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Alexander J. Matejko

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ownership is more effective than indirect ownership; administration of the plan must be fair and clearly spelled out; gains sharing should not serve as a substitute of good pay; there should be enough opportunity for employees to increase their involvement; training of managers and supervisors in participation is required; implementation of innovation has to be carefully analysed and corrected whenever necessary (pp. 33-34). At all levels of the organizational hierarchy participation should be welcomed, but the specificity of a given level has to be taken into consideration. Equity sharing as well as gain sharing both are needed.

Alexander J. MATEJKO

University of Alberta

Employment Injuries and Occupational Illnesses 1972-1981 (including preliminary data for 1982), prepared by Jim Wong, Ottawa, Minister of Supply and Services Canada, 1984, pp. XV + 134, ISBN 0-662-53002-0

Injuries and illnesses take away a considerable value, in addition to suffering. The number of work days lost due to work injuries and occupational deceases has grown in the period 1972-1982 from 10 million to 15,4 million in comparison with respectively 8 million and 6 million of person days lost due to strikes and lockouts. In addition, in the first case we do not have the exact numbers; the real injury and fatality incidence rates may be understated up to 20 percent.

In terms of the total worktime, the loss due to injuries and deceases has grown in the period 1972-1981 from 0.6 percent to 0.8 percent when the loss on work stoppages has remained at the level of 0.4 percent (0.2 percent in 1983 and 0.25 percent in 1982). It is clear from these basic data that work stoppages may be more spectacular but injuries and deceases are actually much more harmful.

If taking arbitrarily the ratio 1:5 of direct to indirect cost (failure to meet customer demands, lower employee morale, decreased efficiency, lost supervisory time, etc.) in the period 1972-1981 the loss in GNP due to injuries and illnesses has grown from 2.4 percent to 3.4 percent ($ 11,4 billion in 1981). The benefit payments have grown in the period 1972-1981 per $ 100 payroll from 0.68 to 0.92, in current dollars totally from 368 millions to 1,627 millions (in 1982, 1,966 millions). In the period 1971-1981 the actual increase of compensation (in 1971 dollars) was 7 percent. A half of compensation goes to pay for wage loss, 29 percent goes to pensions and the rest to medical aid expenses.

A half of all reported injuries are disabling. One third of all injuries result from striking against or being struck by objects. Close to another one third arise from overexertion of bodily reaction. About 20 percent result from falls on the same or to a different level. 25 percent occur to the hand or finger; about 20 percent occur to the back or spinal cord. Most of accidents happen in services (31 percent), manufacturing (20 percent) and trade (17 percent); the fatality rates are highest in fishing (147 cases per 100,000 workers), forestry (91 cases per 100,000 workers), mining (71 cases per 100,000 workers) and construction (37 cases per 100,000 workers).

There is an obvious need in Canada of the effective preventive measures. Employers should have more vested interest in this prevention instead of shifting the main burden on the taxpayers. In the period 1972-1981 the real increase of funds allocated to prevention was 61 percent but much more has to be done. First of all, a close cooperation between trade unions and employers is needed in this field; much may be learned in this respect from Sweden. Secondly, management has to be better trained in the accident and sickness prevention in order to provide a much better ground for an effective administration of human resources.

The statistical study here under review is a very useful source of information. At the same time it shows the limits of our current collection of data. We should know at least something who actually is responsible for a given accident. Comparison with other countries should be made possible by paying more

concern for the common basis of data. Actual gravity of injuries and illnesses has to be evaluated. In order to develop adequate prevention policies it is necessary to have a much more analytical statistical basis, and this actually should be expected at the federal level.

Alexander J. MATEJKO

University of Alberta

The Working Conditions in Canadian Hospitals. Constrains and Opportunities, by Joan Kahn & William A. Westley, Ottawa: Minister of Supply and Services Canada, 1984, pp. XV + 112. ISBN 0-662-52924-3

Hospitals need to redesign their work systems in order to improve the motivation of the personnel and make the organization more responsible to change. The survey of 392 hospitals across Canada done in the Spring of 1983 concentrated on the leading personnel: directors of nursing, personnel directors, and union representatives. They were asked about professional nurses, remaining nurses, medical support staff and non-medical support staff.

Taking the perspective of the last three years, the adherence ot recommended work standards has increased quite often among the nurses, but rarely among the support staff. In around one fourth of cases willingness of nurses to help co-workers and supervisors has decreased (much more often in the teaching hospitals than in the non-teaching hospitals). Willingness to follow directives of co-workers and supervisors has decreased among professional nurses in one fifth of cases and among non-medical support personnel in one fourth of cases (again more common in teaching hospitals). Willingness to assume responsibility has decreased in one fourth of cases in all categories except among the medical support staff. Willingness to perform duties not specifically part of one's job description has diminished among three fifth of cases regarding the professional nurses, a half of cases regarding non-professional nursing staff and non-medical support staff, and among one third of cases regarding the medical support staff. Willingness to work overtime has declined in 30 percent of cases regarding the nursing personnel and the non-medical support staff, and in 20 percent of cases regarding the medical support staff.

It is significant that in all the above mentioned cases the work morale of the non-medical support staff was much worse in the teaching hospitals in comparison with the non-teaching hospitals. According to the authors, «such evidence of stress is not surprising, since teaching hospitals must be most responsive to change, to new developments in technology, and to community demands» (pp. 15-16). In the areas where there are no norms of professional behaviour a decrease has been reported in the general willingness to work towards organizational goals. However, even among the professional personnel, the level of organizational commitment is far from being satisfactory.

The expectations of the hospital personnel are growing. Over a half of union officers acknowledged the often complaints of the workers about the lack of opportunity to make decisions and the lack of opportunity for advancement. The same was valid for two fifths of union officers regarding the lack of opportunity to learn new skills. Only one fifth of union officers never had complaints about the lack of mutual respect and support among co-workers. Among the non-medical support staff, the frequency of such complaints seems to rise with an increase in the size of the city in which the hospital is located. One fifth of the union officers acknowledged often complaints about boredom with their jobs, as well as about the lack of meaningfulness of their tasks. With an increase in hospital size, an increase was found in the percentage of directors of nursing who reported complaints by professional nurses about boredom of their jobs.

According to the survey data, there is definitely the growth of sick leave absenteeism, complaints about the quality of