Health and Safety in Small Workplaces: Refocusing Upstream

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ABSTRACT

Small workplaces have particular injury risks and are enduringly difficult for the occupational health and safety (OHS) system to reach. This paper puts forward an "upstream" perspective on OHS in small workplaces that moves beyond the attributes of the workplace and those who work there.

The paper draws on and synthesizes ideas and findings from emerging upstream OHS research, our own empirical investigations in Ontario and Quebec, and our collected research experience in small workplace health.

Upstream structures and processes (regulations, policies, services, interventions, professional practices) are often misaligned with the conditions of work and social relations of small workplaces. Key upstream factors include regulatory exemption, subcontracting, unionization levels, the changing character of small enterprise, joint management, service and inspection constraints, competing institutional accountabilities, institutional orientation to large business, and inappropriate service and policy.

Misalignment of the OHS system with the nature and practical realities of small workplaces can undermine prevention and the management of ill health and injury. To address such misalignments, the paper calls for: 1) restructuring of data collection and consultation processes to increase the visibility, voice and credibility of small workplaces; 2) "audits" of OHS-related legislation, policy and interventions to assess and address implications for small workplaces; 3) reflection on current terms and concepts that render workers invisible and capture poorly the essence and (increasing) diversity of these workplaces; and 4) extension of the upstream gaze to the global level.

Key words: Social sciences; government agencies; government regulation; safety management; small business

There were almost one million "small" businesses (SBs)* in Canada in 2004.[1] These enterprises, often defined as those employing fewer than 50 persons, include over 4 million workers, about 39% of the private labour force.[1] Industries dominated by small businesses tend to have higher fatality rates than do industries dominated by larger-sized organizations,[2] and they present enduring, unresolved challenges to the occupational health and safety (OHS) system in terms of prevention, disability and return to work.

Internationally, small workplaces are widely considered hard to reach in terms of health and safety regulation and service[3,4] and relatively impervious to the regular tools of the trade for assessing risk, providing service and designing interventions. To improve OHS in small firms, research and practice have concentrated on linking the level of risk to attributes of the workplace and those who work there, including the risk profiles of workers (e.g., higher risk groups like immigrants and young people are disproportionately employed in this sector) or the deficits of management (e.g., employers may lack the resources, knowledge, skills, time and motivation to deal effectively with OHS).[5] Associated with this definition of the problem are intervention approaches that are educational or motivational in nature (e.g., informing employers of obligations and risks, offering financial incentives for prevention activities) and that are of low cost, simplified and industry specific. Service delivery has been adapted to the small workplace situation, for example, through the introduction of more appropriate measurement tools,[6]

more understandable and relevant educational materials,[7] upgraded management systems[8,9] and special modes of consultation, such as those involving safety representatives, worker participation[10,11] and intermediaries.[12,13]

More recently, attention has moved upstream, in the sense of McKinlay's iconic notion of upstream-downstream thinking:[14] searching for cause and locating intervention further from the most immediate local site of the phenomenon. An upstream perspective on small workplace health focuses on broad contextual influences (e.g., economic systems, structure of labour markets[15] and organizational/regulatory arrangements such as subcontracting[16] and outsourcing[17]) and on intermediate structures and processes (e.g., the institutions, programs and professional service providers of the OHS system itself). An upstream perspective focuses less on the problematic features of small workplaces than on the conditions that set the terms for and influence such problems.[18]

The purpose of this paper is to contribute to an upstream perspective on OHS in small workplaces and thereby to advance our understanding of why small workplaces are the way they are and of

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* Although there are distinctions between the terms, in this paper we use "small business" and "small workplaces" interchangeably.

how OHS intervention can be improved. Integrating selected findings from our own three separate research projects and Canadian data, we identify the implications of some key upstream system elements for small workplace OHS. We argue that the assumptions, design and mechanisms of the OHS system – including legislation, policy, labour/market structures, institutional and intervention processes – impede the recognition and documentation of occupational risk in small workplaces and undermine efforts to improve health and safety within them.

Key upstream issues of consequence for OHS in small businesses

MacEachen et al.[19] conducted a mixed-method systematic review of the international (multi-language) literature on OHS in workplaces with 100 or fewer employees. A review of qualitative studies[20] focused on processes related to OHS in SBs, and several papers in the review considered the link between OHS conditions and the broader, upstream circumstances in which SBs operate. Drawing on this literature, across different jurisdictions we identify four issues in particular that have implications for OHS in SBs and show how policy and practice can fail to accommodate small workplace realities, with particular illustrations from Quebec and Ontario.

Exemption

A common approach to addressing OHS in SB is through exempting them from general legal and policy provisions.[4,12] For instance, in Ontario and Quebec businesses employing fewer than 20 workers, unlike larger businesses, are not generally obliged to have safety committees or to re-employ injured workers.[21] However, such exemptions and the relative freedom from safety inspection can reduce the pressure on SBs to be aware of and address OHS risks, and to know about and comply with safety regulations,[17,22] leading to lack of OHS knowledge and compliance.[23-25] Exemption from regulations, coupled with the rarity of health and safety inspections in small workplaces, may increase worker exposure to hazards by making small firms an attractive "reduced regulation" destination for outsourced dangerous work (e.g., asbestos removal).[16] Even where regulations do apply to SB, the distinct social and organizational arrangement of work in SBs can foster improvised implementation practices that do not support the intent of the regulations.[24,26,27] The literature suggests that SBs require tailored regulations rather than exemption.

Subcontracting

Subcontracting is a regular feature of SBs, especially those doing specialized jobs for larger firms. In some SB sectors, such as construction, small companies are contracted to do work for larger firms, and they in turn further subcontract out parts of this work. Such vertical and horizontal subcontracting arrangements have implications for work-related health and safety. For example, by fragmenting tasks and authority, subcontracting can create complex conditions of legal responsibility that can confuse the different employer parties, confound OHS accountability and render ambiguous the workers' employment status.[16] In the construction and forestry industries this situation is compounded by the practice of workers owning their own tools, which can lead workers to assume that they have the health-related role and responsibilities of an owner-operator.[28]

Low Levels of Unionization

Unions play a significant role in the development of workplace OHS systems: they support their members, engage in health and safety education and training, represent labour in multipartite deliberations, advocate for system change and so on. Typically, however, the level of unionization in SBs is low, with a corresponding likelihood of irregular norms and standards, and greater imbalance of power between labour and management. The absence of unions in whole sectors dominated by SBs (e.g., farming, construction, dry cleaning) may explain in part their low levels of health and safety knowledge and training,[16,23,29] and the prevalence in SBs of "improvised" health and safety measures (e.g., re-using safety gloves or opening a window instead of wearing a mask).[22,23,26]

Beyond Neighbourhood Shops

The literature suggests that SBs can no longer be conceptualized simply as economically fragile "neighborhood shops" operations. With improved telecommunications and a globalized economy, so-called SBs now include high technology firms with international reach. Those firms may have some features in common with conventional notions of SB, but they are not necessarily financially precarious or local. One study of small biotechnology firms showed that they have traits more typical of large firms: they are run by highly educated professionals trained in safe laboratory practices, and they have funds to outsource their own hazardous work (e.g., disposal of biohazards) and to hire lawyers and consultants to advise on OHS compliance.[30] The diversity and changing nature of SBs constitute an important upstream dimension of the OHS problem in small workplaces.

Upstream implications for SB of OHS legislation, policy and intervention

Further upstream concerns emerge from Champoux and Brun's ongoing research in Quebec on the implications for SB of regulatory, policy and service structures and practices.[31] The study is based on semi-directed interviews with policy makers, system managers, worksite inspectors for the CSST (Quebec's occupational health and safety and compensation authority*), employers' and workers' representatives, injured workers' associations and occupational health professionals.

Conceptions of Small Business

Champoux and Brun report that SBs are portrayed within the OHS field as being largely incapable of taking charge of OHS.[9] Further, they are seen as a less promising target for intervention compared with large businesses, which have a higher absolute prevalence of accidents and greater share of the labour force.[32,33] In Quebec, actuaries estimate that there is one accident every eight years in SBs, even though OHS statistics are not collected or analyzed by business size. This estimate, combined with the absence of data related to size, obscures health and safety issues in SBs. Invisibility, along with cliché conceptions of the capabilities of SBs, may help account for why SB might be of lesser priority within the OHS system and uninvolved in the law and policy-making process.[34,35]

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* Quebec's Commission de la santé et de la sécurité du travail oversees the application of the province's OHS legislation and administers the OHS regime, including financing, inspection and compensation. Inspection for occupational safety is the responsibility of the CSST, and inspection for occupational health is supervised by the Ministry of Health, within the public health system.

Bipartisanism

The notion of joint or bipartite management of OHS embedded in Quebec's legislation can be a disadvantage for small workplaces. For example, legislation assumes that workers will participate in local OHS committees and thereby put pressure on employers to comply. Although such an assumption is reasonable for large, unionized workplaces, it seldom applies to small workplaces.[5,36,37] Even where SBs have been obliged to set up such committees (e.g., imposed by inspectors in the aftermath of an accident), they have been found to be generally ineffective or short-lived because of time constraints and inadequate independent sources of information and support for workers.[38,39]

The belated 2005 inclusion of SB in the CSST's Board of Directors should facilitate consideration of SB employers' concerns. However, with minimal unionization, the 35% of the labour force employed in the SB sector still has no participation in the decision-making process and lacks access to the training funds distributed through unions and to the union legal services needed in increasingly frequent compensation claims disputes.

Intervention Constraints

The study identifies a number of upstream constraints on OHS interventions. For example, public health OHS professionals report waiting up to one year before first visiting newly registered SBs, in part because of their assessment of the low survival rate of SBs. Further, although originally done annually, follow-up worksite evaluations can now be up to seven years apart because of the rising workload of professionals. Additionally troubling are indications that bipartite sector-specific occupational health and safety associations (*Associations sectorielles paritaires*) refuse to collaborate directly with CSST inspectors for fear of seeing their coaching and technical role jeopardized by association with the enforcement body.

One promising intervention program consisted of an unusual collaboration between CSST inspectors and public health occupational health teams targeting workplaces with particular risks (e.g., electrostatic paint, silica dust). Since the strategy was to visit and coach to compliance *all* workplaces with the targeted risks, small workplaces were automatically included, and requirements were uniformly applied regardless of enterprise size. Informants in the study observed that this approach seemed fairer to SBs and was better attuned to their capacities because it involved a visit, a focused intervention and effective collaboration of different agencies. Service providers stress that sustainable prevention in SB requires much greater investment of time and technical and management support, and a larger share of the intervention effort than is the case in larger businesses. Strained resources and conflicting rationalities among agencies are important structural impediments to the promotion of OHS in small workplaces.

Upstream implications for SB of prevention and compensation service provision

Upstream issues and misalignments associated with service institutions and service provision were also identified in Eakin et al.'s study of front-line service work to SB clients in Ontario's Workplace Safety and Insurance Board (WSIB).[40] This project emerged from prior research on the impact on return to work outcomes of strained relations between the WSIB and SB clients and of the stigmatization of injured workers by a "discourse of abuse," i.e., the imputation that compensation claimants are misusing the system.[27,41] Using qualitative interviews, observation of everyday work practices and document analysis, the study examined the work logic, interactions and practices of adjudicators, nurse case managers and customer service representatives servicing SB clients.

Competing Institutional Accountabilities

Compensation and prevention work at the front lines operates as a "professional assembly line" (highly standardized work flow combined with need for professional judgement) and is heavily framed by the core roles of the WSIB as an institution: controlling costs, being administratively efficient, addressing the contradictory interests of employers and workers, acting as gatekeeper to resources and managing involuntary clients. These complex institutional accountabilities can be contradictory, creating service challenges that are played out and mediated by front-line staff. Eakin et al.[40] found that the positioning of the front-line staff at the nexus of conflicting institutional goals set the stage for how service was provided to small workplace clients. Strategic practices helped service providers to handle conflicting job responsibilities, both discursive (the management of work and clients through the way they are conceived, named and framed) and discretionary (the strategic management of work problems and process blockages through informal arrangements and social interactions).

Institutional Orientation to Large Business

Overlaying and accentuating the core character of front-line work were many of the distinctive issues associated with servicing SBs identified earlier in this paper. First, the underlying assumptions, operating principles and policies of the WSIB are designed primarily with large enterprises in mind (e.g., the presumption that the workforce is unionized or that there are health and safety management systems in place). Acknowledged differences between small and large workplaces are addressed mostly through exemption from regulations and special premium arrangements. However, SBs face the same standard policies and procedures as do large firms (such as strategies of "self-reliance" and "early" return to work), which assume that SBs have expertise, resources, circumstances and labour relations that they may not actually have.[27]

Because front-line service rationality is heavily centred on cost and the perception that the system is paid for by employer premiums, SBs tend to be seen, compared with larger businesses, as generating less income relative to the cost of servicing and as costlier to service per worker. Further, small workplaces have a fluctuating presence/absence on the WSIB's institutional radar screen. For example, a special unit for servicing SBs was instituted during one operational re-organization and disbanded during the next. Frequent re-positioning of SB in the WSIB and the absence of a dedicated unit can signal institutional ambivalence about the priority of SB, demand constant re-configuration of work practices at the front lines, reduce the institutional visibility of SB issues and impede the accumulation of collective knowledge and skills particular to servicing this sector.

Inappropriate Policy and Service

Service providers found that certain policies were difficult to apply in small enterprises (e.g., accommodation of injured workers

through modified jobs) or produced complicating perverse consequences (e.g., workplace self-regulated return-to-work schemes can involve SB employers inappropriately in the medical affairs of their injured workers[15]). Existing guidelines for judging compensation claims often did not contemplate the situation of SBs, leaving adjudicators to engage in improvised discretionary practices that could work for or against their own and the broader institution's interests. Idiosyncratic individualized arrangements, for example, can speed up and unblock the processing of files. However, they can also appear inequitable and be resisted by injured workers, which can undermine the front-line staff's ability to do their jobs and, more critically, the WSIB's efforts to maintain institutional political neutrality.

CONCLUSION

Drawing on existing upstream OHS research, our own empirical Canadian investigations and our collective research experience in small workplace health, the paper proposes the following:

- The "problem" of OHS in small workplaces does not just reside downstream in the attributes of the workplace or those who work there, but also upstream in the broader systems in which the workplaces are located.
- "Upstream" refers to broad contextual conditions influencing health and safety (changing labour market, economy, nature of work) and to the structure and functioning of the occupational health system (organization, philosophy, strategies, practices).
- Legislation, policy, organizational processes, interventions and service practices are, in many respects, misaligned with the character and context of small workplaces and their health and safety problems.
- Misalignments are located in formal, official sites (regulatory texts, procedural guidelines) and reproduced in the informal nooks and crannies of organizational process and service practices.
- Misalignments are both conceptual and ideological (assumptions, discursive constructions of the problem and players, dominant preoccupations and principles) and material (practical difficulties of fitting round pegs into square holes).

What are the implications of these conclusions for the promotion of health in small workplaces? How does one go about addressing upstream misalignments? We need to ensure that OHS legislation and policy take SB into account[37,42] and re-direct resources towards this sector. To achieve this we need to bring the problems of small workplace health into view, and generate the political commitment and financial motivation for them to be addressed. This is much more easily said than done. Where to begin?

We might start by developing an information system that gathers and analyzes OHS data by size of workplace (the significant role of data and indicators in the OHS field is discussed by Balka and Freilich[43]). This might help us develop a more compelling case – in health and in monetary terms – for addressing SB. Then, we could re-structure our policy and regulatory consultation processes to ensure that small workplaces are involved and that their voices are heard, respected and better positioned in what Becker has called the "hierarchy of credibility".[44]

The consultation process could be buttressed by an SB audit requirement (much like an environmental impact review) that pre-

scribes explicit assessment of the relevance of regulatory and policy interventions for small workplaces. Such an audit might even try to extend beyond the immediate impact and anticipate the new problems that so often lurk in the solutions. For instance, regulatory exemptions that have excluded small workplaces from system-level control have also deprived workers of the ability to exercise their rights in the system, and the formation of safety "mutuals" for Quebec SBs fostered more claims management than prevention and negatively affected employment relations and return to work.

Since the paper has flagged the conceptual dimension of upstream thinking, we might also reflect on a primary issue: the very idea of small business. How is this phenomenon conceived, what assumptions are we making, and how does the notion shape the way we define and address OHS problems? Are conceptions of SBs as "mom and pop operations" with insufficient managerial, motivational and economic resources accurate and realistic, or out of date and patronizing? Where are the workers in the notion of small business, a term that implicitly refers to the organization and employers, and assumes that interests of employers and workers are the same? Indeed, how useful is the concept of small business, given this weighting in favour of the employer/corporate dimension, the increasing diversity of organizational forms and social characteristics encompassed by it, and the observation that employers may not even think of themselves in such terms.[25]

In re-thinking our concepts and re-framing the structural context for promoting health in small workplaces, we might extend our upstream gaze to the global context. Emerging changes in trade, financial and labour markets, and in political and social systems have immense implications for the growing proportion of small workplaces around the world and for the OHS systems that strive to reduce occupational harm. Further, at a time of great economic upheaval and change in the public regard of large corporate enterprises, we might even find novel opportunities for creative advance of the upstream agenda for small workplace health and safety.

REFERENCES

1. Statistics Canada, Business Register, December 2004.
2. Lentz TJ, Wenzl TB. Small businesses with high fatality rates: Assessment of hazards and their prevention. *J Occup Environ Hygiene* 2006;3:D8-D14.
3. Eakin J, Lamm F, Limborg H. International perspective on the promotion of health and safety in small workplaces. In: Frick K, Langaa-Jensen P, Quinlan M, Wilthagen T (Eds), *Systematic Occupational Health and Safety Management: Perspectives on an International Development*. Oxford: Elsevier Science Ltd., 2000;227-47.
4. Walters D. *Work Safety in Small Enterprises in Europe: Toward a Sustainable System for Worker Participation and Representation*. Brussels: European Trade Union Confederation, 2002.
5. Dawson S, Willman P, Clinton A, Bamford M. *Safety at Work: The Limits of Self-Regulation*. Cambridge: University of Cambridge Press, 1988.
6. Antonsson A-B. A method to support small companies in improving their work environment: A manual for the plastics industry. *Ann Occup Hygiene* 1990;34:29-34.
7. Hasle P, Limborg HJ. A review of the literature on preventive occupational health and safety activities in small enterprises. *Ind Health* 2006;44:6-12.
8. Frick K, Jensen PL, Quinlan M, Wilthagen T. *Systematic Occupational Health and Safety Management: Perspectives on an International Development*. Oxford, UK: Elsevier Science Ltd., 2000.
9. Champoux D, Brun J-P. Occupational health and safety management in small size enterprises: An overview of the situation and avenues for intervention and research. *Safety Sci* 2003;41:301-18.
10. Frick K. Health and safety representation in small firms: A Swedish success under threat. In: Walters D, Nichols T (Eds), *Workplace Health and Safety – International Perspectives on Worker Representation*. Basingstoke: Palgrave Macmillan, 2009;154-67.
11. Walters D. Worker representation and health and safety in small enterprises in Europe. *Ind Relat J* 2004;35:169-86.

12. Antonsson A, Birgersdotter L, Bornberger-Dankvardt S. Small Enterprises in Sweden: Health and Safety and the Significance of Intermediaries in Preventive Health and Safety. Stockholm: National Institute for Working Life, 2002.
13. Lamm F. Small businesses and OHS advisors. *Br J Safety Sci* 1997;25:153-61.
14. McKinlay J. A case for refocusing upstream: The political economy of illness. In: Jaco EG (Ed), *Patients, Physicians, and Illness: A Sourcebook in Behavioral Science and Health.* New York, NY: Free Press, 1979;9-25.
15. Quinlan M. The impact of labour market restructuring on occupational health and safety in industrialised societies. *Econ Ind Democracy* 1999;20:427-60.
16. Mayhew C, Quinlan M. Subcontracting and occupational health and safety in the residential building industry. *Ind Relat J* 1997;28:192-205.
17. Mayhew C, Quinlan M. Outsourcing and Occupational Health and Safety: A Comparative Study of Factory-based and Outworkers in the Australian TCF Industry. Sydney, Australia: Industrial Relations Research Centre, 1997.
18. Dyhrberg MB, Jensen PL. Organizations in context: Proposal for a new theoretical approach in prescriptive accident research. *Safety Sci* 2004;42:961-77.
19. MacEachen E, Breslin C, Kyle N, Irvin E, Kosny A, Bigelow P, et al. Effectiveness and Implementation of Health and Safety in Small Enterprises. Toronto: Institute for Work & Health, 2008.
20. MacEachen E, Kosny A, Scott-Dixon K, Facey M, Chambers L, Breslin C, et al.; the Small Business Systematic Review Team. Workplace health understandings and processes in small businesses: A systematic review of the qualitative literature. *J Occup Rehab* 2010 Feb 7 (Epub ahead of print).
21. A Guide for Joint Health and Safety Committees (JHSCs) and Representatives in the Workplace. Ontario Ministry of Labour, 2002. Available at: http://www.labour.gov.on.ca/english/ hs/pubs/jhsc/index.php (Accessed February 10, 2009).
22. Wulfhorst B, Schobel K, Schwanitz HJ. Prevention of work-related skin diseases in hairdressers: First results. *Prev Rehab* 1996;8:22-28.
23. Niewohner J, Cox P, Garrard S, Pidgeon N. Evaluating the efficacy of a mental models approach for improving occupational chemical risk protection. *Risk Anal* 2004;24:349-61.
24. Walters D. Health and safety and trade union workplace representation: A case study in the printing industry. *Ind Relat J* 1987;18:40-49.
25. Eakin J. 'Leaving it up to the workers': Sociological perspective on the management of health and safety in small workplaces. *Int J Health Serv* 1992;22:689-704.
26. Aragon A, Aragon C, Thorn A. Pests, peasants and pesticides on the northern Nicaraguan Pacific plain. *Int J Occup Environ Health* 2001;7:295-302.
27. Eakin J, MacEachen E, Clarke J. 'Playing it smart' with return to work: Small workplace experience under Ontario's policy of self-reliance and early return. *Policy Pract Health Safety* 2003;1:19-42.
28. Laflamme L, Cloutier E. Working conditions and safety in forestry work. In: *Encyclopedia of Occupational Health and Safety,* 4th ed. Geneva: Bureau international du travail, 1997;68.32-68.35.
29. Walters D. Employee representation on health and safety in small enterprises. *Employee Relat* 1998;20:164-79.
30. Corneliusson F. The impact of regulations on firms: A case study of the biotech industry. *Law Policy* 2005;27:429-49.
31. Champoux D, Brun JP. Dispositions, capacités et pratiques de SST dans les petites entreprises : opinions de patrons, d'employés et d'intervenants en SST au Québec. *PISTES* (in press).
32. Walters D. *Health and Safety in Small Enterprises.* Brussels: P.I.E.-Peter Lang, 2001.
33. Walters D, Jensen PL. The discourses and purposes behind the development of the EU framework directive 89/391. In: Frick K, Jensen PL, Quinlan M, Wilthagen T (Eds), *Systematic Occupational Health and Safety Management.* Amsterdam: Pergamon, 2000;87-98.
34. Tucker E. *Working Disasters: The Politics of Recognition and Response.* Amityville, NY: Baywood Publishing, 2006.
35. Gollac M, Volkoff S. La santé au travail et ses masques. *Actes de la recherche en sciences sociales* 2006;163:5-17.
36. Hall A, Forrest A, Sears A, Carlan N. Making a difference. Knowledge, activism and worker representation in joint OHS committees. *Relations Industrielles* 2006;61:408-36.
37. Lamm F, Walters D. Regulating occupational health and safety in small businesses. In: Bluff L, Gunningham N, Johnstone R (Eds), *Occupational Health and Safety Regulation for a Changing World.* Sydney: The Federation Press, 2004.
38. Demarais L. Évaluation de l'implantation des comités de santé et de sécurité du travail : une étude de cas multiples réalisée dans les petites et moyennes entreprises au Québec. Montreal: Université de Québec à Montréal (UQAM), 2004.
39. Simard M. *Étude des Mécanismes de Prévention et de Participation en Santé-Sécurité du Travail au Canada.* Montreal: Commission de la santé et de la sécurité du travail (CSST), 2000.
40. Eakin J, MacEachen E, Mansfield E, Clarke J. The Logic of Practice: An Ethnographic Study of Front-line Service Work with Small Businesses in Ontario's Workplace Safety and Insurance Board. Toronto: Workplace Safety and Insurance Board, 2009.
41. Eakin J. The discourse of abuse in return-to-work: A hidden epidemic of suffering. In: Peterson C, Mayhew C (Eds), *Occupational Health and Safety: International Influences and the New Epidemics.* Amityville, NY: Baywood Publishing, 2005.
42. Ram M, Edwards P, Gilman M, Arrowsmith J. The dynamics of informality: Employment relations in small firms and the effects of regulatory change. *Work Employ Soc* 2001;15:845-61.
43. Balka E, Freilich J. Evaluating nurses' injury rates: Challenges associated with information technology and indicator content and design. *Policy Pract Health Safety* 2008;6:83-99.
44. Becker H. Whose side are we on? *Soc Probl* 1967;14:239-48.

RÉSUMÉ

Les risques à la santé et à la sécurité sont particuliers dans les établissements de petite taille, et les systèmes de sécurité et de santé au travail (SST) ont toujours du mal à joindre ces établissements. Dans cet article, nous présentons la SST dans les petits établissements selon une perspective « en amont » qui va au-delà des attributs de l'établissement et des personnes qui y travaillent.

Notre article est basé sur la synthèse d'idées et de résultats provenant de nouvelles études sur la SST adoptant une perspective « en amont », de nos propres recherches empiriques en Ontario et au Québec, et du cumul de notre expérience de recherche sur la santé dans les établissements de petite taille.

Les structures et les processus « en amont » (règlements, politiques, services, interventions, pratiques professionnelles) sont souvent décalés par rapport aux conditions de travail et aux relations sociales dans les petits établissements. Les facteurs clés ciblés par cette perspective incluent les exemptions réglementaires, la sous-traitance, les niveaux de syndicalisation, l'évolution de la petite entreprise, la codirection, les contraintes aux services et aux inspections, les objectifs institutionnels concurrents, l'orientation institutionnelle vers les grandes entreprises, et les services et les politiques inadaptés.

Le décalage du système de SST par rapport à la nature et aux réalités pratiques des établissements de petite taille peut nuire à la prévention et à la prise en charge des problèmes de santé et des blessures. Pour aborder ces décalages, notre article réclame : 1) une restructuration des processus de collecte de données et de consultation afin d'accroître la visibilité, la prise en compte et la crédibilité des petits établissements; 2) une évaluation de la capacité des lois, des politiques et des interventions de SST à prendre en compte les petits établissements; 3) une réflexion sur la terminologie et les concepts actuels qui rendent les travailleurs invisibles et qui ne reflètent pas adéquatement la nature et la diversité (croissante) de ces lieux de travail; et 4) une application très large de cette perspective « en amont » aux études en SST.

Mots clés : sciences sociales; agences gouvernementales; réglementation gouvernementale; gestion de la sécurité; petites entreprises