON
OCCUPATIONAL HEALTH AND SAFETY

I. Preamble:

Workers, employers and the Government of British Columbia share the objective of promoting safe and healthy workplaces throughout the health care sector in the province.

Hospitals, long term care facilities and community health care agencies have not had good health and safety records. For example the Workers’ Compensation Board reports that there were 4,591 short term disability claims among health care workers in 1995 and 23,756 claims in the five years between 1992 and 1996 inclusive. Experts estimate that, at any one time, fully 5 percent of union members in the facilities sub-sector are on long term disability and annually losing over 200,000 lost days of work.

Unions, the employers and the Government all have an economic incentive and a social responsibility to foster safety and reduce injuries. Improved health and safety practices, better health and safety training and the adoption of best practices across the sector are in the interests of workers, employers, patients and the broader public. Workplace injuries and occupational diseases impose a very significant burden on health care workers and their families. They also result in the loss of skilled and experienced workers to the health care system, while resulting in significant additional costs for treatment, recovery and income replacement.

In light of the significant benefits to workers, employers and the province’s health care system from policies and programs which prevent accidents and occupational diseases, the Unions (represented by bargaining Associations), Employers (represented by the Health Employers Association of BC) (HRABC) and the Government of British Columbia (the Government), have concluded a new Occupational Health and Safety Accord, explicitly designed to promote these goals.

II. Objectives of the Accord:

The objectives of the Accord are set out in the attached addendums and are summarized as follows:

1
• promote a safe and healthy work environment through healthy workforces, safe workloads and promotion of safer work practices
• reduce the incidence of accidents and occupational diseases
• facilitate co-operation between unions and employers on health and safety issues
• implement pilot and demonstration programs
• provide education and training to health care workers through local OH&S committees
• encourage safe early return to work programs
• share information and experience across the sector
• research and implement innovative health and safety solutions and best practices
• strengthen linkages with the accident prevention programs of the WCB
• establish an institutional framework for implementing these objectives
• improved compliance with WCB regulations and recommendations
• promote the adoption of the practice, program or model
• provide an equal or greater degree of protection to workers

III. Parties to the Accord:

There are three Parties to the Accord: the Unions (represented by bargaining associations), HEABC and the Government of British Columbia. Each Party commits to working co-operatively to implement both the spirit and the specific undertakings of this accord. Further, the Parties may wish to involve other agencies through partnership arrangements.

IV. Establishment of a Health Care Occupational Health and Safety Agency:

To facilitate achievement of the objectives of the Accord, the Parties have agreed to establish a Health Care Occupational Health and Safety Agency. The Agency will be jointly administered with equal representation from the unions and employers with a neutral chair selected by the unions and employers. It will work with all members of the health care community to develop guidelines and programs designed to promote better health and safety practices through prevention, safe workloads, promotion of safe work practices, safe early return to work, pilot programs and sharing of best practices. It will also develop new measures to assess the effectiveness of programs and innovations in this area.
The Agency will develop a methodology for evaluating outcomes, establish goals for its programs, including measurable outcomes, and apply the methodology to audit outcomes. These audits will be available to the Parties and the public.

V. Funding:

The Agency will be self-financing, that is funded on a cost-neutral basis through savings resulting from better health and safety practices. Resources will be generated from a variety of different sources, including savings from lower accident and injury rates, improved safe return to work programs, lower WCB assessment rating and the implementation of new WCB worksafe programs. The Agency will directly negotiate these arrangements with the Workers' Compensation Board.

As savings will not be realised until after new Agency programs have had time to demonstrate their effectiveness, the Province will provide an accountable advance from the Ministry of Health to enable it to begin operations. This advance will be repaid over time from the savings resulting from the Agency’s activities.

The Ministry of Health of the Government of British Columbia will provide to the Health Care Occupational Health and Safety Agency for the initial three year period from the date of its formal establishment by the Parties, accountable advances in the following amounts:

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal 1998 – 1999</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Fiscal 1999 - 2000</td>
<td>$4,000,000</td>
</tr>
<tr>
<td>Fiscal 2000 - 2001</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

and, with the condition that no more than $1,000,000 annually be devoted to operating expenditures, and that unexpended funds be carried forward into the following years.

The Agency will audit its programs to document expenditures and identify savings achieved. It will publish annual reports of the audits.
VI. Implementation:

On ratification of the Accord, a working group composed of equal representation from the Unions (represented by the bargaining associations) and HEABC will be established. This working group shall be guided by collective agreement language in developing a workplan for the establishment of the Agency, including the appointment of an Executive Director and appropriate staff.

Tentatively agreed, subject to ratification by the Parties:

Health Services and Support Facilities Association

Health Services and Support Community Association

Health Employers Association of B.C.

The Government of British Columbia

Date: __________________
This proposal is tabled on the condition that the Parties secure a commitment from the Government of B.C. to fund the Health Care Occupational Health and Safety Agency.

ADDENDUM
HEALTH CARE OCCUPATIONAL HEALTH AND SAFETY AGENCY

The Parties recognize that there is an ability to involve other agencies and government through partnerships, thereby multiplying the advantages of working together.

The Parties recognize that the ability to promote best practices and conduct necessary research is enhanced through a joint effort, thereby increasing acceptance, trust and understanding of solutions to mutually beneficial objectives.

The Parties recognize the benefit of and are committed to establishing a government-funded approach to joint identification and implementation strategies where safe work environments, healthy workforces and quality patient care can be achieved through prevention, safe workloads, promotion of safe work practices, safe early return to work, pilot programs and sharing of best practices among union members, employers, and industry at large.

To that end, the Parties agree to establish a jointly run agency for the purpose of developing and evaluating program objectives with respect to prevention programs and compliance with Workers’ Compensation Board requirements.

Where the Agency identifies practices, programs or models which have the potential to improve occupational health and safety or improve compliance with Workers’ Compensation Board regulations and recommendations in the health sector, the Agency shall promote the adoption of the practice, program or model in accordance with Agency guidelines or with such modifications deemed by the Agency to provide an equal or greater degree of protection to workers.

Agreed to on April 8, 1998

On Behalf of HEABC

On Behalf of Health and Support Worker - Facilities Association
Appendix B.

Statement from BCNU on End to OHSAH Funding

BCNU

Occupational Health and Safety Agency funding ends
June 24, 2010

The Occupational Health and Safety Agency (OHSAH) was conceived in early 1998 in an accord between management and union representatives. OHSAH partners included health authorities, unions, WorkSafeBC, and university researchers. This organizational collaboration has achieved remarkable success. OHSAH's mandate was to reduce workplace injuries and illness in healthcare workers and to return injured workers back to the job quickly and safely. From 1998 - 2005 both 'injury rate' and 'days lost' showed a steady decline.

The Provincial Ministry of Health Services has ended funding to OHSAH, and as a result the agency will cease operations in the coming months. Core programs that will continue to be provided within B.C.'s healthcare system are; White.net, MSDS and OHS Connect. There is a commitment to completing the important work of the Provincial Violence Prevention Steering Committee (PVPSC), which will include the completion of the Provincial Violence Prevention Training Curriculum.

OHSAH will no longer be providing support to the Provincial Musculoskeletal Injury Prevention (MSIP) and Biohazardous Exposures Steering Committees.

Thank-you to all BCNU members who participated in both regional and provincial roles.

The work of OHSAH has been outstanding, affecting the health and safety of health care workers throughout B.C.

BCNU regrets the loss of this valuable organization which has worked tirelessly to prioritize health workers' need for healthy workplaces.
Appendix C.

Literature Search Parameters for OHSAH Thesis

Parameters: 
- Languages: English
- Subjects: Humans only
- Location: British Columbia
- Gender: Men, Women, Transgendered

Identify subsets:
- Unions (represented by bargaining associations) British Columbia Nursing Union or BCNU, Health Employers Union (HEU), Health Employers Association of British Columbia (HEABC), Government of British Columbia,
- Health Employers Association of British Columbia (HEABC)
- Government of British Columbia
- Healthcare workers in BC
- Individual players: Annalee Yassi, Gary Moser, Catherine Fast, Dave Keen. George Heyman, Tony Pennikett

Information sources: journals, databases, grey lit, systematic reviews, government websites, government documents, think tanks (e.g. Fraser Institute), policy institutes (e.g. CHSRF, CCPA)

PICO
- P – Subject – Occupational Health & Safety Association of Healthcare Workers of British Columbia (OHSAH)

Subsets:
- Unions (represented by bargaining associations)
- Health Employers Association of British Columbia (HEABC)
- Government of British Columbia
• Healthcare workers in BC – RNs, LPNs
• Health authorities

I – Intervention: What do we want to do?
• Identify why OHSAH was established and why the Government of BC decided to disband it, effective Nov. 2010
• Identify why the Government decided to disband it
• Find any government documents discussing OHSAH between 1998 and 2011
• Find articles and reports stating that OHSAH was responsible for reducing injury and loss time among healthcare workers

C – Comparison: If we don’t intervene as above, what are the alternative interventions?
• Continued high rates of injury and lost work time among healthcare workers
• Without OHSAH, what’s left? Canadian Centre for Occupational Health and Safety (CCOHS), WorkSafeBC

O - Desired outcome: Fewer healthcare injuries and lost days of employment

Databases:
• BC Stats Publications
• BioMed Central
• British Columbia Government Publications Index
• Canadian Research Index
• Canadian Institute for Health Information (CIHI)
• Cochrane Collaboration
• EBSCO Academic Search Premier
• Medline (US National Library of Medicine –CINAHL (nursing & allied health)
• NHS Economic Evaluation Database
• Ovid EBM Reviews
• PubMed Central
• Statistics Canada
• WorkSafeBC
Appendix D.

Semi-Structured Interview Guide to

_The Dance of Dissent: The Rise and Fall of the Occupational Health and Safety Association of Healthcare Workers of British Columbia_

Identification #: Date:

**Sector:** (Select one: government, health authority, union, H&S agency, academia)

Thank you for taking the time to participate in this interview. I would like to gain a sense of the thinking behind the Government of British Columbia’s decision to create the Occupational Health and Safety Association of Healthcare Workers in 1999 and subsequently dismantle it in 2010.

**Interview Questions:**

1. Was there something about the political and labour environments that presented a window of opportunity for a policy decision supporting the creation of an occupational health and safety agency specifically for healthcare workers? What were the political and labour conditions leading up to OHSAH’s establishment in 1999?

2. Why was a bipartite structure used and how did this structure influence how decisions were made?

3. OHSAH did not have binding powers. How did its advisory nature influence decision making and union and management compliance with decisions made?

4. Please describe what you see as OHSAH’s two most important contributions to occupational health and safety in BC.

5. Why do you think OHSAH became a candidate for dismantling? When that decision was made, what thoughts were given to preserving the legacy of OHSAH? Do you still draw on the relationship built while OHSAH was in operation? What steps have been taken to ensure the preservation of OHSAH’s research into occupational health & safety?

Thank you for participating in this interview.
Appendix E.

Subject Consent Form

Ethics Application # 2011s0764

The Rise and Fall of the Occupational Health and Safety Agency for Healthcare (OHSAH) in British Columbia:

Information and Consent Form for Participating in Semi-Structured Interviews

About this study

As a Master’s student in the Faculty of Health Sciences at Simon Fraser University, I am conducting research for my thesis under the supervision of Dr. John Calvert. The purpose of this study is to gain a sense of the thinking behind the Government of British Columbia’s decision to create the Occupational Health and Safety Agency for Healthcare (OHSAH) and subsequently dismantle it, to understand OHSAH’s structure, assess its most important contributions, and identify ways to preserve its legacy. I am not a member of any union, but am an employee of Fraser Health Authority (FHA). The work I conduct as an employee of FHA is not related in any way to my thesis and is not supervised by anyone who may be interviewed for this study. I do not have any involvement in labour or industrial relations or workplace health & safety at FHA.

Being interviewed

To be eligible to participate in an interview, you must be 19 years of age or older and able to communicate in English. Your participation in this research is completely voluntary and you may withdraw at any time without any negative consequence. You are not required to answer my questions and may choose not to answer any question with which you are not comfortable. By agreeing to participate, you grant me permission to use your input in my analysis of the data. The interview will take approximately 45 minutes to 1 hour. If at a later date you wish to withdraw from participating in the study, you may do so until the study is complete. If you withdraw from participating in the study, your transcript will not be used. To withdraw from the study, please contact me in writing at scamus@sfu.ca to advise you wish to withdraw from the study.

Your privacy

I value your privacy. To protect your privacy, your identity will be kept secret during all stages of the study. You will be assigned a number that is used for data collection and inputting, analysis of the data, and writing the thesis. My thesis supervisor and I are the only ones who will know your identity, and a code sheet with identities will be kept in a locked cabinet. Confidentiality with respect to the law is therefore guaranteed. Raw data will be stored as paper files in a locked cabinet. Electronic files will be stored on a secure
server and on a flash drive stored in a locked cabinet. Data will be retained for three years.

**Your well-being**

Your personal well-being is important. There are no physical and psychological risks to you. There are also no known direct benefits to you.

**Value of your information**

The information gathered during the interview will be used to write a master's thesis. To obtain an electronic copy, please complete the attached form, “Request for a Copy of Report.”

**Contact us**

Feel free to ask any questions you may have during the interview. Concerns or complaints can be directed to my thesis supervisor, Dr. John Calvert, Associate Professor, Faculty of Health Sciences, Simon Fraser University, Burnaby, BC V5A 1S6 at [jrc@sfu.ca](mailto:jrc@sfu.ca) or by telephone at (778) 782-8163. Concerns or complaints may also be directed to Dr. Hal Weinberg, Director, Office of Research Ethics, Simon Fraser University, Burnaby, BC V5A 1S6 at [hal_weinberg@sfu.ca](mailto:hal_weinberg@sfu.ca) or by telephone at (778) 782-6593.

By signing my name below, I am indicating my agreement to participate in this study.

---

(Name — please print)  Signature  (Date)