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**The Royal Australasian College of
Physicians' submission to
Education and Workforce
Committee on Health and Safety at
Work Amendment Bill**

Introduction

The Royal Australasian College of Physicians (RACP), including specialists in Occupational and Environmental Medicine, welcomes the opportunity to comment on the [Health and Safety at Work Amendment Bill](#).

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that support healthcare and promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

Occupational and Environmental Medicine specialists work at the interface of clinical medicine, workplace risk assessment, and regulatory systems. Work-related illness represents a major but often under-recognised public health issue. In Aotearoa New Zealand, the **majority of work-related harm arises from cumulative occupational exposures rather than acute incidents**. A worker is **15 times more likely to die from a work-related disease** than from a workplace accident. For example, the annual deaths from asbestos-related disease alone (200–250 deaths per year) substantially exceeds the number of acute workplace fatalities (approximately 54–81 per year)^{1,2}.

Executive summary

The Health and Safety at Work Amendment Bill (the Bill) makes amendments to the Health and Safety at Work Act 2015 and seeks to clarify legal definitions of serious work-related illness, surveillance expectations, regulatory standards and the role of medical expertise in workplace health governance.

The proposed amendments are significant, as they influence how serious work-related illness is defined, how health hazards are monitored and reported, and the role of medical expertise in workplace health governance.

The RACP supports efforts to strengthen prevention of serious work-related harm. However, aspects of the Bill risk unintentionally narrowing regulatory attention toward acute catastrophic events rather than the much larger burden of occupational disease caused by cumulative workplace exposures.

Occupational disease prevention requires anticipatory regulation. If the Bill shifts attention to what is visible and dramatic, it will miss what is common and costly. That would be a regression in worker health protection.

¹ WorkSafe. Work-related health data sheet [internet]. Wellington: WorkSafe. Available from [Work-related health | WorkSafe](#). Downloaded on 16 March 2026.

² WorkSafe. Work health and Safety. An Overview of Work-Related Harm and Risk. Wellington: WorkSafe, June 2024. Available from: [WKS-17-work-health-and-safety-overview-of-work-related-harm-risk-new-zealand-dashboard \(2\).pdf](#). Downloaded on 16 March 2026.

An Occupational and Environmental Medicine approach reduces illness and injury by preventing hazards and managing health issues early. This lowers medical and compensation costs, cuts absenteeism, and reduces long-duration claims. Effective monitoring, early intervention, and tailored return-to-work plans help workers recover faster and stay productive.

Aotearoa New Zealand data shows rising treatment and rehabilitation costs. A recent Accident Compensation Corporation (ACC) report shows that in the past 20 years since 2004, the costs of supporting New Zealanders with injury have climbed from just under \$1 billion to nearly \$4.4 billion in 2024, highlighting the financial importance of preventing avoidable injuries and intervening early³.

Recommendations

To ensure the Health and Safety at Work Amendment Bill strengthens prevention of occupational illness as well as injury and ensures worker safety, the RACP recommends the Education and Workforce Committee consider the following amendments:

1. Explicitly include **cumulative and long-latency harm within “critical risk”**.
2. Ensure **notification thresholds capture serious occupational illness** at an early stage, rather than only after acute hospitalisation or permanent disability.
3. Provide **clearer recognition of psychosocial hazards** and expectations for systematic workplace risk management.
4. Ensure **provisions for small PCBUs do not weaken substantive health protections**, including exposure monitoring and health surveillance.
5. Embed **specialist occupational medical expertise** in the development of Approved Codes of Practice processes.
6. Undertake an **explicit equity impact assessment** to ensure reforms do not exacerbate occupational health inequities.
7. Provide **supports** for increased clinical demand.

Key Points

1. Explicitly include cumulative and long-latency harm within “critical risk”

The proposed definition of “critical risk” appears weighted toward acute, catastrophic harm. While these risks must be addressed, most work-related harms arise from chronic exposures over time.

In Aotearoa New Zealand, significant contributors to occupational disease occur from sub-threshold, repeated exposures over years and include:

- chronic exposure to respirable crystalline silica
- asbestos-related disease
- noise-induced hearing loss
- solvent and welding fume neurotoxicity

³ Accident Compensation Corporation (ACC). Te Kaporeihana Āwhina Hunga Whara. Injuries in New Zealand [internet]. Wellington: ACC, 2024. Available from [Injuries-in-New-Zealand-2024.pdf](#) Downloaded on 11 March 2026.

- work-related musculoskeletal disorders
- psychosocial injury and stress-mediated disease⁴.

If “critical risk” becomes the organising concept for compliance prioritisation, without explicitly including cumulative harm there is a real danger that:

- chronic exposure management will be deprioritised
- health surveillance will decline
- investment will shift toward visible safety controls rather than exposure control
- PCBUs will focus on catastrophic injury metrics rather than occupational disease prevention.

The legislation should therefore explicitly confirm that “**critical risk**” includes **foreseeable cumulative and long-latency exposure to hazardous agents**, including chemical, biological, physical and psychosocial hazards.

2. Ensure notification thresholds capture serious occupational illness at an early stage

The Bill proposes changes to notification thresholds for serious injury and illness. Changes to notification thresholds should reflect the clinical realities of occupational disease.

If notification is limited to acute hospitalisation or immediate incapacity, the majority of work-related illness will not be captured.

Serious occupational illness can include conditions such as:

- accelerated silicosis detected radiologically before respiratory failure
- occupational asthma confirmed by spirometry and exposure correlation
- significant lead absorption
- work-related mental injury with functional impairment
- noise-induced hearing loss exceeding baseline shifts⁴.

Waiting until hospitalisation or permanent disability occurs before triggering notification undermines prevention and reinforces the longstanding problem of under-reporting of occupational disease.

A more appropriate threshold would include notification where there is:

- diagnosed occupational disease with demonstrable impairment
- biological monitoring exceeding action limits
- confirmed work-related mental injury requiring treatment and time off work.

Early detection and reporting is essential for preventing further harm to workers and for identifying hazardous workplaces. Otherwise, the system incentivises late detection.

3. Provide clearer recognition of psychosocial hazards

⁴ WorkSafe. Mahi Haumarū. Aotearoa. Work health and safety. An overview of work-related harm and risk in Aotearoa NZ. [internet]. Wellington: WorkSafe, June 2024. Available from: [WKS-17-work-health-and-safety-overview-of-work-related-harm-risk-new-zealand-report-v2.pdf](#) Downloaded on 10 March 2026.

Contemporary occupational medicine includes mental health as a legitimate work-related harm. There remains insufficient operational clarity around psychosocial hazards. The risks include:

- bullying and harassment
- excessive workload and job strain
- low job control
- traumatic exposure
- shift-related circadian disruption⁵.

These are not abstract wellbeing concepts. These risks are associated with a range of health outcomes including depression, cardiovascular disease, metabolic dysfunction, and increased risk of injury.

The Bill would benefit from greater clarity that psychosocial hazards are recognised as workplace hazards under the Health and Safety at Work Act, and that risk management should involve systematic organisational controls rather than solely individual resilience approaches. Without clear expectations, enforcement is likely to remain inconsistent and reactive.

Psychosocial injury is already a major contributor to ACC mental injury claims. Ambiguity will not reduce liability, only shift it downstream.

4. Ensure provisions for small PCBUs do not weaken substantive health protections

The Bill proposes adjustments intended to reduce compliance burdens for small PCBUs. While administrative proportionality may be appropriate, substantive health protections should not be weakened. Tailoring obligations for small PCBUs introduces predictable risk.

Smaller businesses:

- often lack internal health and safety expertise
- rarely have structured exposure monitoring
- underutilise occupational health services
- may rely on informal controls.

At the same time, many high-risk industries consist primarily of small businesses. For example, a small, engineered stone workshop can present the same risk of silica exposure as a large manufacturing operation. Occupational disease risk does not scale with company size.

If compliance thresholds are relaxed, health hazards that require technical understanding, such as airborne contaminants, solvent exposure, or ergonomic risk, are likely to be under-recognised.

Any proportionality provisions should therefore apply to administrative requirements rather than to exposure standards, hazard identification, or health surveillance obligations.

⁵ Safe Work Australia. Managing Psychosocial Risks at Work. Code of Practice [internet]. Canberra: Safe Work Australia, July 2022. Available from: [model code of practice - managing psychosocial hazards at work 25082022_0.pdf](#)
Downloaded on 11 March 2026.

5. Embed specialist occupational medical expertise in the development of Approved Codes of Practice processes.

Approved Codes of Practice (ACOPs) play a critical role in translating legislation into practical guidance. ACOP development processes should formally embed specialist occupational medicine input. Occupational disease prevention requires integration of **clinical, epidemiological and exposure science expertise**. Without this, Approved Codes of Practice risk focusing primarily on injury prevention rather than disease prevention.

The RACP recommends that ACOP development processes formally include specialist occupational medicine expertise, particularly where health hazards are involved. This should include:

- participation by vocationally registered occupational physicians
- formal consultation with the Australasian Faculty of Occupational and Environmental Medicine
- clear epidemiological review underpinning exposure thresholds
- explicit reference to health surveillance standards.

ACOPs currently rely heavily on engineering and safety disciplines. While these perspectives are essential, effective management of occupational disease also requires clinical expertise in exposure-health relationships and disease prevention. Health risk assessment requires applied clinical and toxicological expertise grounded in real-world workplace exposure assessment, including occupational physicians who regularly attend worksites and understand operational controls, not solely those practising in report-based or retrospective roles. ACOPs shape real-world practice and enforcement; clinical credibility is essential.

6. Undertake an explicit equity impact assessment

There is substantial evidence in Aotearoa New Zealand that workers from lower socio-economic groups and certain ethnic groups (particularly Māori and Pacific peoples) experience higher rates of work-related injury and occupational harm, for example in construction, forestry, manufacturing, transport and primary industries. These sectors carry elevated exposure to:

- dust and silica
- noise
- vibration
- fatigue and shift work
- traumatic injury.

Māori workers are overrepresented in primary industries, manufacturing and construction, and Māori comprise around one-third of the forestry workforce and nearly half of logging workers. As a result, occupational disease contributes to existing health inequities, including higher rates of chronic respiratory disease, hearing impairment, mental health impacts and earlier cardiovascular morbidity. While Pasifika-specific data varies by industry, Pacific peoples are strongly represented in parts of the primary sector workforce, including roles such as fruit picking, which have also grown rapidly

over time and often involve physically demanding, high-risk conditions^{6,7,8,9}. For workers from the Asian sub-continent and Asia-Pacific, the evidence is more complex because injury rates appear lower in official statistics but may be under-reported due to structural barriers such as language barriers, fear of job loss and limited knowledge of ACC rights¹⁰. There are also significant equity implications for casual gig economy workers, who are often concentrated in insecure, higher-exposure roles with limited bargaining power and reduced access to health surveillance or early occupational disease detection.

If the Amendment Bill inadvertently narrows focus to acute critical events, the cumulative disease burden will disproportionately affect these workers. Dilution of chronic risk management would widen health inequities. Reforms to workplace health legislation should seek to reduce these inequities rather than inadvertently widening them.

7. Provide supports for increased clinical demand

Changes to regulatory definition and notification thresholds may increase demand for specialist occupational medicine expertise, including:

- expert determination of whether illness meets “critical risk” criteria
- causation opinions
- medico-legal reporting
- independent assessments in disputed cases.

If definitions remain unclear, medicine specialists may be required to interpret legislative thresholds in clinical practice, potentially increasing demand on the workforce to provide threshold interpretation, advise on notification decisions and provide complex medico-legal exposure-health condition causality analysis and opinions.

To support the Amendments proposals implementation should therefore include:

- clear guidance documents for occupational health practitioners, GPs, Occupational Medicine Specialists and other doctors working in occupational health
- clear guidance for hospital specialists who encounter occupational health diseases, such as respiratory, oncology, dermatology, immunology medicine specialists
- training on revised notification obligations

⁶ Ministry of Business Innovation and Employment (MBIE). Hīkina Whakatutuki. Māori Workers [internet]. Wellington: MBIE. Available from: [Maori workers](#). Downloaded on 9 March 2026.

⁷ Muka Tangata Workforce Development Council. Occupational Insights [internet]. Wellington: Muka Tangata Workforce Development Council; 28 July, 2025. Available from: [Occupational insights - Muka Tangata](#). Downloaded on 9 March 2026.

⁸ Business and Economic Research Limited (BERL). The Future Māori Workforce – Part Four [internet]. Wellington: BERL. Future Māori Workforce; 22 November, 2019. Available from: Downloaded on 9 March 2026.

⁹ Muka Tangata Workforce Development Council. Forestry Workforce Demographics [internet]. Wellington: Muka Tangata Workforce Development Council; 5 May, 2025. Available from [Workforce Demographics » Muka Tangata Workforce Development Council](#). Downloaded on 9 March 2026.

¹⁰ Superdiversity Institute for Law, Policy and Business. Health and safety regulators in a superdiverse context: review of challenges and lessons from New Zealand and overseas [internet]. Auckland: Superdiversity Institute for Law, Policy and Business; 2018. Available from: <https://www.maichen.nz/wp-content/uploads/superdiversity-institute-worksafe-report-dec-2018.pdf>

- clear reporting pathways.

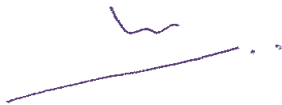
Without these supports, reporting practices are likely to vary across sectors and regions.

The government, Health NZ and ACC need to strengthen support for the training and recruitment of Occupational Medicine specialists to ensure a sustainable workforce.

Aotearoa New Zealand also urgently requires mandatory reporting and national registries for critical occupational diseases, similar to systems used internationally such as NORDR in Australia and THOR/SWORD in the UK, to support surveillance, tracking and prevention.

Conclusion

The RACP thanks the Education and Workforce Committee for the opportunity to provide feedback on this consultation. To discuss this submission further, please contact Di Cookson, Manager Policy & Advocacy, Aotearoa New Zealand at policy@racp.org.nz.



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