Workplace exposure standards framework under the model work health and safety laws

Australian Council of Trade Unions submission on the consultation Regulatory Impact Statement.

ACTU Submission, 12 September 2018
ACTU D. No 180/2018

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ACTU position

The ACTU supports Option 2 for the following reasons:

- Reduction of burden of disease
- As a consequence of the above, a reduction in the burden borne by workers and the community due to work related ill health. The ACTU notes that the burden borne by workers has in fact been underestimated in the RIS when studies have shown workers bear up to 77% of the cost of work-related injury and disease to the Australian economy[1] – more than $540 million a year.
- Improvements in the quality of life of workers and their families
- Update out of date and currently non-protective exposure standards for hazardous substances
- Provide clear obligations for PCBUs/employers
- Provide clarity to health and safety regulators on what constitutes compliance
- Provides the ability to fast track previously ignored or emerging health hazards e.g. exposures to diesel fumes
- Potentially align exposures standards with overseas best practice.

The ACTU does not support the status quo, Option 1, as it has failed to provide the level of protection that Australian H&S laws are designed to provide. The ACTU has consistently opposed the adoption of advisory standards[2] and therefore does not support Option 3, a self-regulation model with an advisory standard. The reasons for our position include:

- Strong feedback from affiliates that WES must be mandatory to ensure workplace safety
- That advisory standards make it harder for all PCBUs, including small/medium sized, to know they are complying [the 2004 Maxwell Review in Victoria clearly outlined the reasons why business likes to know what compliance looks like]
- The high cost burden to workers of work-related injury or disease
- Advisory standards fail to provide clear advice to workers and their HSRs
- Option 3 would implement a dangerous policy position that if compliance is not achieved then the decisions made to improve health and safety are incorrect and the standards applied by law must be lowered – this is an approach designed to increase the risks faced by workers
- Any other option may lead to further variation across jurisdiction, as individual state regulators would be likely to adopt selected mandatory standards or maintain the current WES as mandatory

[1] *The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012–13*
[2] Discussion Paper: The role of chemical exposure standards in work health and safety laws: Comment ACTU December 2015

- Other options would create further potential for lack of compliance as WES would not have any regulatory status. Regulators will need considerable effort deciding on what is or is not compliance and any voluntary health-based standard [which are supported by the ACTU] would effectively become a pragmatic standard
- The introduction of a voluntary system would devalue the exposure standards and remove the current ceiling provided by mandatory standards.

The ACTU has consistently argued that

- Workplace Exposure Standards for Airborne Contaminants [WES] need to be updated regularly and has previously supported the fast tracking of WES
- Action levels of 50% of WES need to be adopted in workplaces, given that WES are a statutory upper ceiling, not a definitive "safe level".

Specific ACTU comment

Para 6	According to international expert Dr Takala [3] 90% of work related ill health is due to occupational cancers and diseases of respiratory, cardiovascular, digestive and genitourinary diseases. These are due to exposure to workplace agents.
Para 16	ACTU notes that *The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012–13* states that workers bear up to 77% of the cost of work-related injury and disease to the Australian economy[4]. It would not be unreasonable to extrapolate that workers would more than likely bear 77% of the $708 million-dollar cost identified The ACTU is unsure whether skin disorders are included in the estimation of burden of disease.
Paras 29-31	ACTU supports conclusion
Para 40-43	ACTU is unsure why dermal absorption is ignored in the discussion – we acknowledge that it nearly impossible to quantify but it is important for certain substances.
Para 55	ACTU notes that compliance issues require much more than an education strategy. If that was the case, the toll on workers from exposures to benzene, asbestos and silica [for example] would have been considerably lower than past and current burden of disease.

[3] Eliminating occupational cancer in Europe and globally, Jukka Takala. Working Paper 2015.10, ETUI

[4] *The Cost of Work-related Injury and Illness for Australian Employers, Workers and the Community: 2012–13*

Para 59	ACTU supports the hierarchy of control but notes there is still considerable reliance on lower order controls, and whilst that continues to be the case, mandatory exposure standards are necessary. Unfortunately, Australian industry is a slow adopter of the principle 'that the best way to reduce exposures is to address the root cause: the decision to use toxics in the first place'. Substances such as n-hexane are still in use in our workplaces.
Para 93	ACTU affiliates from the health industry are particularly concerned about the following substances: <u>Formaldehyde</u> The exposure in Australia is 1 ppm as opposed to 0.3 internationally. There has been no review since deemed a carcinogen or following the NICNAS recommendations of 2006. <u>Peracetic Acid</u> Utilised as a cleaning agent for scopes – duodenal, bronchoscopy and endoscopes. Replaced glutaraldehyde. No exposure limits in Australia. This chemical is a sensitiser, creates respiratory risk and is corrosive to the eyes. The links below demonstrate the exposure limits and testing performed internationally. The regulatory environment concerning peracetic acid is changing. In 2014, the ACGIH released a Short-Term Exposure Limit (STEL) for peracetic acid of 0.4 ppm. http://www.chemdaq.com/osha-cracking-peracetic-acid-exposure/ http://www.anpro.com/assets/eo-toxicity-comparison.pdf https://www.cdc.gov/niosh/ipcsneng/neng1031.html <u>Cytotoxic drugs</u> Refers to a large class of drugs used in the treatment of cancer as a chemotherapy agent and also used in the treatment of a number of other conditions such as rheumatoid arthritis, also used in veterinary and research areas. At the moment, despite serious health risks, including being known carcinogens, there is very limited regulation on the safe use of cytotoxins, and no biological testing available for the broad range of cytotoxics. Currently cyclophosphamide is the only cytotoxic referenced in legislation (referenced in the WHS Regs as a notifiable carcinogen – Table 10.2 Restricted carcinogens) whilst numerous others are carcinogenic, and many are of greater risk than cyclophosphamide. There is guidance material only in each state with the NSW document the most recent

	publication. More needs to be done to regulate the safe use of cytotoxic drugs to ensure nurses are not being exposed. No safe level is provided, no limits are set and the determination of exposure is difficult although environmental testing is available for some agents. Exposure levels are not available for biological monitoring – This is an area for greater research. http://www.safework.nsw.gov.au/__data/assets/pdf_file/0005/287042/SW08559-Cytotoxic-drugs-and-related-risk-management-guide.pdf https://www.eviq.org.au/clinical-resources/administration-of-antineoplastic-drugs/188-safe-handling-and-waste-management-of-hazardou
Para 96-97	The boxed example for "over protective" WES is concerning. The ACTU notes that any exposure to known carcinogens needs to be either eliminated or keep as low as possible. Is there a threshold level for carcinogenesis of acetaldehyde which could justify an elevation of the WES? The example is contrary to the advice given for example in the ACGIH TLVs – *for A2 [suspected human carcinogens] worker exposure by all routes should be carefully controlled to levels as low as possible below the TLV.* [5]
Para 139	The ACTU is concerned with the source data used to come to the conclusion that some substances are not currently in use. This fails to acknowledge use of stored or old chemicals, the possible re-introduction of chemicals in another form eg nano or the lack of costs for business of the WES if the substance is not in use. The ACTU requests further information on the accuracy of the AICS, one of the databases maintained by NICNAS. We understood that there is no requirement to notify if the substance is on AICS and that the source of information regarding imports, for example, would be the ABS. Is that correct?
Para 137	Again, the commentary in the box regarding Xylene is concerning. The assumption made in the RIS is that those countries with a lower WES have not considered the levels for dangerously harmful side effects of xylene. As this substance can cause Upper Respiratory Tract, eye and skin irritations. It is unclear from the commentary if these are included in the reference to "dangerously harmful side effects". The ACTU supports WES which protects workers from harmful effects, not just dangerously harmful effects.

[5] ACGIH TLVs and BEIs, Appendix A Carcinogenicity

Para 163	The ACTU notes that the WES do include substances other than chemicals e.g. dusts and fumes, which we assume are covered in the considerations.
Para 167	ACTU strongly supports flexibility to review emerging or *ignored* WES.
Para 179	ACTU supports name change to workplace exposure limits
Para 197	The ACTU notes the use of old data regarding the cost of treating mesothelioma sufferers. ASEA has published more recent analysis.
Para 200	Due to the examples given in this RIS the ACTU has reservations about this statement. See above.

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ACTU D No.

180/2018