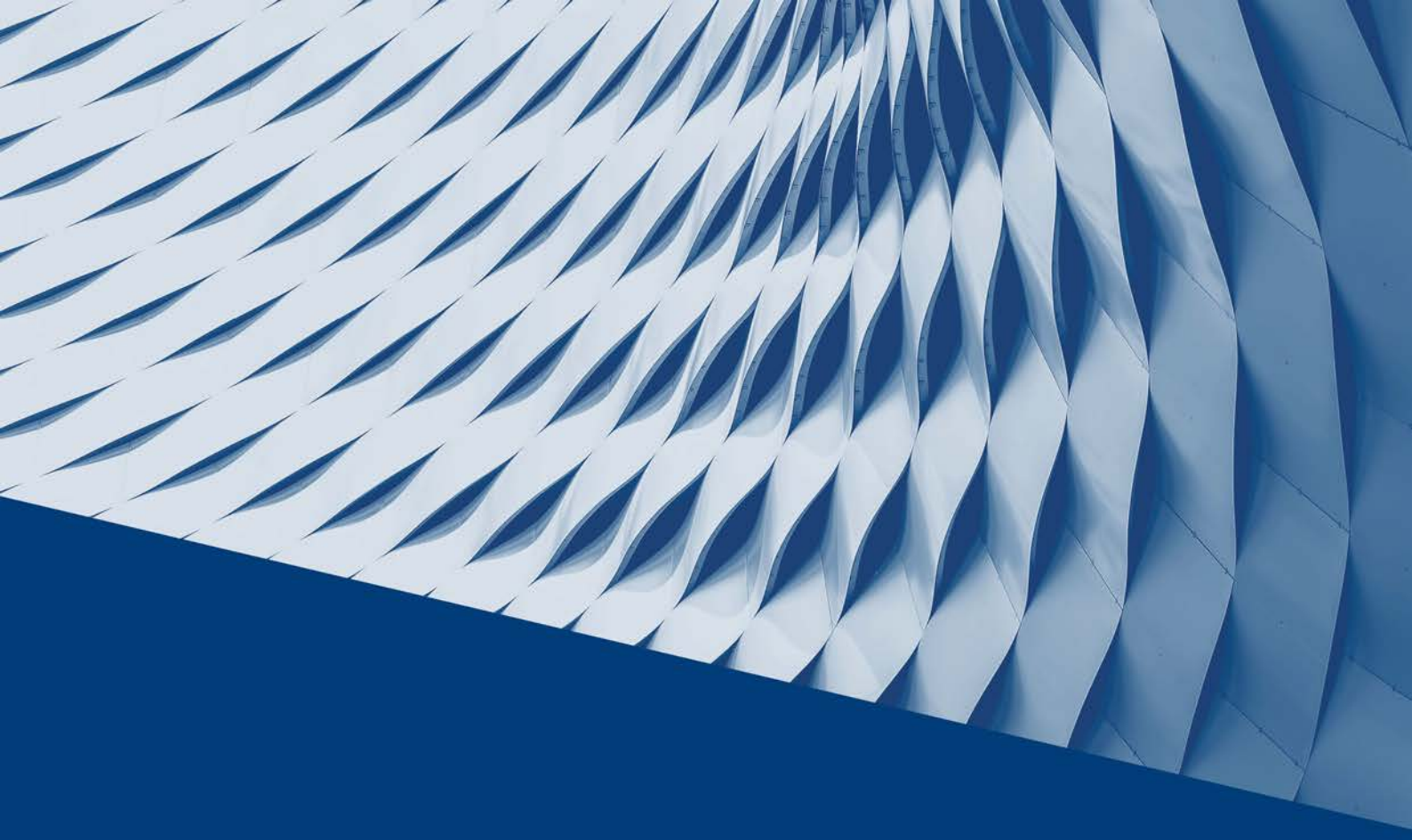

Achieving Health Equity: The inclusion of occupational disease

Submission on the Role and Function of an Australian Centre for Disease Control

Consultation Paper 2022

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ACTU
australian council of trade unions

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About the ACTU

Since its formation in 1927, the ACTU has been the peak trade union body in Australia. It has played the leading role in advocating for, and winning the improvement of working conditions, including on almost every Commonwealth legislative measure concerning employment conditions and trade union regulation. The ACTU has also appeared regularly before the Fair Work Commission and its statutory predecessors, in numerous high-profile test cases, as well as annual national minimum and award wage reviews.

The ACTU is Australia's sole peak body of trade unions, consisting of affiliated unions and state and regional trades and labour councils. There are currently 43 ACTU affiliates who together have over 1.7 million members who are engaged across a broad spectrum of industries and occupations in the public and private sector. The ACTU and its affiliates have represented workers on health and safety at work since our formation and is the national voice representing workers at Safe Work Australia (SWA).

Recommendations

Recommendation 1

The scope of the Centre for Disease Control (CDC) must include the research and surveillance of occupational diseases. The establishment of this function should consider appropriate linkages to, and mechanisms to collaborate with, work health and safety regulators and Australia's national work health and safety policy agency, Safe Work Australia.

Recommendation 2

In meeting the challenge of early detection and prevention of communicable disease a focus on 'work' and 'workplaces' is critical. The CDC should ensure appropriate and strong linkages with work health and safety through direct engagement and collaboration with Safe Work Australia and its members, including social partners (unions and employers). This will ensure that effective and equitable public health measures can be designed in consultation with employers and unions.

Recommendation 3

Trust in public health advice has never been more important. Whether it be threats posed by pandemics, climate change or the impact of work on our health the medical science must move beyond politics. The CDC must be independent of government and provide robust, evidence-based advice to inform both public policy and individual decision making.

Introduction

1. The right to a healthy and safe working environment is a fundamental human right and essential to decent work. Every year 200 workers are killed in Australian workplaces with thousands more dying from diseases caused by their work. Unions understand that good, decent, well-designed work contributes positively to our health and wellbeing. Equally, poorly designed, insecure work that exposes workers to both physical and psychosocial hazards is harmful to our health and wellbeing and increases the burden of injury and disease.

2. Occupational disease in Australia is poorly understood. Unlike other comparable countries Australian jurisdictions, with one exception, do not even record deaths from occupational disease as workplace fatalities.[1] As a consequence work health and safety policy makers rely on delayed workers' compensation data which provides an incomplete picture of the extent of work-related injury and disease. This gross underestimate of disease means prevention activities are not taken or de-prioritised and workers remain exposed to harm.

3. The ACTU welcomes the opportunity to make a submission on the role and functions of an Australian Centre for Disease Control (CDC). Unions recognise the enormous task in establishing a CDC and support the initial focus on communicable disease, however, whilst the early detection and prevention of communicable diseases should be a priority for the CDC we should be aspirational in our goals and should, like they do in other countries, provide scope for the surveillance and research of occupational diseases. The ACTU supports a CDC with a mission that incorporates 'all hazards', and to be the "nation's leader in health protection, prevention and promotion". The promotion of work that is good for our health and the prevention of work-related ill health should be within the remit of a CDC.

[1] In 2021 Victoria commenced recording deaths attributable to disease. The methods used still significantly underestimate the impact of disease, especially those with longer latency periods.

4. Occupational disease will benefit from the multidisciplinary approach to research and surveillance offered by a CDC and lead to better understanding of occupational disease and improved prevention measures.

5. Finally, trusted public health advice has never been more important. Pandemic fatigue and the economic and social disruption that has occurred in combatting COVID-19 has undermined public confidence in institutions. Whilst the solutions to this are complex and require addressing multiple factors that have led to social and economic exclusion, we must safeguard important institutions to ensure they retain the trust of the Australian people. There is no more important an institution than that of a CDC that provides public health advice and information. It is critical that a CDC is established independent of government to provide evidence-based health advice to guide effective public health intervention.

6. The following submission will focus on the key questions and issues of scope in relation to a CDC and the need to include the research and surveillance of occupational disease, drawing on local and international evidence. We also take the opportunity to support and endorse the submissions made by the Public Health Association of Australia (PHAA) and the Australian Institute of Occupational Hygienists (AIOH).

What gets measured gets managed

7. The impact of work on our health in Australia, and around the world, is poorly understood. Every so often stories emerge where workers from a particular workplace or industry die. These stories briefly capture our attention and lead to sporadic political and government action. The interventions that follow are nearly always insufficient and often too late to prevent widespread disease and death. One such contemporary example is the epidemic of silicosis being experienced by workers across our mining, quarrying, building and constructions sectors. Recent estimates suggest that as many as 100,000 workers will be diagnosed with silicosis and a further 10,000 with lung cancer.[2] Many of these

[2] Carey, R, Fritschi, L, *The future burden of lung cancer and silicosis from occupational exposure in Australia: A preliminary analysis,* 2022 https://www.curtin.edu.au/about/wp-content/uploads/sites/5/2022/07/FEFreport_formatted.pdf

workers are young, some in the early twenties, and are now consigned to (shortened) life with a debilitating and incurable disease that could have been prevented with the early identification of disease and the implementation of stronger workplace measures.

8. Our ability to undertake comprehensive, accurate, timely and transparent monitoring and surveillance of occupational disease means that we are incapable of quantifying the impact that work has on our health and detecting early disease. Instead of comprehensive real-time data drawn from the numerous health datasets available we rely upon backward looking workers' compensation data. Data that records only those who have made, and had approved, a claim for workers' compensation insurance. Most research, including the ACTU's longitudinal study on working conditions in Australia: Work Shouldn't Hurt, highlights the limitations in this data with as few as 1 in 10 workers actually making a claim following work-related injury and illness. In the case of disease and ill health, especially those of longer latency, these numbers are even lower and highlights the significant underestimate of the impact of work on our health.

9. That is not say that there are not more robust and accurate studies of the impact of work on our health and in particular the burden of occupational disease. The most recent (2015) Australian Burden of Disease Study conducted by the Australian Institute for Health and Welfare (AIHW) highlights the significant impact that work has on health with 2% of the total burden of disease in Australia due to occupational exposures and hazards.[3] This research links 29 diseases and injuries including 10 types of cancers, 15 types of injuries including asthma, chronic obstructive pulmonary disease (COPD) and all pneumoconiosis to occupational exposure.

10. A CDC that includes, amongst its design principles, an "all hazards' approach, cannot ignore the threats to public health posed by work. A CDC, as a national coordinating body, should work to improve available health data, including hospital data, to enable better surveillance of occupational disease.

[3] AIHW, *Australian Burden of Disease Study 2015: Interactive data on risk factor burden*, https://www.aihw.gov.au/reports/burden-of-disease/interactive-data-risk-factor-burden/contents/occupational-exposures-and-hazards

11. The ACTU agrees with the proposition in the discussion paper at page 20, that a CDC '*could also provide surveillance and identification of emerging threats and risks in relation to non-communicable disease, an opportunity to integrate genomics data and metadata, and provide a foundation for the incorporation of other associated data (such as animal health) which builds towards an integrated One Health approach.'*

Health equity

12. The discussion paper released on the role and function of an Australian CDC highlights the need for a specific focus on equity in the work of the CDC. Australian unions consider this a commendable objective and agree that influencing the wider determinants of health such as social, economic and environmental inequities are important.

13. Health is distributed unequally by occupation in Australia with a person's work a critical factor in influencing other key determinants to health. Whether it be socioeconomic status, exposure to hazards at work or even simply access to health care our work is central. Occupational disease in Australia does discriminate. The AIHW study in 2015 revealed that the disease burden attributable to occupational exposures & hazards was 1.6 times greater in the lowest (most disadvantaged) socioeconomic group compared with the highest (least disadvantaged) group.[4]

14. The physical and psychological hazards that workers are exposed to play a significant role in the unequal distribution of health in our community. The more than half a million people injured or made ill at work every year highlights the burden that work places on our health.[5] The changing nature of work and the rise of insecure work have further compounded these challenges with job insecurity a significant risk factor contributing to poorer work health and safety outcomes.

[4] AIHW (2015)
[5] Work-related injuries 2017-2018, ABS

COVID-19

15. Many of the socioeconomic factors that determine health coalesced with the onset of COVID-19 in Australia. Whilst a significant proportion (30%) of Australians were fortunate enough to work in secure jobs that afforded relative safety from the virus as they retreated to their home offices, for millions of Australians they were expected to front up to work, with limited protection, in what was affectionately described as 'essential work'.

16. The 'essential' nature of this work did not afford these workers higher status, improved safety or anything material that would indicate the relative importance of the work they did. Instead workers in sectors such as health and social care, transport, retail and hospitality along with numerous public services risked their lives every day to keep the community safe and society functioning. In a very real sense the type of work you do, and the environment that you work in, has become a significant factor in your exposure to COVID-19.

17. For a significant proportion of these workers they attend work without the basic social protection of sick leave that enables them to safely isolate if unwell and avoid infecting others. With more that 4.1 million people in Australia in some form of insecure work we became highly vulnerable to transmission in these communities. The limited focus on work in our initial health response meant that measures such as the absence of sick leave meant these workers were without income whilst isolating. It was only after unions campaigned for the introduction of pandemic leave that some, albeit limited, measures were introduced to encourage and support workers to isolate.

18. COVID-19 further highlighted the failure of health policy makers to understand the impact of work, which underscores the significant opportunity for a Centre to include work and work-related illness in its scope, purpose and functions. Throughout the pandemic policy makers have played catch up with workplace practices that have traditionally been the domain of work health and safety policy units and regulators. Whether it be the delayed and limited introduction of Pandemic Leave Disaster Pay (PLDP) to address the aforementioned issue of insecure work and isolation through to the development of blunt, confusing public health orders around workplace safety or even the fraught efforts to implement vaccine mandates highlighted the limited understanding of work.

19. Even today the unions remain concerned that with the removal of Public Health Orders (PHOs) workplace are without clear enforceable guidance when it comes to managing

transmission at work. Effective workplace transmission control measures are critical to not only keeping workplaces safe, but, given that work is a key place of human contact, it is a critical setting for managing and minimising transmission of the virus and reducing future waves.

20. Given all of these concerns it is not surprising that, given the lack of understanding and focus on work and workplaces, that in the first year of the pandemic there were almost 4 times as many deaths due to COVID-19 among people from the lowest socioeconomic group compared with the highest group, and age standardised mortality rates were 2.6 times as high.[6] This 'work blind spot' in our response is partly due to the disconnect between "public health" and "work-related health". There are very limited connections between those health agencies dealing with infectious disease and work health and safety agencies. There is a lack of information and data sharing, as well as approaches to infection control relevant to work. If a future CDC is going to effectively prevent and manage future pandemics a strong link to work is critical.

Climate

21. Over the last quarter of a century climate change has emerged as the greatest threat to human health. Climate change will cause an increase in vector related infectious diseases, exposures to extreme climate events and particulate pollution due to bushfire smoke. These exposures have significant impacts on people at work.

22. A significant proportion of Australians undertake some or all of their work outdoors. Workers who lack protection from climate hazards or are unable to stop work to avoid climate hazards are at particular risk. Recent flooding throughout eastern Australia in 2022 or the 2020 summer bushfires highlighted the vulnerability of workers when it comes to the impacts of climate change.[7] A CDC would provide a basis for data collection

[6] AIHW 2021. The first year of COVID-19 in Australia: direct and indirect health effects. Cat. no. PHE 287. Canberra: AIHW. https://www.aihw.gov.au/getmedia/a69ee08a-857f-412b-b617-a29acb66a475/aihw-phe-287.pdf.aspx?inline=true

[7] https://www.mja.com.au/journal/2022/217/9/2022-report-mja-lancet-countdown-health-and-climate-change-australia-unprepared

and dissemination to help inform climate adaptations which will be necessary over the foreseeable future. These will be critical to informing public health and work-related health policy.

Lifestyle diseases

23. Lifestyle-related risk factors are significant contributors to disability and death in Australia. Whether it is alcohol and tobacco use, weight, unhealthy diet and physical activity these factors not only impact the individuals concerned but they represent significant social and economic cost to the community through greater burden on the health system, lost productivity and national output.[8]

24. There are significant socioeconomic factors that impact lifestyle and therefore contribute to a greater burden of disease amongst poorer Australians. Again, the Australian Institute for Health and Welfare (AIHW) has analysed ABS data arising from the 2017-18 National Health Survey and concluded, after adjusting for age difference it is estimated that, when compared with adults living in the highest socioeconomic areas, adults living in the lowest socioeconomic areas were:
    - 1.6 times as likely to be obese (38% and 24%) (AIHW 2020f) (figure 1)
    - 1.3 times as likely to be insufficiently active (63% and 48%) (AIHW 2020d)
    - 1.2 times as likely to have uncontrolled high blood pressure (24% and 19%).

25. They also reviewed the 2019 National Drug Strategy Household Survey using a similar composite measure of socioeconomic position, the Index of Relative Socioeconomic Advantage and Disadvantage (IRSAD) for people aged 14 years and over. When compared to those living in the highest socioeconomic areas those in the lowest socioeconomic areas were:
    - 3.6 times as likely to smoke daily (18% and 5.0%) (AIHW 2020e).

[8] Paul Crosland, Jaithri Ananthapavan, Jacqueline Davison, Michael Lambert, Rob Carter, *The health burden of preventable disease in Australia: a systematic review*, Australia and New Zealand Journal of Public Health, 2019 https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12882

26. A CDC that "*strives to achieve health equity with a focus on eliminating preventable health disparities*'[9] and take an 'all hazards' approach cannot ignore the threats posed by lifestyle factors in determining its scope. Consideration must be given to ensuring that a CDC is capable of providing independent evidence-based advice to governments on the threats posed by lifestyle factors.

World's best practice

27. Australia's commitment to establish a Centre for Disease Control is long overdue and whilst our public health capability is strong we should look to the world to identify the best examples of national health leadership in the prevention and control of disease.

28. The US Centre for Disease Control (US CDC) is one of the oldest and most mature centres tasked with the control and prevention of disease in the world. Organised into centres, institutes and offices these components implement the agency's activities in their particular field of expertise. The National Institute of Occupational Safety and Health (NIOSH) is the federal agency responsible for conducting research and making recommendations for the prevention of work-related injury and illness and is part of the US CDC.[10] NIOSH along with the Occupational Safety and Health Administration (OSHA), the agency responsible for developing and enforcing health and safety regulation, were created by the Occupational Safety and Health Act 1970 and have worked collaboratively in protecting worker health.

29. NIOSH scientists work in multi-disciplinary teams undertaking research to prevent or reduce work-related injury and illness. In 1996 NIOSH launched the National Occupational Research Agenda. Now in its third decade the agenda now consists of ten industry sectors based on major areas of the US economy, and seven health and safety

[9] CDC Consultation paper – Strategic Intent p10

[10] National Institute for Occupational Safety and Health Fact Sheet (2003-116), CDC https://www.cdc.gov/niosh/docs/2003-116/default.html

cross-sectors organised according to the major health and safety issues affecting the US working population.[11]

30. Similar models have existed in Australia's past. Between 1986 and 2005 the National Occupational Health and Safety Commission (NOHSC) had a broad range of functions including the national occupational health and safety strategy and development of standards and policy. Like the current Safe Work Australia the NOHSC governing body included representatives of the social partners, state and territory governments and representatives appointed by the Ministers for Industrial Relations and Health.

31. The NOHSC functions included:
    - to collect, interpret and disseminate information relating to occupational health and safety matters
    - to direct the conduct of inquiries in respect of occupational health and safety
    - to publish reports, periodicals and papers relating to occupational health and safety matters
    - by arrangement with particular employers, to carry out, arrange for, or assist in the evaluation of occupational hazards at work
    - carry out, arrange for, or assist testing of matters and things relevant to occupational health and safety matters
    - to carry out, arrange for, or assist research on occupational health and safety matters.

32. NOHSC funded external research and undertook its own research through the Research and Scientific Division of the National Institute of Occupational Health and Safety. This was organised into eight disciplinary groups – occupational medicine, ergonomic, toxicology, work environment, epidemiology, statistics, psychology, occupational hygiene and safety engineering.[12]

33. Significant funding cuts in 1996 resulted in NOHSC focussing on standards development and in 2005 NOHSC was abolished and its replacement, the Australian Safety and

[11] National Occupational Research Agenda (NORA), CDC, https://www.cdc.gov/nora/about.html
[12] Johnstone R, Occupational Health and Safety Law and Policy, LBC information services, 1997 – pages 141- 156.

Compensation Council, had a significantly narrower mandate.[13] The membership of the Commission included a representative of the Minister of Health[14] and the ability to conduct its own inquiries and research are models that the proposed CDC could replicate.

34. Australia should consider similar scope and model in future phases of the CDC. The US model, with an interconnected occupational research institute that draws from the multi-disciplinary skills of the wider CDC and establishes strong links with work health and safety policy agencies has strong potential in Australia.

Conclusion

35. It is easy to understand, in the midst of a pandemic, the importance of getting the basics right. Detecting, preventing and controlling communicable diseases is central to the reason we are even having this discussion. In fact, if you look to the comparable centres around the world their origins lay in similar pandemic events. Ensuring that we establish a CDC that is independent of government and free to provide evidence-based public health advice to guide public health interventions is the bare minimum for any national health prevention body.

36. However, whilst Australians rightly expect that following the lessons of the last few years we establish a CDC with a strong focus on communicable disease, we also demand that we be bold in our aspiration to tackle all threats to public health.

37. If we are truly going to take an 'all hazards' approach to public health then we cannot ignore the threat to our health posed by work. **Two percent** of all disease is attributable to occupational exposures and hazards. The burden of occupational disease has significant distributional impacts and undermines health equity.

38. Occupational disease has for too long been the poor cousin of disease research. We don't have 'walks for mesothelioma or silicosis'. Those that 'live' with occupational

[13] National Occupational Health and Safety Commission (Repeal, Consequential and Transitional Provisions) Bill 2005
[14] https://www.legislation.gov.au/Details/C2004A03074

diseases are not celebrities that can draw attention to their illness and raise the necessary funds for research and prevention. A CDC with a focus on occupational disease provides the only hope to raise awareness of and eliminate occupational disease which will in turn, significantly improve public health.

39. It is critical that the scope of the CDC include the coordinated surveillance and research of occupational disease that can inform evidence-based policy aimed at prevention. It is an aspiration that aligns with the egalitarian spirit of Australia.

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