"Re-Braining" Corporate Safety & Health

IT'S TIME TO THINK AGAIN!

By Larry L. Hansen

IF THE BUSINESS SAGES ARE CORRECT, corporate America has but five short years to complete its transformation in order to meet the challenges of the new millennium. Based on progress to date, it appears the hardest challenges are yet to come.

Efforts to re-engineer, automate, computerize, downsize and restructure the corporation have not produced the productivity gains envisioned. In fact, results have been far from stellar. Computerization has not significantly increased white-collar productivity, while downsizing has, in some cases, lowered productivity. One must wonder (as did Peter Drucker): Is doing things "righter" really the answer?

These efforts, focused on structure, overlook the true source of productivity: people. The new frontier for productivity enhancement is "re-braining" the organization—a shift to doing right things right!

Re-braining safety requires a major shift in current beliefs about what drives safety performance. The challenge is set forth here, and 12 guiding principles that will drive the process are discussed.

"We cannot expect someone who works for an insurance company to give advice on the use of their products and services to solve our workers' compensation problems. That's a lot like following free advice on hen house security from the Red Fox Alarm Co." —Brent Winans

Such is the voiced opinion of one enlightened risk manager and likely the silent perception of many. With losses and insurance costs continuing to escalate as senior managers focus on "re-engineering the corporation," the heat is on to stop the bleeding. This heightened priority has exposed numerous realities; everything is open to review.

Questioning Convention

Risk managers are questioning the conventional wisdom of traditional safety philosophies. Based on the "hard-number" evidence, these questions are valid. Insurers and insureds alike have misdiagnosed and ignored opportunities to alter lackluster results produced by the current safety paradigm. Business remains loyal to the status quo, content in following prescribed ways and complacent in "doing things right."

Price Prichett, an organizational change consultant, cautions that in times such as these: "The need for change is most evident [in] the results produced by people doing the wrong things flawlessly." He contends that organizations must "face reality; do what works." With the nation's output of "human scrap" (workers' compensation; WC) approaching $60 billion, it is clearly time to "think" again.

Karl Albrecht (1992) says: When one starts with wrong assumptions, applies quick-fix reasoning, then delegates to a committee, it is hard to arrive at sound conclusions. Yet, this is the typical approach in

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FROM THE ARCHIVES

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The safety profession continues to evolve as its practitioners adapt to the changing world of work and business, apply advancements in science and technology, and respond to world events. Yet, regardless of the era, safety professionals consistently demonstrate strong dedication to making the world a safer, healthier place.

This article from the 1995 *Professional Safety* archives challenged readers to shift from the mindset of perceiving people as the problem to recognizing process as the problem.

safety. "Success ultimately depends on the assumptions from which you work; if they are wrong to start with, it doesn't really matter what you do" (Koln, 1993).

The message is clear. The future belongs to those willing to question current ways of doing business, abandon existing mindsets and break the rules that bind business to the past.

Separating Myth From Reality

When "Safety for (R)evolution" was published (*PSJ*, March 1993, pp. 16-21), some recognized its challenge as radical and these people should be applauded. Why? 1. They are "thinkers"' they care enough about the future to participate in it; 2. They are "risk takers" (an uncommon breed in today's organizations).

If radical means being willing to ignore "prevailing wisdom" in favor of seeking the "uncommon logic," and if revolutionary means a willingness to "question traditional ways" rather than "blindly accept the status quo," then, without question, I am all of these and more. The truth is: "There are no legitimate theories for success, there are only actions: highly intelligent, not so bright and absolutely stupid. The common theme among all that are highly intelligent is that 'they work'" (Heller, 1985).

It is time to separate myth from reality. Safety and health practitioners need to abandon the prevailing (but false) wisdom of tradition in favor of the "uncommon logic" of success. This necessitates a shift in premise from:

People as the problem. "Accidents are the result of unsafe employee acts and behavior."

To the "uncommon logic" that the:

Process is the problem. "Accidents are the result of flawed management values, decisions and practices." This represents a difficult change for many, and will be strongly opposed by those heavily vested in tradition. However, as paradigm pioneer Joel Barker proclaims: "Those who say it can't be done need get out of the way of those who are doing it."

Following are 12 guiding principles that will drive the re-braining of Safety 2000: Success Via the Uncommon Logic.

No. 1: It's In the Organization

Prevailing wisdom: If a company has escalating WC costs, it definitely needs to implement a safety program.

Uncommon logic: If a company has escalating WC costs, it most likely has organizational problems that no safety program will fix.

In the late 1970s, Alex Cohen, Robert Cleveland and Harvey Cohen conducted a series of studies to identify practices that equal good and poor safety results. They studied two issues: traditional safety elements and basic management competencies. Results clearly indicated that implementation of traditional safety programs had minimal impact on accident rates.

These organizations were also examined from the standpoint of basic management competencies (i.e., planning, efficiency, budgeting, quality of supervision, communication and employee relations). Based on these criteria, accident rates were differentiated and stratified. The key finding: Companies that effectively managed core business processes produced superior safety results.

These studies reveal a core problem with traditional safety: Safety is perceived only as a "program" and is typically a "staff responsibility." To succeed, safety must belong to line management. American Spring & Wire Corp., Bedford Heights, OH, has recently achieved a significant turnaround in its WC losses. When asked to identify the key driver of this turn-around, Jim McDonald, company vice president, concluded, "I learned that to solve a safety problem, you need to approach it thinking 'I'm to blame . . . no one else'" (Avers, 1994).

"Success takes more thinking; failure takes more time."
—Hank Sarkis

"We're running out of time!"
—L.L. Hansen

No. 2: Build Positive Employee Relations

Prevailing wisdom: Employee accidents drive WC costs.

Uncommon logic: Employee claims drive WC costs. People frequently confuse accidents with claims. They are not, in fact, one in the same; one costs large amounts of money!

Traditionally, the insurance industry has built an incurred-but-not-reported (IBNR) factor into loss reserving practices. This charge funds losses that have occurred, but have yet to be "claimed" because of a delay in either injury manifestation or reporting. Today, a new phenomenon exists: reported-but-not-incurred (RBNI). It, too, is a charge embedded in WC costs; in this case, however, the employer determines the amount.

Dennis Brooks, president of Comp Management Inc., Long Beach, CA, believes all businesses need a "claim deterrent process (CDP)," a strategy that goes beyond accidents to address their ultimate outcome claims.

Claims (the dollar value of accidents) are (to a large extent) subjective, a matter of employee perception and attitude. Employees involved in accidents often sustain injuries that may, or may not, lead to a claim. The decision to file a claim, lose time, extend leave or return to work, and the ultimate degree of residual disability, are choices employees make based on their perception of the organization and its management. "Why do some workers remain on the job while others with similar ailments file for workers' compensation?" asks Presley Reed, psychiatrist and occupational health consultant. "Because," he suggests, "disability is as much a state of mind as it is a state of body."

Human resource practices offer great opportunity to shape attitudes and reduce WC "claim costs." When a company fails to build positive employee relationships, it simply fuels the "claim development process."

"If you're running your business right, people are going to stop throwing hand grenades."
—Ed Walsh

No. 3: Just Because It's Traditional . . .

Prevailing wisdom: Traditional safety programs are valid and well-founded; they work.

Uncommon logic: Traditional safety programs are more conventional than wise, frequently lies they make work.

The "truth" about safety program effectiveness can be found on Route 281 near San Antonio, TX, where a billboard proclaims (in all capital letters): Texas Country Fried Steak—Voted the Best in the Nation. Printed below (in small letters): Almost 3 dozen sold! The truth is in the numbers . . . and the nation's numbers do not suggest that safety is winning.

Anthony Veltri, an Oregon State University professor, conducted a survey to determine safety strategies most frequently employed in workplaces. The predominant strategy (77%): "Reluctant compliance," which calls on the safety department to shield the line organization from regulators and ensure statutory compliance. Speaking to industry's focus on results (quality) via compliance, Koln (1993) says: "If temporary compliance is the goal of managers, then we just explained the problem with U.S. industry. Temporary is obviously inadequate. As for compliance, quality never comes from mindless obedience." Neither will safety!

"If 50 million people say a foolish thing, it's still a foolish thing."

—B. Russell

No. 4: Management Action Required

Prevailing wisdom: Management "commitment" is the key to overall safety success.

Uncommon logic: Management "action" is the sole requisite to achieving overall safety success.

Talk is cheap. Most safety programs are a lot of talk. "Commitment" is a passive state and can never direct the complex interactions needed to improve an organization's safety performance. Only active involvement can overcome the corporate inertia that inhibits an organization from attaining higher levels of safe performance.

Simonds and Shafai-Sahrai confirmed this via their research of businesses located in Michigan. They identified 11 matched pairs of companies comparable in most demographic categories except for accident outcomes. One set had extremely high accident rates, the other extremely low. Analysis of operational differences between the two demonstrated that companies which "followed through" by acting on their commitment produced safe outcomes.

Commitment without action only produces "cynicism," which is typical of employee reaction to "write 'em and post 'em" corporate policies that proclaim: No Job Is So Important That We (Employees) Can't Take The Time To Do It Safely. Employee response: Why can't they (management) take the time to design it right in the first place so we don't have to take the time to fix it out here? As Tom Peters and Nancy Austin (1985) say, "They watch your feet not your lips."

However, an interesting paradox arises concerning this requisite for "executive action." It is best demonstrated in a large U.S. consumer product corporation, where safety is not dealt with above the mid-level of the organization. This firm believes so strongly in safety as a corporate value that it need not call on its CEO to drive the process. Safety has become an inherent expectation, fully integrated into all processes. Simply put, safe is how things are done, no exceptions; it is not a program.

"It is not enough that top management commits itself, they must know what it is that they are committed to. Action is required."

—W. Edwards Deming

No. 5: Management Creates Bad Attitudes

Prevailing wisdom: Poor employee attitudes cause the WC problem.

Uncommon logic: Poor management practices cause employee attitudes; it is not a matter of fate.

All business issues ultimately are reduced to "make or buy decisions." Without question, employee attitudes (poor as they may be) are a "make" decision by managers.

Business has invested heavily in "selecting out" problems by dedicating an entire corporate function (personnel) to design and implement procedures to "select in" right people. Such efforts have been successful. Managers do not intentionally hire "bad attitudes." This leaves but one conclusion: If bad attitudes are prevalent, managers are highly efficient at "making them."

Bad attitudes are an issue but not the problem. Their cause, the reasons bad attitudes exist—specifically, the practices that create them—is the problem. In *The Customer Comes Second*, Hal Rosenbluth says that "business earns the bad attitudes of its employees."

Employee attitudes are a "reaction" to management "actions" (a make decision). Attitudes span a spectrum from B.A.D. (Belligerent And Destructive) through average J.O.E. (Just Ordinary Employees) to S.A.I.N.T., those who Say All Injuries are Negligible and Temporary. Employees position themselves along this spectrum based on how they are treated. In other words, some companies take advantage of their employees (maximizing them as a resource), while others take advantage (disregard or exploit) of their workers. Employees react accordingly!

The "Law of Subordinate Superpower" is a peculiar phenomenon in employee relations. Unlike the laws of physics, which state that "for every action, there is an equal and opposite reaction," this phenomenon holds that "for every manipulative management action, there is an employee reaction, which will definitely be opposite but will never be equal!" Michael Shor, president of Health Care First Inc., agrees: "The best loss control program in the world can never make up for [an organization's] lousy employee relations."

"Employee attitudes are important, but the fact is they are irrelevant until management attitudes are addressed."

—J. Michael Crouch

No.6: It's the Process, Not the Employees

Prevailing wisdom: Unsafe employee acts are responsible for 85% of all accidents. In other words, employees are the problem.

Uncommon logic: The process, designed and administered by management, is responsible for 94% of all outcomes (including accidents). In other words, management makes the majority of the mistakes!

Peters and Austin (1985) speak of "a blinding flash of the obvious," a phenomenon in which obvious facts simply do not lead to obvious conclusions. Such a phenomenon definitely exists in safety. Managers typically say that the production process (planning, organizing, staffing, developing specs, budgeting, specifying materials, establishing rules, designing layouts, etc.) is a management responsibility.

Yet, when employees are injured thanks to this process, what is management's typical reaction? "Careless employees!" Wrong! Employees sustain injuries, and accidents occur, due to the process, which is designed, operated and owned by management.

A large Midwestern retailer plagued with high WC costs issued a corporate directive identifying the "real causes" of accidents within the organization:

- employee lack of respect
- employees being "above rules"
- employee retaliation
- employee incompetence
- employee indifference

Contrast these pronouncements with the values of Proctor & Gamble Corp. (P&G). At P&G, employees are:

- essential to the ongoing success of the enterprise
- entitled to preservation of health
- the key to productive, high-performance work systems

Commenting on the value of employees, P&G's CEO said, "[We] could lose all [our] plants in a single major catastrophe and conceivably be back in business with restored market share within 10 years. If we were to lose our people, there is no return . . . there is no future . . . it's all over" (Fulweiler, 1994).

"The American work ethic is alive and well, urgently wishes to express itself, and is hobbled at every turn by management."

—Daniel Yankelovitch

No. 7: Thinking Is Critical

Prevailing wisdom: Compliance with safety rules ensures safe operations. "Obedience" is, therefore, required.

Uncommon logic: Rules can never adequately address hazard variables inherent in a dynamic organization. Thus, "thinking" is critical.

Obedience and thinking are at opposite ends of the business spectrum, directly aligned with failure and success. Progressive companies recognize that success is not achieved via "rules"; employees will follow rules (no matter how ridiculous). Dana Corp. attributes much of its success to the fact that the company "burned its procedure manuals." Dana Corp. understands that rules promote blind compliance, while real success is driven by "thinking."

My son Eric, a third-year business student, experienced "real-world" compliance management during a summer job. He calls the experience "anti-think/double think," which he describes this way: In the past, business was operated under the premise that managers did the thinking and employees did the "doing" (i.e., no thinking allowed). New philosophies call for empowerment, participation and employee involvement, which, he observed, is really just a ploy (anti-think/double think). Managers say they want employees to participate and offer opinions; yet, when employees do become involved and tell managers what is really wrong, employees are ignored, chastised or labeled "not team players." America's workplaces do, indeed, need to be "re-engineered"; what is needed is more employee "head room."

"Regulations are for the obedience of fools and for the guidance of wise men."

—R.A.F. Motto

No. 8: Effort Needed Upfront

Prevailing wisdom: Safety inspections are a timely, effective way to identify problems and prevent serious accidents.

Uncommon logic: Safety inspections rarely identify real causes of accidents and only defer, in time, their ultimate occurrence.

Abraham Lincoln once said: "If I had eight hours to cut down a tree, I'd spend six hours sharpening the ax." Success requires time and effort upfront—planning, organizing and facilitating a process, rather tl1an at the end, correcting mistakes. Traditional safety programs devote little time to critical upfront issues; consequently, most time is spent after-the-fact, patching holes.

True accident causes rarely lie on the production floor; symptoms do. Real causes are found in corporate offices and planning rooms, places not frequented by safety directors. Managers should cease reliance on inspecting hazards out of the process and dedicate efforts to designing safety in.

"Man will occasionally stumble over the truth, but most of the time he will pick himself up and continue on."

—Winston Churchill

No. 9: Find the Real Accident Causes

Prevailing wisdom: Accident investigations reveal critical facts that prevent accidents from recurring.

Uncommon logic: Accident investigations rarely identify real accident causes, which are embedded deep within the organization. Therefore, recurrence is clearly inevitable.

If one believes the findings of most accident investigations, then the real causes of workplace accidents are:

1. Careless employees: 40%;
2. Beats me, I dunno!: 25%;
3. All other: 35%. This "catch-all" category would include: Employee carelessly used broken ladder; Without thinking, employee plugged defective tool into power source; Inattentive employee fell over crate in the aisle; Employee was performing normal job; back started to hurt; or Distracted employee became trapped in unguarded machine.

Obviously, such conclusions are open to question yet seldom are! The problem: Accident investigations are a responsibility placed at a level within the organization (first-line) that cannot truly address real accident causes—upper-level management decisions. If accident investigations do not identify system failures, they do not produce accurate information. Most do not!

Lieberman's Law: "Everybody lies . . . but it doesn't matter; nobody's listening."

No. 10: No Quick-Fix Solutions Here

Prevailing wisdom: Safety incentive programs are quick, easy and inexpensive; they drive safety improvement.

Uncommon logic: Safety incentive programs are quick, easy and inexpensive—sufficient evidence that they do not work!

Here is a tip: Buy stock in safety incentive corporations; they are a growth industry. As the WC crisis deepens and executives become aware of the real costs of accidents, they will frantically seek quick, easy solutions: Voila—incentive programs!

The truth remains, however, that over time, incentives do not produce lasting results. In Punished by Rewards,

Koln (1993) identifies key reasons why these programs have little impact on long-term accident costs:

•They are only incentive programs. They do not obligate change in existing processes or procedures.

•Incentives ignore reasons. They disguise genuine deficiencies and strategic flaws that exist within the organization and/or process.

Add one more reason to this list: They are *premised on "wrong-headed" assumptions* that accidents are intentional acts and that a baseball cap, belt buckle or savings bond will cause employees to stop placing limbs into unguarded machines.

One upstate New York manufacturer attempted to address high accident rates and poor employee relations (typical companions) via a monthly drawing for baseball tickets. The industrial relations manager, excited about the first drawing, planned a ceremony with free coffee in order to visibly demonstrate management interest. No one showed up! Employee involvement cannot be won by a few game show prizes.

During a recent interview with Safe Workplace, Peg Seminerio, director of health and safety for AFL-CIO, explained, "The use of incentives and rewards sends the wrong message to workers. There's growing concern that incentive programs don't necessarily [address] underlying problems in safety." Koln (1993) adds: "There is an important thought process regarding the question, do incentive plans work? Many are willing to say not now. Not so many are willing to say *not ever*!"

"There's always an easy solution to every human problem, neat, plausible . . . and wrong."

—H.L. Menken

No. 11: You Can't Train the Process

Prevailing wisdom: To improve safety, an organization must make a significant commitment to employee training.

Uncommon logic: To improve safety, an organization must make a significant commitment to fix whatever is truly wrong (which is generally not employees).

Organizational problems—deficient planning, poor organization, unclear goals, lack of vision, vague responsibilities, autocratic direction, lack of employee involvement, conflicting priorities, poor communication and incompetent supervision—are the real accident sources. When these factors interact and culminate in accidents, management's frequent response: "We need a training program." Such a reaction says "people at fault" rather than "process at fault."

As W. Edwards Deming noted, management is responsible for most outcomes of the production system, including its volume of "human scrap." The process needs fixing 94% of the time . . . not the people.

"No amount of care or skill in workmanship can overcome fundamental faults of the system."

—W. Edwards Deming

No. 12: Safety Sits on the Board

Prevailing wisdom: Safety is an employee issue that is most effectively handled by the personnel department and safety committees.

Uncommon logic: Safety is a boardroom issue, which can only be impacted by that group. Accident costs are no longer a negligible pass-on expense that can be ignored or buried in the cost of doing business. Escalating WC costs have truly become a boardroom issue. In the auto industry, for example, employee accident and health costs are now a major raw material cost of manufacturing a vehicle. In other industries, these costs often exceed 50% to 75% of payroll.

Yet, how do corporations typically deal with such problems? By creating staff/employee committees that lack direction, time, funding and authority needed to truly impact real (organizational) accident causes. The result: Monthly meetings (whether needed or not) and the predictable "gripe list."

Five years ago, Hoechst Celanese Corp. changed its approach to safety. At that time, says Dave Johnson, safety manager, the company maintained industry-average incident rates, and its safety program was "traditional."

Reality hit when a severe accident and audit report from a major customer negatively impacted revenue. This turn of events impacted decision-makers and prompted a strategic rethinking of safety as a core value. Incident rates have improved each year since that organization's transformation.

Results such as these cannot be produced through monthly safety committee meetings. Such results can be produced by a "board of directors" and they usually only meet quarterly!

"Lots of people confuse bad management with destiny."

—E. Hubbard **PSJ**

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