The Development of Worker-Controlled Occupational Health Centers in Canada

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Abstract: Over the past decade worker-controlled occupational health centers have been established in three Canadian provinces. This development has been a response to the slowness in recognizing occupational medicine in the Canadian medical community, the limited availability and questionable acceptability of existing services, as well as the growth of worker control in occupational health matters generally. The history, funding, organizational structure, personnel, resources, and programs of these worker-controlled centers are outlined, illustrating the extensive programs that can be provided despite small budgets of these operations. Advantages to workers include direct access to resources as well as expert professional advice with the focus on work place hazards. Furthermore, the centers provide for extensive interaction among workers on their common concerns. Disadvantages of the model include restricted access to work places associated with frequent distrust of employers. Employer-based and university-based models are compared to worker-controlled centers, and it is suggested that the latter may influence the pattern of practice of occupational health as well as the ability of workers and their unions to promote improved occupational health and safety conditions. (*Am J Public Health* 1988; 78:689–693.)

Introduction

The 1980s have witnessed a growing interest in alternatives to company-provided occupational health services. In the United States these alternatives have generally been established by providers themselves, usually through university and hospital based clinics[1] or "group practice" medical-industrial services.[2] In Europe government has tended to play a more direct role in setting up or otherwise supporting community-based multi-plant services.[3] This article documents the development in Canada of three labor-controlled occupational health centers (OHCs) and discusses the implications of this initiative.

Worker Control in Occupational Health

The concept of worker control in occupational health and safety is neither new nor unique to Canada. In some countries, workers have for many years had the right to refuse unsafe work, and worker health and safety committee members have even had powers to shut down operations if they believe a significant health hazard to be present. A review of legislation internationally reveals that worker participation, worker rights, and worker control in occupational health and safety matters have become increasingly entrenched.[4,5]

With respect to actual professional and technical occupational health services, legislation has been enacted in several European countries which acknowledges worker involvement in work place-based occupational health services as a matter of principle. In The Netherlands, France, Belgium, Denmark, and West Germany, legislation dictates that *the* occupational health service of the area or plant must have a specified proportion of worker control. This may take various forms—in the case of autonomous services, worker involvement is through health and safety committees, composed of at least 50 per cent worker representation. In Belgium, for example, workers have the authority to request environmental monitoring and receive copies of all reports. Dutch law states that the physician must cooperate and assist the works council, composed solely of worker representatives.[5] Italy's pervasive worker-based model for occupational health has had profound implications on that nation's occupational health system.[6]

In Canada, the right to know about the hazards of the work place is now enshrined in the Workplace Hazardous Materials Information System (WHMIS), which was proclaimed into law on June 30, 1987. Mandatory joint employer-employee health and safety committees and the right to refuse unsafe work are also incorporated in the legislation of all federal and provincial jurisdictions in Canada.

Throughout the 1980s, Canadian labor organizations have played a major role in educating their members about occupational health and safety hazards, with many provincial labor federations conducting courses and publishing regular health and safety newsletters. Union representatives have become adequately sophisticated about the issues in occupational disease and injury to competently handle the workers' compensation claims of their members. Some unions have taught their members enough about basic epidemiology to conduct their own health surveys in the work place, and workers now play a major role in designing full-scale research studies.[7] However, in only one Canadian province (Quebec) do workers have some direct legislated power over the selection of occupational health services (via joint worker-management committees).

In a US-based survey of occupational health services which were independent of employers, 72 centers were listed, only one of which was clearly and completely worker-controlled; 43 were hospital- or university-affiliated, one clinic was government-run and 28 were free standing.* Many of the university- or hospital-affiliated occupational health clinics are highly regarded by workers and their organizations and could well be considered "worker-oriented". In Canada, several university programs are in the process of developing such clinics and several community health centers across the country are also in the process of developing worker-oriented occupational health clinics.

The most significant development on the Canadian scene, however, has been the emergence of dedicated occupational health worker-controlled centers based in Ontario, Manitoba, and Alberta. While only the Manitoba center has a board of directors which is composed solely of labor

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* Mooser S: Occupational Medicine Clinic Survey. Presentation at the American Public Health Association 113th Annual Meeting in Anaheim, California, November 1984.

representatives, all three are distinct from other models of occupational health clinics in that they were established and controlled by workers' organizations. Although there have been some preliminary discussions in other Canadian provinces, the occupational health centers described here are the only three currently functioning worker-controlled occupational health clinics in the country, as this is written.

Reasons for Establishing Worker-Controlled OHCs

Alice Hamilton, a well-known pioneer in occupational health, lamented in 1910 that while industrial medicine was well-recognized in European medical sciences, this was not the case in the United States.[8] Recognition of this body of knowledge has been even slower in Canada. The Royal College of Physicians and Surgeons of Canada has only now formally accepted this specialty, with the first fellowship examinations scheduled for 1988.

Consequently, while some 25 per cent of the average person's time is spent in the work place, less than one-half a per cent of Canadian physicians have specialized knowledge in occupational health. Furthermore, in the vast majority of Canadian medical schools, like their American counterparts,[9,10] only a few hours of medical training are devoted to work-related factors in health. As a result of the poor availability of qualified occupational health personnel, faulty clinical and/or administrative advice is often provided.

Perhaps even more important than the general lack of expertise among physicians in matters of toxicology, industrial hygiene, and occupational epidemiology is the limited accessibility and questionable acceptability of occupational health services to workers due to the tendency for services to be established at the discretion of employers.

An employer-based occupational health service, in the final analysis, is generally evaluated by its contribution to the economic performance of the company.[11] This has tended to encourage the establishment of services only in the larger work places where services are seen to be cost-effective. Furthermore, as costs of work-related illness are only minimally borne in the short-run by employers, programs such as medical testing and emergency medical attention have tended to take precedence over health hazard evaluations which may more effectively address workers' concerns regarding the prevention of occupational disease. In this context, company physicians have also, consciously or otherwise, contributed to blaming occupational illness on those unfortunate enough to have become afflicted, referring to personal hygiene, life-style, or preexisting condition.[12]

Past practice of occupational physicians in Canada has led to the undeniable perception that the doctor serves the interest of the company's productivity over and above the interest of the workers' health.[13–15] Indeed, studies on company physicians have led to the conclusion that workers' views on this topic are often a good reflection of reality.[15]

*Emergence of the Workers' Clinics in Canada***

Unlike the US trade union movement which has been rapidly declining in political and economic power,[16] the Canadian union movement has been growing steadily, with more than 30 per cent of the work force now organized. In this context, it is not surprising that Canadian workers have demanded direct access to occupational health professionals, who could provide them with medical assessments and the expertise they need on the issues of their choosing.

History, Funding and Control

The first of the workers' clinics began in 1980, when the largest union local in Canada (United Steel Workers of America Local 1005 in Hamilton, Ontario) decided to fund its own occupational health clinic. A budget of $117,000 was drawn up, endorsed by the local membership, and the clinic opened its doors in 1981. Entirely funded by the one union local, rivalries within the local had repercussions on the clinic, eventually resulting in its closing. However, within a short time, other unions in the area combined with various community activists to reestablish the clinic which has since flourished and expanded to include satellite operations in Toronto, Sudbury, and Windsor, Ontario. Still not in receipt of government funding, the Ontario Workers' Health Center (OWHC) funds its operation (over $150,000/year) through union donations, work place hazard assessment contracts, and fee-for-service billings; its Windsor office is entirely funded by the Canadian Autoworkers.

The Manitoba Federation of Labor (MFL) resolved in 1981 to establish an occupational health center. Donations from unions totaled over $230,000. Unlike its Ontario counterpart, the social democratic government in Manitoba has been providing the MFL Occupational Health Center with its operating funds (almost $280,000 annually). Thus union donations are able to be allocated largely to maintaining and enhancing resources.

The Alberta Federation of Labor (AFL) Occupational Health Center was conceived at the AFL's 1982 convention but did not open until April 1987. It represents yet a third variation on the theme of worker-control. Like the MFL Clinic, it too was founded and funded by the umbrella provincial labor organization. However, as the Alberta government is much more conservative than its Manitoba counterpart, this center does not receive government funds. Funding for its $120,000 current operating budget is entirely from union donations, with $1 per capita per year pledged by the AFL affiliates at its last three conventions.

The Board of Directors of the Ontario Workers' Health Clinic, originally entirely from USWA Local 1005, now consists of various union officials, as well as community leaders, from organizations such as the National Action Committee on the Status of Women, injured workers' groups, and COSH groups. This differs from the Manitoba model in which the Board of Directors is controlled by the Manitoba Federation of Labor. Chaired by the president of the MFL, the 17-member Board has two representatives elected at the MFL convention and the MFL executive appoints the remainder from affiliates. An advisory council consisting of affiliates and non-affiliates, including the nurses association and the teachers association, is also appointed by and is represented on the Board. While the Alberta Occupational Health Center was founded and funded by The Alberta Federation of Labor, its Board of Directors is composed of community as well as labor representatives; the senior occupational medical consultant from the local university sits on the Board. Thus while all three centers are worker-controlled, they differ in the extent of control by official labor bodies and, perhaps consequently, in their degree of militancy, as noted below.

** Most of this information is from the author's first-hand experience as founding physician of the Hamilton Workers' Occupational Health Center in Ontario and, currently, as occupational physician at the Manitoba Federation of Labor Occupational Health Center.

Personnel, Resources and Programs

With the new structure of the Ontario Workers' Health Center, a longtime health and safety activist within the labor movement was hired as executive director. Medical services are provided on-site at all locations. The center's full-time staff consists entirely of non-professionals, and the center often situates its medical assessments in the context of a larger consciousness-raising experience for workers on the potential health affects of their work place conditions and their preventability. This is illustrated by the following examples:

- Over a hundred workers in a Toronto sewage plant were assessed in a health survey, the results of which are being used by the union to demonstrate that work-related conditions, not "malingering" as suggested by the employer, were responsible for a high rate of absenteeism found; it is also being used as a lever for promoting work place improvements.
- A highly publicized health hazard appraisal in an isocyanate-using plant resulted in some 40 compensation cases, the development of a training program, and a $70 million new ventilation system.
- All previous employees of an auto parts shop where there had been heavy asbestos exposure were offered medical assessments for asbestos effects. Two compensation cases for asbestos-induced lung cancer were allowed from that work force after a protracted struggle, and more claims are being filed.
- A health questionnaire was circulated to all Ontario rodmen to asses the extent of back problems in this branch of structural ironwork. Following a specially arranged mass meeting of the union membership, medical assessments were conducted, again with a view to finding potentially compensable cases and to promoting the establishment of a rehabilitation program for injured workers in this trade.

Such examples illustrate that while offering clinical services to individual workers, as do other occupational health clinics, the center's clear preference is to address work forces in a pro-active approach to stimulating health and safety improvements and/or changes to workers' compensation practices. This approach differs slightly from that of the MFL OHC in which the staffing reflects more of a conventional medical rather than advocacy focus. The original personnel consisted of an executive director, an administrative assistant/receptionist, a nurse-practitioner, and two physicians with specialized knowledge in occupational medicine. Two part-time physicians joined the staff and recently an occupational hygienist was hired as well. Despite its more traditional approach, several large work forces have been directly served by this center. For example, in one severe outbreak of "sick building syndrome" in which 95 per cent of a 55-person work force had clinical findings consistent with air quality problems, the entire work force was relocated out of the building based on the work of the center. Also, aside from the direct work of the center's staff, trade unionists often use the center's resources in their negotiations for health and safety improvements.

Perhaps because the Manitoba center is well endowed with a comprehensive occupational health library, as well as a computer hook-up to international data bases, it is seen as a major center of occupational health expertise for this small province with a population of only one million. Last year 287 information requests were processed ranging from how to test for health effects and how to set up an occupational health service, to legislative issues and control measures; and 50 educationals on occupational health topics were provided free of charge to groups of workers, labor organizations, college students, nursing and medical students, conferences, and professional associations. All individuals with concerns about their work place or who have developed possibly work-related health problems are accepted as patients with no charge. This includes management as well as employees, union as well as non-union. Although only roughly 30 per cent of the Manitoba work force is unionized, of the 245 new patients seen in 1986–87, 77 per cent were unionized workers. Thus clearly some sectors of the work force find the center more accessible than others. Also, despite the preference of the staff to focus on prevention activities, a large portion of the staff time revolves around individual workers' compensation claims.

The Alberta center has an executive director, an occupational health nurse, and an administrative assistant. Rather than conducting medical assessments on site, appointments are arranged with the local university-based occupational health clinic and the AFL OHC functions more as a resource and referral center than a medical clinic. While facilitating medical assessments, the staff focuses its attention on preparing resource material, conducting community educational programs, and aiding in providing health hazard advice to individuals and groups.

While these centers are all slightly different, they share some advantages and disadvantages compared to employer-based services and to university-based models.

Advantages of Worker-Controlled OHCs

In the traditional company-oriented approach, occupational health professionals often spend considerable time trying to reduce absenteeism or workers' compensation claims, through back programs or stricter fitness to work examinations.[15] Workers, however, may be more concerned with long-term hazards such as exposure to potential carcinogens in a work place. Unimpeded by the priorities and concerns of the employer, worker-controlled health centers can focus more directly on hazard evaluation and control. This advantage is not necessarily unique to worker-controlled centers, as illustrated by the finding that 88 per cent of the 40 clinics that responded to Mooser's survey of occupational health services which were independent of employers reported conducting work place hazard assessments.

Specific contrasts between the practices at employer-based and worker-based models are continually highlighted in Ontario. For example, the Ontario Workers' Health Center recently embarrassed one of Canada's major steel companies in documenting that two workers—one with occupational lung disease, the other with noise-induced hearing loss—had not been told of their findings despite years of medical testing. The Center demonstrated that this had been common practice in a local aircraft company as well. Not only were compensation claims subsequently allowed but the company physician also was charged before the College of Physicians and Surgeons (the disciplining body) for withholding medical information. Conversely, the Manitoba Occupational Health Center documented a clear violation of medical confidentiality at one of the lead-using plants in the province. The company "controlled" its lead problem by laying off workers with high lead levels, upon the company doctor's notification. Again, compensation claims were allowed and the physician

involved was called before the disciplining body. Seventeen examples of what were felt to be questionable health and safety practices were documented by the OWHC in a brief to a commission investigating health and safety in Ontario.*** This type of controversy, in which there is a systematic attempt to document failure of employer-based services is generally shunned in university settings, where often great pains are taken to try to remain "neutral" and avoid publicly embarrassing corporations or professional colleagues.

A second advantage of these worker-controlled centers from the worker's perspective is that these centers are designed specifically to allow for time, energy, and multidisciplinary expertise needed to educate workers about hazards, control measures, and their rights under the law. In contrast, the medical model occupational program widely found in industry tends to stress measures which physicians are more readily capable of implementing. Ten of the university-based clinics surveyed by Mooser have occupational hygienists on staff but rarely are able to devote substantial efforts to worker educationals and advocacy (only four of the clinics in Mooser's survey employed health educators).

Third, and most important, workers see these centers as their own and trust the professional advice provided. As many Canadian labor movement activists are distrustful of academics, there has been greater reluctance in Canada for labor to embrace the university-based model. In contrast to the Italian worker-based model,[6] Canadian centers have not (at least as yet) created tensions between workers and experts. Also, unlike the Italian experience,[6] the diversity of workers involved enhanced rather than reduces the center's collective ability to identity and address common occupational health problems.

From the point of view of the professional, advantages included the fact that tasks are varied—some clinical, some research and education—and include the broader preventive approach. In addition, like the Italian movement,[6] for young physicians who had become activists in the late 1960s and 1970s, these centers provide a direct link to the workers' movement for social change.

Disadvantages of Worker-Controlled OHCs

As with any model, there are some distinct disadvantages. For example, the law, in most Canadian jurisdictions, does not obligate companies to provide access to the work place to "third parties", such as the personnel from these centers. Enlightened management often will allow touring of the plant, but this is at their discretion. Therefore preventive recommendations could be restricted by being based only on verbal and written information provided, at least until the law is amended, as it has been in Quebec, to allow workers to bring in experts of their choice.

Second, it is very difficult for one center to properly serve an entire city or province. In reality, only a few work places get the attention, and this is not systematic. Although some elements from these centers can be generalized, the model itself would require considerable modifications to serve the entire work force.

Third, some companies do prefer, or are legally required, to hire their own doctors, e.g., in lead-using plants, there will be a company doctor monitoring blood lead levels. Workers from these plants, however, may come to the workers' clinics as well, potentially leading to duplication and conflicting medical advice. In fact, in Manitoba, workers regularly present to the MFL OHC with symptomatic lead poisoning, elevated enzymes, and high blood leads, having been told by the company doctor that all they need is to switch to a lower lead area in the plant. The MFL OHC physicians, on assessing the individual and plant hygiene reports, may recommend workers' compensation instead, thereby creating antagonism between professionals and confusion for the worker. Whereas the advocacy orientation is an advantage from the viewpoint of the labor movement, the acrimony with which it is associated may be a disadvantage from the perspective of the professional as well as the individual client.

Finally, and most important, although the professionals working in these centers have generally earned the respect of their colleagues, the Workers' Compensation Boards and many companies do not generally trust them. In Ontario, where legislation obligates employers to pay for certain medical tests conducted by the physician of the worker's choice, some companies have refused payment when the worker selected the OWHC, resulting in court battles. Occupational health nurses from a few plants in Manitoba have been reprimanded by management for referring workers to these centers, and there are some consultants who will not accept referrals from them, presumably for ideological reasons. University-based centers are, at least theoretically, less prone to this problem, and many health professionals prefer university affiliation as a symbol of scientific objectivity.

Implications for the Future

There is some evidence that worker-controlled occupational health centers may be having a substantial impact in the Canadian occupational health community. This is reflected by numerous government advisory committee reports, discussion papers, and conferences addressing ethical and organizational issues in occupational health services in this country. For example, an Ontario task force on health surveillance in occupational health programs explored the concept of workers selecting plant physicians[17]; organization of occupational health services was the major theme in the 1986 annual convention of the Canadian Occupational Health Association, with the role of workers' clinics specifically addressed; the concept of worker-control was also discussed in a Manitoba government study on occupational health services. Physicians who work for companies now know that they can not be flippant with their remarks and advice, because an expert second opinion is waiting in the wings.

As some companies continue to resist meaningful worker input into the occupational health services they use, an adversarial relationship has and will continue to build up. Nevertheless, employers' monopoly over occupational health services has been challenged, creating pressures for greater sensitivity among existing services and encouraging the development of "independent" alternatives, such as the university-based model and other community-based models. It is noteworthy in this context that in 1987 the Ontario government decided to fund its first occupational health program in a community clinic.

The extent to which labor control can exist in an occupational health service can vary greatly from joint control (as theoretically exists in Quebec and several European countries), to majority worker control (along the Swedish model), to worker-oriented labor and community boards (as is the current Ontario center), to complete government-

*** Gray S: Brief to the Laskin Inquiry on Health and Safety in Ontario. Presented to Cooper/Lybrand by S. Gray, Director, Ontario Workers' Health Center, Hamilton, Ontario, 1986.

funded labor-controlled centers as is the MFL center. With respect to professional staff, worker-oriented centers can employ their own physicians, as does the MFL OHC; they could contract local physicians, as does the OWHC; or they can establish an affiliation agreement with a university and utilize university personnel, as the AFL OHC is attempting to do.

There is no single model that can apply everywhere. Perhaps a mix of models may be required. In Canada, labor established its own clinics precisely because the concerns of workers have not been adequately accommodated by employer-controlled health services. Workers' priorities differ from those of employers, and Canada's unions have increasingly valued direct access to occupational health resources as well as sympathetic clinical expertise. The importance of worker-controlled occupational health centers goes beyond the new type of service they offer workers. As an effective challenge to the hegemony of employer-provided services, these centers are playing a large role in altering the pattern of occupational health practice in Canada.

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