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GAO

Report to Congressional Requesters

February [illegible]

OCCUPATIONAL SAFETY AND HEALTH

Changes Needed in the Combined Federal-State Approach

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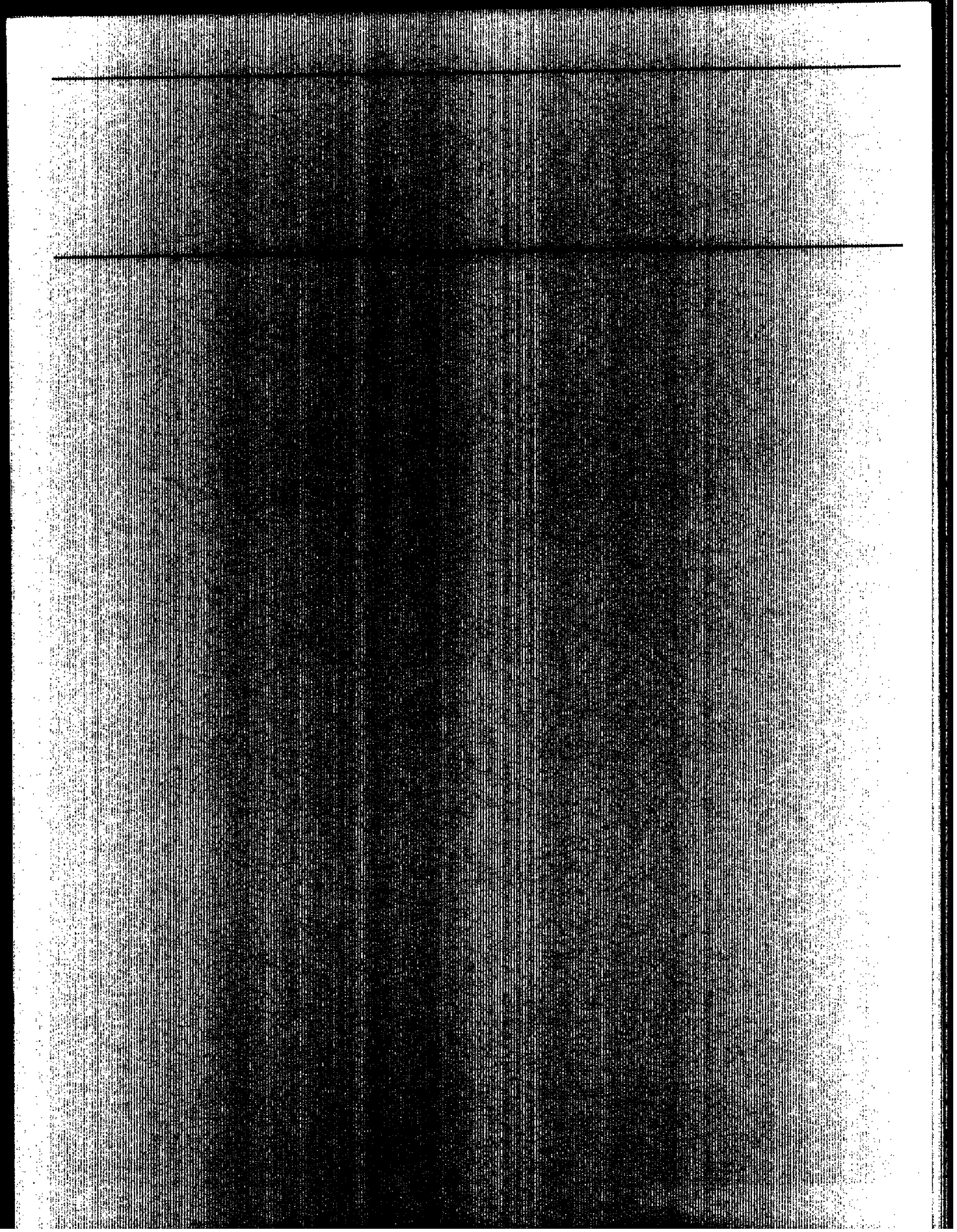

United States
General Accounting Office
Washington, D.C. 20548

150819

Health, Education, and
Human Services Division

B-247492

February 28, 1994

The Honorable William D. Ford
Chairman, Committee on Education
and Labor
House of Representatives

The Honorable William F. Goodling
Ranking Minority Member
Committee on Education and Labor
House of Representatives

In response to your request, this report provides information on the weaknesses in the Occupational Safety and Health Administration's (OSHA) oversight process, the unique features of OSHA and state programs, and the results of OSHA's special evaluations of 21 state-operated safety and health programs during fiscal year 1992. The report also includes recommendations to the Secretary of Labor for improving the combined federal-state safety and health approach.

We are sending copies of this report to interested congressional committees, the Secretary of Labor, the Commissioner of the Bureau of Labor Statistics, and other interested parties. Copies also will be made available to others on request.

This report was prepared under the direction of Linda G. Morra, Director, Education and Employment Issues, who may be reached on (202) 512-7014 if you or your staff have any questions. Other major contributors are listed in appendix VIII.

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Executive Summary

Purpose

In September 1991, 25 workers were killed and over 50 others were injured in a fire at a North Carolina chicken processing plant, primarily because the fire doors had been locked. Because the plant had never been inspected by the Occupational Safety and Health Administration (OSHA) or by the state—which was operating its own safety and health program under approval of OSHA—congressional attention focused on whether the incident indicated a need for changes in OSHA and state-operated safety and health programs.

The Chairman and Ranking Republican Member of the House Committee on Education and Labor asked GAO to examine ways in which the combined federal and state approach to ensuring workplace safety and health can be improved. Their specific questions were as follows:

- How adequate is OSHA's oversight, including its "special" evaluations,[1] of state-operated safety and health programs?
- What safety and health program features warrant further consideration for broader use?

Background

The Occupational Safety and Health Act of 1970 establishes a joint federal-state approach to workplace safety and health (with exceptions for certain transportation and mining operations). It authorizes states to operate their own safety and health programs, but it gives the Department of Labor responsibility for approving state programs and monitoring their performance to make sure they remain "at least as effective" as the program operated by the Labor Department. The Secretary of Labor established OSHA to carry out the federal enforcement role.

The act authorizes federal grants to the states to cover up to half of a state's total program cost. In fiscal year 1993, $67 million—about 23 percent of OSHA's $288 million appropriation—went to state programs. Twenty-one state programs cover both the private-sector and state and local government employees;[2] two other states (New York and Connecticut) have programs for only state and local employees. (See fig. 1.) OSHA covers private-sector employees in 29 states.

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[1]During fiscal year 1992, OSHA conducted special and follow-up evaluations of 21 state programs with responsibility for both private- and public-sector (state and local government) employees. These evaluations resulted from questions raised in a September 12, 1991, hearing Before the House Committee on Education and Labor. After that year, OSHA resumed its routine monitoring and evaluation.

[2]Our study was limited to these 21 states that exercise enforcement authority in both the public and private sectors.

The act also requires the Secretary of Labor to collect statistics on injuries and illnesses in the workplace. These data serve multiple purposes, including targeting inspections and focusing on education and training programs. The Bureau of Labor Statistics (BLS) collects injury and illness data from a sample of employers and provides summary information, by industry, to OSHA and the public. Because of confidentiality constraints, BLS does not give OSHA access to worksite-level data.

In 1988, GAO identified ways to improve OSHA's routine monitoring and evaluation process and recommended that OSHA (1) establish desired performance levels for state programs and (2) require states to develop and implement plans for evaluating the impact of their programs. In 1989, the Department of Labor's Office of the Inspector General (OIG) issued a report that included similar recommendations for improving OSHA's oversight process.[3] OSHA agreed to conduct a comprehensive review of its monitoring and evaluation process and to take action to address our concerns and those of the OIG by September 30, 1991. As of January 1994, however, OSHA had made little progress in revising the process. (See app. II.)

GAO also previously examined the differences between OSHA and state programs, although those reviews were not as comprehensive as this study. OSHA continues to move forward in addressing GAO's concerns and options for improvement. Two task forces are currently working on policies and procedures for improving OSHA's oversight, but no final decisions had been made by January 1994.

Results in Brief

OSHA's oversight of state-operated safety and health programs continues to have substantial weaknesses. One of the fundamental weaknesses is that OSHA has little information about the outcomes and effectiveness of either its own program or state programs. Basically, OSHA measures 115 program activities, such as the number of inspections conducted; its oversight approach assumes that states must use activities similar to its own in order to be equally effective. OSHA makes this assumption despite the fact that OSHA and the states have conducted few evaluation studies to determine which specific program features are effective. While OSHA is considering placing more emphasis on doing assessments of program outcomes, it has not yet done so.

[3] OSHA's Monitoring of State Programs, Final Report No. 05-88-003-10-105, Department of Labor, Office of the Inspector General (Jan. 30, 1989).

Several other weaknesses that GAO and the OIG identified some 5 years ago remain in OSHA's routine evaluation of state programs: (1) inadequate measures of program activities and no specific program activity goals, (2) no requirement for states to conduct internal audits or self-assessments that would allow OSHA to consider these results in its evaluations, and (3) a lack of follow-up procedures for ensuring that states correct problems in program areas identified by OSHA as unacceptable.[4]

Some improvements did occur in the way OSHA assessed the state programs during its special evaluations. However, OSHA did not adopt these improved practices in its routine evaluations of state programs that resumed in 1992.

With the authority provided under the Occupational Safety and Health Act, some states have developed unique program features that OSHA does not have. Two features adopted by several states (and supported by empirical studies that warrant the consideration of OSHA and other states) are (1) a requirement for comprehensive worksite safety and health programs and (2) the use of worksite-specific injury and illness data. Two other program features have also been adopted by several states and supported by previous GAO studies, but they need OSHA's further analysis to determine whether legislation should be amended to add them to OSHA law: (1) coverage of state and local government employees and (2) shutdown authority in imminent danger situations.

Principal Findings

OSHA's Oversight of State-Operated Programs Has Substantial Weaknesses

The most fundamental weakness in OSHA's oversight of state programs is that it has little information with which to judge whether a program has achieved desired outcomes or results. Rather, to assess state programs, OSHA measures their program activities: for example, standards adopted, inspections conducted, violations cited, or penalties levied. OSHA has not performed the program evaluations that could enable it to determine which policies, procedures, or standards can achieve specific outcomes. Further, OSHA does not set specific program activity goals but instead assesses states' performance relative to its own performance during the

[4]OSHA considers a state program unacceptable in a given program activity area when its performance is not equivalent to OSHA's performance in a given fiscal year. For example, during OSHA's special evaluations any state that cited serious violations more than 20 percent below OSHA's performance (66 percent of total violations cited) was subject to further review.

subject year. Since OSHA's performance can vary from one year to another, states in effect are asked to meet a "moving performance target."

Other weaknesses remain in OSHA's monitoring and evaluation of state programs, as GAO has previously reported. OSHA (1) neither sets priorities nor identifies key program activity measures but treats all 115 measures as equally important; (2) does not require states to conduct annual internal audits or require OSHA to consider the results in its evaluations; and (3) lacks follow-up procedures for ensuring that states correct problems in program areas identified by OSHA as unacceptable.

In conducting its special evaluations, OSHA made significant improvements. First, OSHA reduced the number of activity measures it used and established some priorities among the remaining ones. (OSHA officials are now proposing to reduce routine program activity measures from 115 to 48 by September 1994.) Second, OSHA required the states to correct or substantially improve problems identified in the special evaluations as a condition for continued approval of their state programs. However, OSHA resumed its routine evaluations in 1992 but has not yet incorporated these improvements.

States Have Additional Unique Program Features

Although state program procedures are generally similar to those of OSHA, some states have developed additional program features that are different from those of OSHA. GAO identified two particularly noteworthy program features found in several states.

- First, nine states require comprehensive worksite safety and health programs. GAO proposed in a 1992 report[5] that the Congress consider passing legislation that would require high-risk employers to have these programs. Since that report was issued, two of these nine states passed legislation requiring such programs.
- Second, 14 states use worksite-specific injury and illness data. The states' experience using data from workers' compensation programs, as well as empirical studies done by GAO and other researchers, indicates that using worksite-specific data, as well as industry averages, could improve OSHA's inspection targeting, education and training efforts, and evaluations of program effectiveness. These data will be more useful when OSHA completes the quality assurance program it is now developing. The program will improve the accuracy of employers' injury and illness

[5]Occupational Safety and Health: Worksite Safety and Health Programs Show Promise (GAO/HRD-92-68, May 19, 1992).

records and, as GAO previously recommended, will incorporate improved procedures for inspectors to verify the accuracy of employers' records.

Historically, BLS officials have not shared worksite-specific data with OSHA because the data are collected by BLS under strict confidentiality pledges. On October 21, 1993, however, officials at OSHA and BLS signed an agreement acknowledging OSHA's need to obtain worksite-specific data from employers. The two agencies are currently working on ways for each to obtain the data without compromising the independence and confidentiality of the data-collection process.

In addition, GAO noted that some states have greater statutory authority than OSHA does to take immediate action in imminent danger situations. However, GAO could not determine the appropriate data source to show how often these situations occur and the consequences of this limitation on OSHA's authority.

All state-operated programs differ from OSHA in that they cover state and local government employees, while OSHA is prohibited by law from doing so. As a result, an estimated 7.3 million state and local public employees in 27 states are not protected by federal safety and health statute or regulations. GAO did not determine what coverage these employees may have from other sources, such as state workers' compensation programs or private insurers.

Recommendations

To improve OSHA's oversight of state programs and the federal-state approach to workplace safety and health, GAO recommends that the Secretary of Labor require the Assistant Secretary for Occupational Safety and Health to

- emphasize measures of program outcome and evaluations of the effectiveness of specific program features as it assesses both its own activities and those of the state-operated programs (see ch. 2);
- revise OSHA's state program monitoring and evaluation approach by (1) developing a set of improved performance measures, (2) setting performance goals and eliminating the "moving target" performance criteria, (3) requiring states to conduct annual internal audits, and (4) establishing more effective procedures to obtain state corrective action on significant issues (see ch. 2); and
- assess the need for legislative change to (1) extend OSHA's coverage to state and local government employees in states without OSHA-approved

safety and health programs and (2) give OSHA greater authority to protect workers in imminent danger situations (see ch. 3).

GAO also recommends that the Secretary of Labor require the Assistant Secretary for Occupational Safety and Health to (1) develop procedures for OSHA to obtain worksite-specific injury and illness data from employers and (2) implement its procedures for ensuring that employers accurately record occupational injuries and illnesses.

Agency Comments

The Secretary of Labor agreed with the majority of GAO's findings, conclusions, and recommendations. (See app. VII.) OSHA agreed to (1) set improved outcome measures and goals to better assess its own activities and those of state programs, (2) establish requirements for states to conduct annual self-assessments and submit corrective action plans, and (3) review the issues of extending coverage to state and local government employees and providing additional authority to inspectors in imminent danger situations. Both OSHA and BLS agreed that procedures are needed to obtain worksite-specific data from employers. OSHA officials also agreed that procedures are needed to ensure the accuracy of the records at the worksite.

OSHA officials, however, disagreed with our recommendations to eliminate the moving target criteria when assessing states' performance standards. GAO believes that OSHA needs to reconsider options for eliminating the moving target criteria and setting more outcome measures and goals. Eliminating the moving target criteria will enable OSHA to more accurately measure a state's performance in a given program activity area and provide a better assessment of states' overall efforts in improving safety and health in the workplace.

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Abbreviations

BLS	Bureau of Labor Statistics
OIG	Office of the Inspector General
OSHA	Occupational Safety and Health Administration

Introduction

The Occupational Safety and Health Act of 1970 sets out the joint federal-state approach to ensure workplace safety and health.[1] This law authorizes states to operate their own safety and health programs, but it gives the Department of Labor responsibility for approving state programs and monitoring states' performance to make sure they remain "at least as effective" as the federal program. The Secretary of Labor established OSHA to carry out the federal enforcement role.

Section 23(g) of the act authorizes the Secretary of Labor to make grants to the states to assist them in administering and enforcing occupational safety and health programs that have been approved by OSHA. The federal share may not exceed 50 percent of the total cost of a state program. In fiscal year 1993, OSHA allocated $67 million, or 23 percent, of its $288 million operating budget to state programs.

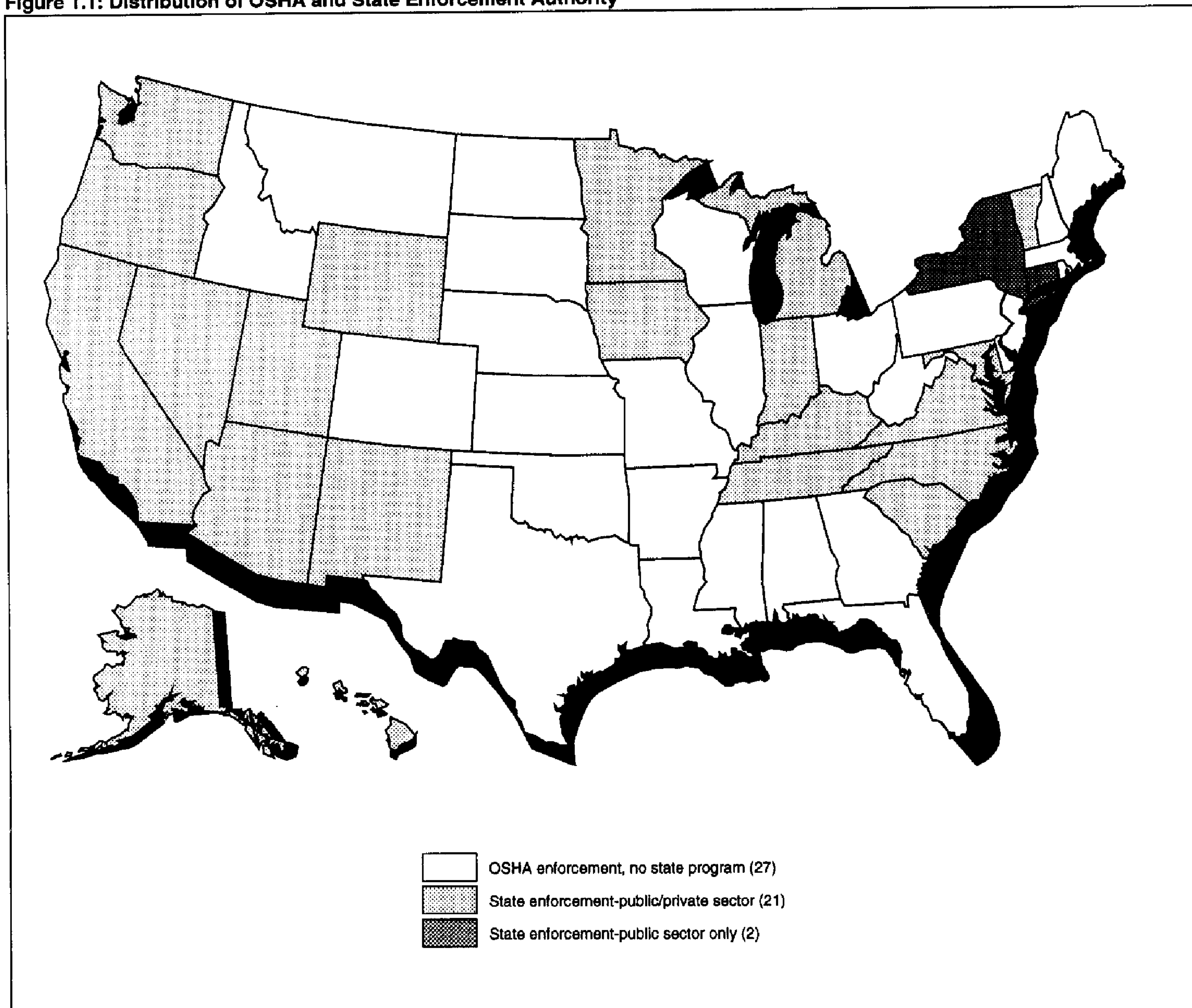
Currently, 21 states and 2 territories (Puerto Rico and the Virgin Islands) operate programs for both private sector and state and local government employees.[2] The 21 states are responsible for enforcing safety and health laws that cover about 45 million employees. Two other states (New York and Connecticut) have programs for only state and local government employees; OSHA provides protections for workers in the private sector. OSHA has given final approval to 13 of the 21 state programs and has "operational status agreements" (which we define below) with the other 8 states[3]. (See fig. 1.1.)

[1]The act covers most workplaces; exceptions are principally for certain transportation and mining operations.

[2]Our study was limited to the 21 states that exercise enforcement authority in both the public and private sectors.

[3]The eight states without final approval are California, Michigan, Nevada, New Mexico, North Carolina, Oregon, Vermont, and Washington.

Figure 1.1: Distribution of OSHA and State Enforcement Authority



OSHA's State Certification and Approval Process

OSHA has established three stages in the state program approval process. During the first stage, initial approval, OSHA continues to have enforcement responsibility, while the state develops a detailed plan to implement its operating policies and procedures. OSHA requires the state to submit a detailed plan that describes how it will ensure workers' safety and health

through (1) appropriate legislation, standard-setting, and enforcement procedures; (2) adequate funding, safety and health training, and education programs; and (3) an adequate number of competent enforcement personnel (referred to as compliance officers or inspectors). Within 3 years of approval, a state must accomplish the developmental goals outlined in its plan.

Second, when a state appears capable of independently enforcing standards and has operated its program for almost 1 year, OSHA may enter into an operational status agreement with the state. During this transition period, OSHA suspends federal enforcement in all or certain activities covered by the state program.

Third, OSHA grants final approval once a state meets its compliance inspector staffing levels and OSHA decides, on the basis of actual operations, that the state program has established standards and provides protections as effective as those provided by OSHA's program. When OSHA gives a state final approval, OSHA relinquishes its right to concurrent enforcement. OSHA, however, continues some enforcement efforts in the state for workers not covered by the state program, such as maritime and federal workers.

When OSHA concludes that state standards or operations are not as effective as its own, OSHA can (1) increase its level of concurrent enforcement within the state or (2) withdraw the state's authority to operate its program and take over that responsibility. In 1991, OSHA increased its level of concurrent enforcement in North Carolina and began the steps necessary to withdraw program approval; however, OSHA later determined that program withdrawal was not warranted. In contrast, state-initiated actions taken to withdraw a state program have created significant difficulties for OSHA because of the additional demand on its resources.[4]

OSHA's Oversight Process

OSHA monitors and evaluates all state safety and health programs at least annually. OSHA's monitoring and evaluation program is directed by its Directorate of Federal-State Operations in Washington, D.C. This office develops the policies and procedures for approving, monitoring, and evaluating state programs. OSHA's regional and area offices perform most of the direct monitoring and evaluation of state programs. The Office of

[4]See, for example, our testimony on the effect on other OSHA activities of the California governor's temporary withdrawal of funds to operate that state program in 1987. (OSHA's Resumption of Private Sector Enforcement Activities in California, GAO/T-HRD-88-19, June 20, 1988.)

Management Data Systems, within the Directorate of Administrative Programs, has primary responsibility for processing federal OSHA and state program performance data into its management information system and distributing the reports.

The two main features of OSHA's routine state monitoring and evaluation process are (1) collection and comparative analysis of data in computerized state program activity measures reports and (2) an annual evaluation of each state, which considers these statistical analyses as well as other information, such as special studies and observations made while accompanying state compliance officers on inspections.

OSHA relies primarily on comparisons of a given year's statistical data about its own program activities with comparable data from state programs. For its annual evaluations, OSHA assesses states on 115 activity measures in 10 major program areas. Generally, OSHA considers a state performance unacceptable when program activity in a given area falls more than 20 percent above or below the national average performance for OSHA.[5] For some measures, however, OSHA has established absolute standards for state activities. For example, states are expected to have 80 percent of their allocated safety compliance officer positions filled.

In addition to comparing program statistics, OSHA reviews case files and meets with state officials quarterly to discuss state performance that differs from that of OSHA. OSHA then conducts additional inquiries, for example accompanying state inspectors on inspections and doing on-site monitoring of the state program office. The latter could involve investigating citizens' complaints about the state program, standards development, budget expenditures, and state legislative provisions and other enforcement activities reported by the state that might affect its performance.

OSHA then prepares an annual evaluation report for each state program that summarizes the statistical analysis and other information to determine whether the state activities and operations are "as effective as" OSHA's program. These reports include (1) an analysis of program areas where OSHA considers state program performance unacceptable, (2) an overall evaluation of state program performance, and (3) recommendations to improve performance. OSHA gives the reports to state program officials and, upon request, to the public.

[5]OSHA conducts further reviews when state performance in a given program activity area is not equivalent to that of OSHA before concluding that a state's performance is acceptable or unacceptable.

OSHA's oversight policy requires each state with unacceptable performance to respond in writing to OSHA's recommendations. Quarterly and annually, OSHA's regional and area office staff conduct follow-up reviews to assess whether the state has implemented the recommendations to correct problems and improve state performance.

In addition to its regular oversight process, OSHA conducted a set of one-time special and follow-up evaluations of state-operated safety and health programs' performance. The special evaluations were conducted between October 1991 and January 1992 because of questions raised in a hearing before the House Committee on Education and Labor in September 1991.[6] Generally, these OSHA evaluations resulted in two reports: (1) a report given to each state and announced in a press release in January 1992 and (2) a follow-up report, released in October 1992, assessing each state's actions to correct deficiencies noted in the special evaluation reports. OSHA issued separate, more detailed reports in January 1992, April 1992, and March 1993, for the North Carolina program. (We discuss and compare OSHA's routine oversight activities and the special evaluations in ch. 2.) Since that time, however, OSHA has returned to the routine procedures.

Occupational Injury and Illness Data

The Occupational Safety and Health Act requires the Department of Labor to collect statistics on injuries and illnesses in the workplace. Within the Labor Department, OSHA defines what information all employers must maintain at their worksites in a log (OSHA 200). Labor has given responsibility for collecting injury and illness data to its Bureau of Labor Statistics (BLS), which, using a sampling approach, conducts an Annual Occupational Injuries and Illnesses Survey. In most states, state-operated safety and health programs or state unemployment agencies collect the data from employers and supply it to BLS; BLS collects the data directly in the remaining states. Based on this survey, BLS reports the nation's work-related injuries and illnesses in aggregate, by industry sector under the standard industrial classification of industries. OSHA uses these aggregated data to target manufacturing sectors with high injury rates for inspection.

BLS confidentiality policies prohibit providing injury and illness data on specific worksites if these data would allow identification of the worksite. These rules of confidentiality are not imposed by federal law, but

[6] Comprehensive Occupational Safety and Health Reform Act, and the Fire at the Imperial Food Products Plant in Hamlet, North Carolina: Hearing Before the House Committee on Education and Labor, First Session (Sept. 12, 1991).

negotiated by BLS with state agencies and survey respondents in an effort to gain industry's cooperation in conducting the survey. OSHA obtains specific injury and illness data for only those worksites that it has inspected.

Congressional Initiatives

The Congress is now considering legislation, the Comprehensive Occupational Safety and Health Reform Act (H.R. 1280 and S. 575), that would significantly change the way OSHA and the states ensure workplace safety and health in this country. Some major provisions would (1) extend OSHA coverage to include state and local government employees, (2) require employers to develop and implement comprehensive safety and health programs, (3) increase protection for workers in imminent danger situations, (4) require employers to immediately abate serious workplace safety and health hazards, and (5) modify the procedures for withdrawing OSHA's approval of state programs.

To address the concerns of the Congress and further improve its oversight process, OSHA established two task forces. The first task force was established in April 1993 to assess the need for administrative or legislative change in several policy areas. In addition, OSHA convened a second task force in June 1993—as part of the new administration's "Reinventing Government" efforts—to explore new and creative ways to improve its effectiveness. The issues under consideration include use of worksite-level injury and illness data, authority in imminent danger situations, development of program outcome measures, and coverage of state and local government employees. In September 1993, the first task force provided several options for improving the occupational safety and health law to the Secretary of Labor, but as of January 1994, the second task force had made no final decisions.

Scope and Methodology

To answer the Committee's questions about OSHA's oversight procedures and ways to improve both federal and state programs, we analyzed federal and state occupational safety and health program policies and procedures. We surveyed program officials in all 21 states with enforcement responsibility in the private sector. (See app. I for the questionnaire results.) We determined state legal requirements by interviewing appropriate officials and examining documents they provided. We did not directly examine all relevant state laws. We obtained information about OSHA's policies and procedures from interviews with agency officials and from documents, including previous GAO reports. We also obtained the

views of OSHA officials and state representatives about ways to improve the federal-state approach to ensuring workplace safety and health.

We reviewed OSHA's 1990 routine and special monitoring procedures and resulting reports. In doing so, we did not validate the data used by OSHA. We also did not fully assess OSHA's proposed revisions to its routine monitoring and evaluation system because they were still under review by OSHA and state program officials. We conducted our audit between October 1991 and November 1993 in accordance with generally accepted government auditing standards.

OSHA's Oversight of State-Operated Safety and Health Programs Has Substantial Weaknesses

OSHA's oversight of state-operated safety and health programs has substantial weaknesses. Both the routine evaluations and the special evaluations are flawed by OSHA's limited information about the outcomes and effectiveness of its own program and state programs. Because OSHA has little information about program outcomes and the effectiveness of its own program and state programs, OSHA's monitoring and evaluation approach requires states to use criteria equivalent to its own in order to be considered equally effective.

Other weaknesses in OSHA's oversight process that we and the OIG identified are (1) inadequate measures of program activities and (2) the absence of a requirement that states conduct annual internal audits of their programs.[1] The OIG also identified a third weakness: ineffective procedures to require and confirm state corrective actions. While OSHA has made some attempts at revising its oversight approach, these changes had not been implemented as of January 1994. (See app. II.) The special evaluations conducted in fiscal year 1992 showed some improvements by reducing the number of program activity measures and establishing priorities for measures and requirements for follow-up. As a result, OSHA officials agreed to reduce routine program activity measures from 115 to 48, but final implementation is not expected before September 30, 1994.

Lack of Emphasis on Program Outcomes and Effectiveness Studies

A substantial weakness in both the routine and special evaluations is OSHA's emphasis on program activities, without similar emphasis on program outcomes. OSHA has considerable information about its program activities, such as the number of inspections performed, but it has much less data about its outcomes, such as the number of workplace hazards or rates of workplace injuries, or the outcomes of state programs. For this reason, OSHA focuses almost exclusively on program activities rather than on program outcomes in both its statutorily-required annual report to the Congress and the performance measures it uses in monitoring and evaluating state programs.

OSHA recognizes that injury and illness statistics from the BLS Annual Survey of Occupational Injuries and Illnesses, alone, do not support

[1] OSHA's Monitoring and Evaluations of State Programs (GAO/T-HRD-88-13, Apr. 20, 1988), OSHA's Monitoring of State Programs, Final Report No. 05-89-029-10-105, Department of Labor, Office of the Inspector General (Jan. 30, 1989), and Labor Issues (GAO/OGC-93-19TR, Dec. 1992).

conclusions about program outcomes for itself or the states.[2] For example, in the special evaluations, each state was compared with OSHA's 5-year average lost workday injury rate.[3] If a state's increase was more than 10 percent above OSHA's 11.8 percent increase for the period, OSHA would conduct additional inquiries. Although 10 of the 21 states exceeded the OSHA increase by more than 10 percent, OSHA concluded that factors other than program performance could plausibly account for the difference. Examples included (1) improved reporting of injuries as a result of stronger enforcement; (2) increased employment, bringing less experienced workers into the workforce; and (3) increased employment in especially hazardous industries, such as construction.

Although little information has been developed on the overall effectiveness of federal and state programs, OSHA has taken some steps to better understand this issue by establishing the Office of Program Evaluation within its Directorate of Policy. In fiscal year 1992, OSHA's Office of Program Evaluation identified 10 potential studies for approved funding. OSHA funded four of these studies, three of which have been completed.

In addition, the Office of Program Evaluation has completed studies that include (1) examination of the petrochemical industry's management of safety and health for contract workers and (2) the effectiveness of OSHA's hazard communication standard. Two ongoing studies address the impact of (1) comprehensive worksite safety and health programs and (2) using workers' compensation data to target enforcement efforts. The study using workers' compensation data is under way in the state of Maine, where OSHA has targeted the "Top Two Hundred" employers (based on state workers' compensation claims) to further assess the value of worksite-specific data.

Our review also found a few examples of state-conducted effectiveness studies. For example, a recent study funded by the Michigan occupational safety and health program focused on the potential benefit to OSHA's inspection targeting strategy of using worksite-specific data. The study concluded that OSHA indeed would benefit from access to worksite-specific

[2]Several researchers have pointed out the difficulty in using a simple change in the number, severity, or rate of injuries and illnesses as a measure of program outcome or effectiveness. See, for example, John W. Ruser, "Workers' Compensation and Occupational Injuries and Illnesses," Journal of Labor Economics 9(4), pp. 325-350, and Robert S. Smith, "Have OSHA and Workers' Compensation Made the Workplace Safer?" in Research Frontiers in Industrial Relations and Human Resources, David Lewin, Olivia S. Mitchell, Peter D. Sherer, eds. (Madison, WI: Industrial Relations Research Association.)

[3]The lost workday injury rate is the average number of injuries that required days away from work or restricted work activity per 100 full-time workers per year.

data in targeting or in other interventions designed to improve occupational safety and health performance. (See ch. 3 for more details about these studies.)

As discussed in chapter 1, OSHA established two task forces to further improve its oversight process. The first task force was established in April 1993 to assess the need for administrative or legislative changes to the Occupational Safety and Health Act in the several policy areas. In addition, OSHA convened a second task force in June 1993—as part of the new administration's "Reinventing Government" efforts—to explore ways to improve the effectiveness of OSHA. In September 1993, the first task force provided several options for improving the occupational safety and health law to the Secretary of Labor, but, as of January 1994, the second task force had made no final decisions.

We recognize the difficulty that OSHA faces in developing meaningful measures of program outcomes and conducting program effectiveness studies. But we believe that OSHA, faced with limited resources, needs better information about the effects of its policies and procedures to make more informed decisions and program improvements.

Inadequate Measures to Access State Programs

The program activity measures OSHA uses and the comparisons it makes with them provide insufficient information about state program activities because OSHA (1) uses a large number of measures and identifies no priorities among them and (2) compares them primarily to the "moving target" of OSHA's most recent performance.

OSHA uses 115 program activity measures in its routine evaluations, with no priorities identified. Although the measures are grouped into program areas, none of the areas or individual measures are identified as essential or most important for a state's performance to be acceptable. There is no minimum or maximum number of measures or areas in which a state must be acceptable in order to retain OSHA's approval for it to continue to operate.

As we have previously noted, OSHA generally compares state performance for a given period with its own performance for the same period even though OSHA's performance fluctuates from one period to another. As a result, states are constantly aiming at "moving targets." For example, in the special evaluations, states were expected to meet OSHA's complaint backlog performance level, which worsened by 300 percent over a

6-month period. As a result, the performance of two states was initially considered unacceptable but would have been considered acceptable if compared with OSHA's performance 6 months later.

We previously recommended that, where feasible, performance levels should be specified in advance as performance goals, for both OSHA and the states. Further, some state officials suggested that a better assessment of performance would be to (1) compare a state program with statistics on OSHA's performance in similar states or (2) compare state programs located in the same OSHA region.

No Requirement for States to Conduct Internal Audits

In 1988, OSHA agreed with us and the OIG that states should conduct annual internal audits of their own programs and that the results of these audits should be among the factors OSHA considers when it evaluates state programs. As shown in appendix II, OSHA and state program officials have worked on developing draft guidelines for an internal audit requirement but have not yet reached agreement. In this process, they are attempting to integrate the internal performance audits with other monitoring and evaluation procedures to minimize duplication of effort. Because these guidelines were still being developed as of January 1994, we were unable to assess their adequacy.

States generally agree with the concept of requiring self-assessments, or internal audits. They believe this would improve their awareness of program weaknesses and assist them in correcting problems. Some state officials, however, believe that OSHA should (1) identify the minimum criteria for states to use in developing and conducting internal audits, (2) supplement states' staffing and funding to conduct the internal audits, and (3) exempt those states that already have legislative requirements for annual internal audits from having to do an additional self-assessment.

Inadequate Procedures to Ensure That States Correct Problems

Under its routine monitoring approach, OSHA recommends changes it believes states should make, but does little to ensure corrective actions are taken by the states. States are responsible only to "respond" to OSHA's recommendations. As with the measures themselves, OSHA does not prioritize its recommendations, nor does it require specific information on state corrective actions.

Both the 1989 OIG study and this review identified cases where states did not implement OSHA's recommended corrective actions. For example, we

found that 11 of 21 states evaluated by OSHA in 1991 had not responded to OSHA's 1990 recommendations. In addition, 6 of the 11 states had not responded to recommendations made in previous OSHA evaluations.

A federal-state task force OSHA established in 1990 to recommend changes to the monitoring and evaluation procedures (described in more detail in app. II) is currently considering whether to require states to submit written action plans regarding OSHA recommendations. Some state officials believe OSHA should consider requiring plans only for follow-up in priority program areas.

Special Evaluations Were in Some Ways an Improvement Over Routine Evaluations

In its special evaluations, OSHA made important program improvements. First, as we recommended in 1988 testimony,[4] OSHA established a set of priority program areas. The priority areas were (1) timely adoption of safety and health standards, (2) inspector staffing levels, (3) adoption of OSHA's fiscal year 1991 700 percent penalty increase, (4) abatement confirmation, and (5) inspectors' right-of-entry to worksites. Several differences between the special and routine evaluations, including the ones we consider most significant, are shown in table 2.1

Table 2.1: Differences Between OSHA's Routine and Special Evaluations

	Routine Evaluations	Special Evaluations
Program priority areas[a]	None	5
Performance measures[a]	115	36
Follow-up[a]	At next scheduled OSHA evaluation (about every 12 months)	Required 6 months after evaluation
Timeframes for conducting evaluation	Staggered over the fiscal year	All states evaluated between October 1991 and January 1992
Coverage	Comprehensive review but limited coverage of unique program features	Primarily focused on enforcement issues, but included information on unique program features
Casefile reviews	Less extensive	More extensive

[a]Significant differences in OSHA's special evaluation process.

Second, OSHA reduced the number of program activity measures from 115 to 36. As shown in table 2.2., of the 36 measures, 12 were not included in OSHA's routine evaluations. (See app. III for a description of the

[4]OSHA's Monitoring and Evaluations of State Programs (GAO/T-HRD-88-13, Apr. 20, 1988).

comparison measures.) OSHA officials have agreed to reduce its routine program activity measures from 115 to 48, but final implementation of these measures is not expected before September 30, 1994.

Table 2.2: Comparison of Program Activity Measures Used in OSHA's Routine and Special Evaluations

	Number of performance measures used	
Program area	**Routine evaluation**	**Special evaluation**
Safety and health standards		
Adoption of standards	4	1
Variances from standards	2	0
Staffing	9	6
Enforcement		
Private sector	29	21
Public sector	17	1
Investigation of discrimination complaints	4	1
Review of contested cases	6	2
Voluntary compliance		
Consultation program	27	1
Education and training	5	0
Funding	0	2
Program administration	10	0
Program results	2	1
Total	**115**	**36**

Third, OSHA conducted follow-up evaluations to ensure that states corrected problems that it had identified as a condition for continued approval of their programs. States were generally given 5 months after submitting their action plans to make corrections. With North Carolina, however, OSHA's approach was somewhat different. For example, OSHA exercised close scrutiny and periodic monitoring over several months in North Carolina but required no specific action plan of the state. To ensure that states made corrective actions, OSHA subsequently conducted follow-up evaluations to determine if state performance had improved. OSHA's follow-up evaluations may have had a positive impact on states' performance. (See app. IV for a more detailed discussion of the results of the special evaluations conducted in fiscal year 1992.) State action may also have been influenced, however, by OSHA's release of the results of the evaluations and follow-up studies to the public.

Although not yet issued in January 1994, OSHA's revised monitoring and procedures manual did at that time include requirements for states to submit corrective action plans for unacceptable performance in specific program activity areas. OSHA officials said they plan to issue the revised policies and procedures manual by September 30, 1994.

State Officials' Opinions About OSHA's Oversight Process

Routine Evaluations

State officials described OSHA's routine monitoring and evaluation procedures in generally favorable terms. Of the 21 officials, 16 said the fiscal year 1990 evaluation and monitoring produced a "mostly accurate" picture of the effectiveness of their state programs. They identified several areas that they considered to be strengths of the routine monitoring and evaluation process: (1) quarterly assessments conducted by OSHA's field staff, which enabled states to address potential deficiencies prior to the issuance of OSHA's annual evaluations; (2) cooperative working relationships developed over time between OSHA and the states; and (3) comprehensive coverage.

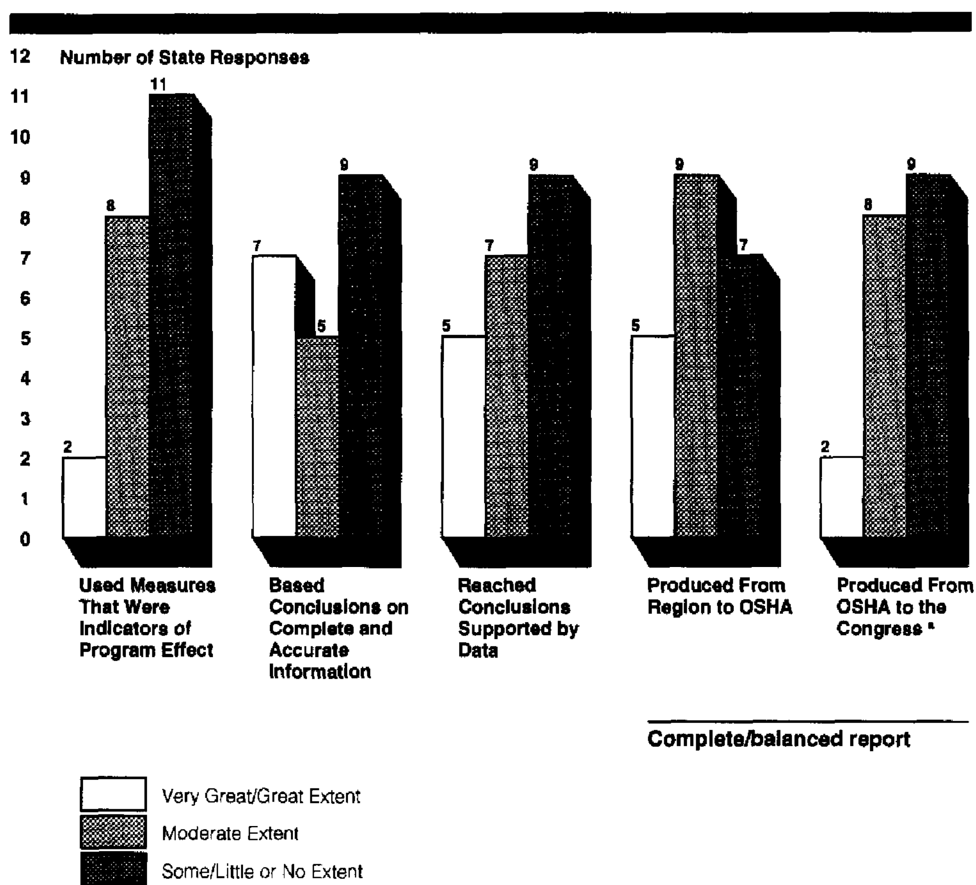
However, state officials expressed the greatest dissatisfaction with the program activity measures and OSHA's use of the moving target performance process. In addition, several state officials believe that OSHA's system focuses on identifying differences between OSHA and states' performance and not on eliminating or preventing workplace safety and health hazards. Other concerns were the lack of experience and training of OSHA's monitoring staff and the lack of completeness and accuracy of the data OSHA uses.

Special Evaluations

Although state program officials identified some advantages of the special evaluations, they were generally more critical of OSHA's special evaluations than of the routine evaluations. Program officials from nine states said the special evaluations produced a less accurate picture of the effectiveness of their programs than the routine evaluations did in fiscal year 1990. In addition, 11 of the 21 state officials also said the special evaluations took "far more time and effort" on the part of the states. (See app. I for the survey form we used and a summary of the responses.)

Figure 2.1 summarizes officials' responses to questions about how OSHA conducted the special evaluations. The most negative assessments were on the validity of the activity measures as indicators of a program's effectiveness and the report to the Congress.

Figure 2.1: State Officials' Opinions About OSHA's Special Evaluations



[a]Two states did not respond in this area.

Program officials reiterated their concern about the activity measures and the accuracy and comprehensiveness of the data OSHA used. Eleven of the 21 officials identified measures they believe OSHA should have used either in addition to or in lieu of the ones used in the special evaluations. Some of the measures suggested by state officials were (1) percentage of employers inspected each year, (2) number of other-than-serious violations per inspection, and (3) time frame for doing inspections.

On the positive side, state officials generally believed that OSHA's final assessments were more timely and, unlike the routine evaluations, provided more emphasis on unique safety and health approaches. Most state officials also viewed OSHA's decision to use fewer performance measures to assess states as a positive step.

Conclusion

OSHA's process for providing oversight of state-operated safety and health programs, although currently undergoing change, has substantial weaknesses. OSHA's special "one-time" evaluations made some improvements in the procedures used to assess state programs' performance, but these one-time improvements, even if fully implemented, will not address the more substantial weaknesses previously identified by us and the OIG.

We support OSHA's incorporating the more significant changes made in the special evaluations of state programs, including establishing priorities, reducing the number of performance measures for assessing states' overall performance, and requiring corrective action plans. However, we believe that OSHA's oversight process could be further enhanced by focusing more on program outcomes and conducting evaluations of the effectiveness of its own program policies and procedures and those of state programs as well. OSHA could, for example, do more assessments of its effectiveness in decreasing occupational injúries and illnesses in the workplace.

Recommendations

To more effectively carry out the department's statutory responsibility for oversight of state programs, we recommend that the Secretary of Labor require the Assistant Secretary for Occupational Safety and Health to

- emphasize measures of program outcome and evaluations of the effectiveness of specific program features as it assesses both its own activities and those of the state-operated programs, and
- revise OSHA's state program monitoring and evaluation approach by (1) developing a set of outcome measures, (2) setting outcome goals and eliminating the "moving target" criteria, (3) requiring states to conduct internal audits, and (4) establishing more effective procedures to obtain state corrective action on significant issues.

Agency Comments and Our Evaluation

OSHA officials agreed with our recommendation for emphasizing measures of program outcome and evaluation in assessing its own activities and

those of state-operated safety and health programs. In fact, OSHA and state officials are developing their fiscal year 1994 program goals—in the areas of enforcement, consultation, and training—with an emphasis on maximizing the impact on workplace safety and health hazards.

Although OSHA officials agreed to implement a performance measurement system that uses better measures to more effectively evaluate and monitor the performance of state-operated safety and health programs, they disagreed with our recommendation for eliminating the "moving target" criteria. OSHA officials stated that because (1) they continually seek to refine and improve the program's effectiveness and (2) states are required to implement these improvements, they cannot eliminate the "moving target" criteria and that "some level of activity measurement will continue to be necessary."

We recognize that standards are not static but must be refined over time, and that states must continually update their programs. However, we also believe that further improvements can be made in the establishment of outcome measures and goals, to replace activity measures, that will eliminate the "moving target" aspect of OSHA's current oversight program.

OSHA officials agreed with our recommendation that would require states to conduct annual internal audits and establish more effective procedures to obtain state corrective actions. These procedures are included in OSHA's revised monitoring and evaluation procedures manual, which OSHA expects to fully implement in fiscal year 1994.

State-Operated Safety and Health Programs Have Some Unique Features

OSHA and state-operated safety and health programs pursue generally similar approaches to improving workplace safety and health. However, all state-administered programs differ from OSHA in that they cover state and local government employees, while OSHA does not. In addition, some states have exercised their statutory flexibility to develop additional program features that OSHA does not have.[1] Five program features found in some states but not in OSHA are (1) requirements for comprehensive worksite safety and health programs, (2) use of worksite-specific injury and illness data to target inspections and education and training activities, (3) added protections in imminent danger situations, (4) extending coverage to state and local government employees, and (5) employer funding for the program. We believe the first two of these—worksite safety and health programs and worksite-specific data—are options for OSHA and other states. Two others—added protections in imminent danger situations and extending coverage to state and local government employees—may warrant further study by OSHA and states that currently have no program. Some state officials also believe the direct tie between employers and program funding encourages employers to reduce worksite safety and health hazards, and this approach could be used by other states to minimize reliance on state appropriations.

Required Comprehensive Worksite Safety and Health Programs

OSHA encourages, but does not require, employers to implement comprehensive worksite safety and health programs, including employee involvement in developing and operating such programs. In contrast, nine state-operated programs mandate written safety and health programs for some or all employers. As we previously reported,[2] we believe that worksite safety and health program requirements show promise for adoption by OSHA or other states.

OSHA encourages the use of comprehensive worksite safety and health programs through a variety of mechanisms including its consultation program, the Voluntary Protection Program, and the negotiation of settlement agreements. OSHA requires employers to develop written safety plans addressing specific hazards through standards, such as those addressing information to workers about chemical hazards (hazard

[1]Generally, OSHA does not object if states design supplemental features for their programs as long as a state's overall program meets minimal OSHA requirements. As described in chapter 1, we based our understanding of state laws on information provided by OSHA and state officials, not our analysis of all state laws.

[2]Occupational Safety and Health: Worksite Safety and Health Programs Show Promise (GAO/HRD-92-68, May 19, 1992), and Occupational Safety and Health: Options for Improving Safety and Health in the Workplace (GAO/HRD-90-66BR, Aug. 24, 1990).

communication), process safety management, and the control of hazardous energy sources (lockout/tagout). As we recommended, OSHA has initiated a study assessing the effectiveness of worksite programs and expects a final report by September 30, 1994.

As of February 1993, nine states had legislative requirements for worksite safety and health programs for some or all employers.[3] (See table 3.1 for a list of these states and app. V for more details about which employers must comply with program requirements.) These comprehensive programs, in general, require the employer to inspect the worksite for known or potential hazards and develop written plans to abate, to the extent possible, these hazards. All nine states require that, where employers are required to have a program, employees must be involved in some way in the development and implementation of the programs. Six of the nine states require this involvement to be through joint labor-management safety and health committees. In addition to these nine states, other states require worksite programs and committees through provisions in their workers' compensation program. For example, the Minnesota workers' compensation statute requires all employers with more than 25 employees and certain small high-risk employers to establish joint safety and health committees.

[3]One state, Nevada, has had legislation requiring these programs since 1991 but is not yet enforcing the requirement pending clarification of important coverage issues by its state legislature.

Table 3.1: States' Requirements for Employers to Have Comprehensive Worksite Safety and Health Programs and Committees

	State requirements			
	Safety and health programs		Labor-management committee	
State	All employers	Some employers	All employers	Some employers
Alaska	X			X
Arizona				
California	X			
Hawaii	X			
Indiana				
Iowa				
Kentucky				
Maryland				
Michigan				
Minnesota		X		
Nevada[a]		X		X
New Mexico				
North Carolina		X		X
Oregon		X		X
South Carolina				
Tennessee		X		X
Utah				
Vermont				
Virginia				
Washington	X		X	
Wyoming				
Total	**4**	**5**	**1**	**5**

[a]Nevada has not enforced this requirement pending clarification of important coverage issues by the state legislature.

In our 1992 report, we concluded that safety and health programs can have positive effects on safety and health at the worksite. In that report we (1) suggested that the Congress consider passing legislation that would require high-risk employers to have comprehensive safety and health programs and (2) recommended that OSHA use evaluation studies to identify the employers that should be required to have these programs. Officials in states requiring such programs believe they result in more efficient inspections and better use of scarce state resources. In addition,

they believe that such programs contribute to the reduction of injuries and illnesses and workers' compensation costs.

Worksite-Level Injury and Illness Data for Targeting Inspections and Directing Education Efforts

In contrast with OSHA, which has data on occupational injuries and illnesses primarily at the industry level, many states use worksite-level data to target their inspections and education and training efforts to the most hazardous worksites. The experience in these states, as well as the results of several empirical studies, lead us to believe that using worksite-specific data in addition to industry-aggregated data could improve OSHA's inspection targeting, education and training efforts, and evaluations of program impact.

State Use of Injury and Illness Data

In using injury and illness data in their inspection activities, the difference between OSHA and many of the states (14 of the 21) is in how they select worksites for targeted inspections. OSHA and the states generally have similar inspection priorities, as follows: (1) imminent danger situations, (2) fatalities and catastrophes, (3) formal complaints, (4) referrals, and (5) targeted inspections. For targeted inspections, OSHA uses industrywide data to identify high-hazard industries and attempts to inspect all employers within those industries, regardless of their individual record of injuries and illnesses or previous violations.[4] In contrast, the 14 states shown in table 3.2 are able to target some or all of their inspection efforts directly to worksites where hazardous conditions exist because of their access to worksite-level data, primarily from workers' compensation files.

Although all 14 states use worksite-specific data, they use the data in different ways. Four of the 14 states—Hawaii, Michigan, Utah, and Washington—rely almost exclusively on worksite-level data. For example, Washington's system establishes a targeted pool of employers within each industry based on a variety of data including workers' compensation claims history, inspection or consultation visits, risk class, size, and nature and types of claims.

[4]For safety inspections, OSHA uses average lost workday injury and illness rates from the BLS Annual Survey of Occupational Injuries and Illnesses to identify the high-hazard manufacturing industries. For health inspections, OSHA ranks industries on a national basis according to the number of serious health violations found during previous OSHA inspections.

Table 3.2: States That Use Worksite-Specific Injury and Illness Data to Target Inspections and Employers With Training and Education Needs

	Targeting	
State	**Inspections**	**Education and training needs**
Alaska	X	X
Arizona	X	
California		
Hawaii	X	X
Indiana		
Iowa		
Kentucky		
Maryland	X	
Michigan	X	X
Minnesota	X	
Nevada		
New Mexico		
North Carolina	X	
Oregon	X	X
South Carolina		
Tennessee	X	X
Utah	X	X
Vermont	X	X
Virginia	X	X
Washington	X	X
Wyoming	X	
Total	**14**	**9**

Ten states use both worksite-specific data and OSHA's high-hazard industry lists, but they use the information in different ways. Two of these states, Minnesota and Oregon, develop their inspection targeting list using worksite-specific data, then refer to OSHA's list of high-hazard industries to supplement that information. For example, Minnesota targets (1) worksites with high numbers of cases of lost workdays due to injuries and (2) employers with larger estimates of expected lost workdays. Oregon targets employers with disabling claim rates that exceed the state average rate; it gives the highest priority to worksites with the most workers' compensation claims and serious violations. A third state, Arizona, has a pilot program under way in which about half of its targeted inspections are based on the number of workers' compensation claims while the remainder are based on OSHA's list of high-hazard industries.

The seven remaining states—Alaska, Maryland, North Carolina, Tennessee, Vermont, Virginia, and Wyoming—refer to OSHA's list of high-hazard industries, then target specific employers within these industries based on workers' compensation data. For example, Maryland refers to OSHA's list of high-hazard industries and updates its list with information from the state employers' first reports of injury, while Wyoming identifies employers with a specific number of workers' compensation claims filed in the prior year.

As table 3.2 shows, 9 of the 21 states also use worksite-specific data to target their education and training efforts. For example, Michigan identifies employers in high-hazard industries and conducts customized training programs to reduce and eliminate workplace injuries and illnesses. Some states target training based on the repeated incidence of certain types of injuries. For example, Vermont uses workers' compensation data to identify employers with high rates of ergonomic-related injuries and targets them for training programs.

Need for Worksite-Specific Data

We agree with program officials in these 14 states, OSHA, and BLS who have expressed their belief that access to worksite-specific data improves the safety and health program. Several research studies also support that belief.

State program directors believe that their access to worksite-specific data has provided them with multiple benefits. These include the ability to (1) target inspections to high-hazard worksites and employers and (2) identify the need for and target education and training programs. Most importantly, they believe it allows them to reallocate scarce resources where they are most needed.

OSHA officials believe that worksite-specific data would help them target inspections and educational efforts; they also believe it would help them evaluate the impact of their programs. To further assess the value of worksite-specific data, OSHA has undertaken a joint project with the state of Maine using worksite-specific data to target enforcement efforts to high-hazard employers. Using workers' compensation data, OSHA has targeted the "Top Two Hundred" high-hazard employers based on their workers' compensation claims. These 200 high-hazard firms comprise about 1 percent of the employers in Maine but account for about 30 percent of the state's employment and 45 percent of the claims under the state's workers' compensation system. In comparing this list of 200

employers with the high-hazard list the regional office would have used for its routine targeting effort, OSHA found that its industry-based list included fewer than 10 percent of the top 200 employers identified using the workers' compensation data. In addition, OSHA's regional administrator responsible for the Top 200 program told us that an added benefit of this program is that inspectors are able to determine likely problems at the worksite prior to a site visit. Based on these data, inspectors can develop information and assistance packages for the employers to help them devise hazard abatement plans for their worksites and employees.

Further, in March 1993, OSHA issued a draft directive to improve the accuracy of employers' records at the worksite that includes records verification through employee interviews and reviews of additional information. OSHA expects to issue this directive in final by March 1995.

Several research studies support the value of worksite-specific data. For example, we did an analysis in 1988 that compared results of about 2,700 inspections in fiscal years 1985, 1986, and 1987; it found that the number of serious violations per inspection was more closely related to an employer's lost workday injury rate than to whether the employer was in a low-hazard or high-hazard industry.[5] More recently, a study[6] examining workers' compensation claims, lost workday cases, and other measures of injury experience found a substantial degree of persistence in injury and disability performance across time at the worksite level. Past injury experience at the worksite was the single most useful predictor of current injury and disability performance—having more explanatory power than industry and employment level. A major conclusion of the study was that "it is obvious that OSHA would benefit from access to establishment-level data in targeting inspections, or other interventions designed to improve occupational safety and health performance."

In another approach to this issue, researchers used data on over 6,000 worksites inspected by OSHA to compare the impact on injury rates of different kinds of OSHA inspections.[7] One comparison involved inspections (1) done in response to a worker complaint and (2) targeted based on OSHA's usual industry-level data, but found to be at worksites with a

[5]The results of this analysis were later published in a GAO report—Occupational Safety and Health: Options for Improving Safety and Health in the Workplace (GAO/HRD-90-66BR, Aug. 24, 1990), p. 29.

[6]H. Allan Hunt, "Analysis of Persistence in Employer Injury Rates," W.E. Upjohn Institute for Employment Research (Mar. 1993), p. v.

[7]Wayne B. Gray and John T. Scholz, "How Effective Are Complaint Inspections?" Report submitted to the Occupational Safety and Health Administration, June 24, 1992.

higher-than-average injury rate over the previous 3 years. They found that inspections at worksites with high injury rates led to a 22-percent reduction in injury rate in the 3 years after an inspection compared with a 14-percent reduction after a complaint inspection.[8] A conclusion of the study was that the effectiveness of OSHA's inspections would be improved if it could target them on the basis of worksite-level injury data.

Historically, BLS officials have been constrained in their ability to share worksite-specific data with OSHA to improve its inspection targeting and education and training efforts. On October 21, 1993, however, officials at OSHA and BLS reached agreement that information collected by BLS in its Annual Survey of Occupational Injuries and Illnesses does not provide an effective basis for OSHA to target inspections at individual establishments. Both agencies agreed that the survey data are inappropriate for identifying individual high-hazard employers because the survey gathers data from only a sample of establishments for inspection by OSHA. As a result, OSHA and BLS are working together to develop procedures and policies to obtain these data without compromising the independence and confidentiality of the data collection process.

Because the law already gives the Secretary of Labor authority to collect injury and illness data from employers, no statutory change is needed for OSHA to obtain worksite-specific data. However, the Secretary would have to decide how best to coordinate OSHA's data needs with the current BLS survey approach. We discuss options for OSHA to obtain these data in appendix VI. One problem common to both options we discuss is the risk that employers may underreport injuries and illnesses if they know OSHA is collecting or has access to data about their worksites. As we discussed earlier, OSHA's draft directive, when implemented, will provide several ways of verifying occupational injury and illness records and, subsequently, reduce the likelihood of employers underreporting occupational injuries and illnesses. Obtaining worksite-specific data would increase the need for OSHA to have a successful combination of education and enforcement to prevent underreporting.

[8]In worksites targeted on the basis of OSHA's usual criteria and found to have below-average injury rates in previous years, the injury rates went up 9 percent in the subsequent 3 years after the inspector's visit. Comparison of the impact is complicated, however, by the fact that these worksites did not receive a full inspection. (During the period of these inspections, OSHA's policy was to conduct a "records check only," that is, to leave the worksite without a full inspection, if records at the worksite showed below-average injury rates.)

Shutdown Authority in Imminent Danger Situations

An imminent danger situation is one in which worksite conditions or practices present a danger that could reasonably be expected to cause death or serious physical harm immediately or before the danger can be eliminated through the usual enforcement procedures. Ten of the 21 state safety and health programs have the authority to shut down operations or areas of a worksite if an employer refuses to remove the hazard. OSHA and other states lack this authority, but we had too little information about the consequences of this lack of authority to determine how important it would be for OSHA or state programs to have it.

OSHA does not have shutdown authority during an imminent danger situation. If an employer refuses to correct such a situation immediately, an OSHA inspector must obtain injunctive relief, such as a temporary restraining order from the appropriate District Court, to shut down all operations or the specific areas of the worksite where imminent danger exists. In contrast, the 10 state programs shown in table 3.3 have authority to shut down worksite operations without pursuing actions through the courts. In 7 of the 10 states, the inspector has the authority to shutdown worksite operations. In the remaining three states—Michigan, Nevada, and Vermont—supervisory approval is required prior to shutdown in imminent danger situations. For example, the Nevada Administrator may issue an emergency order to cease operations based on the inspector's recommendation.

Table 3.3: States With Shutdown Authority in Imminent Danger Situations

State	Shutdown authority
Alaska	X
Arizona	
California	X
Hawaii	
Indiana	
Iowa	
Kentucky	X
Maryland	
Michigan	X
Minnesota	X
Nevada	X
New Mexico	
North Carolina	
Oregon	X
South Carolina	
Tennessee	X
Utah	
Vermont	X
Virginia	
Washington	X
Wyoming	
Total	**10**

State officials believe this increased authority allows them to provide more immediate protection to ensure workers' safety. In a 1992 report[9], we noted the advantages, cited by program officials, of inspectors' authority to shut down operations. For example, this authority often results in the employer correcting a serious hazard immediately, an Alaska official told us, because the employer knows the inspector can stop the operation. Without this authority, worker protection is delayed while an inspector seeks a court order.

We were unable to identify an appropriate source of data to show how often inspectors identify imminent danger situations, how quickly inspectors are able to convince employers to shut down operations or remove the dangers, or how quickly inspectors can get a court order to

[9] Occupational Safety and Health: Options to Improve Hazard-Abatement Procedures in the Workplace (GAO/HRD-92-105, May 12, 1992).

shut down a dangerous operation. As part of its review of reform legislation, OSHA plans to study whether inspectors need additional authority in imminent danger situations.

Coverage of State and Local Government Employees

All state-operated programs differ from OSHA in that they cover state and local government employees, while OSHA is prohibited by law from doing so. As a result, an estimated 7.3 million state and local public employees in 27 states are not protected by federal safety and health statutes or regulations. We did not determine what coverage these employees may have from other sources, such as state workers' compensation programs or private insurers. OSHA officials told us that part of their review of OSHA reform legislation will include a study to determine the coverage these employees may have from other sources.

Program Funding Tied to Employer Assessments

OSHA is funded by an annual appropriation from the Congress, with which it funds up to 50 percent of the costs to operate state programs. In contrast, nine states fund all or part of the state share of their operating costs through assessments that are based, in part, on employers' records of occupational injuries and illnesses or safety and health violations. These state officials believe the direct tie between employers and program funding encourages employers to reduce safety and health hazards; and this approach minimizes reliance on state appropriations to fund state safety and health programs. Because of the complexity involved in OSHA's negotiating funding arrangements separately in each state, however, we do not recommend that OSHA adopt this approach. Still, it is an option other states may wish to consider to fund their portion of the safety and health program.

As shown in table 3.4, seven states fund the entire portion of their safety and health programs from employer assessments, and two states fund only their education and training components through these assessments.

Table 3.4: States That Fund Their Programs Through Employer Assessments

State	Entire state portion funded through assessments	Only education and training activities funded through assessments
Alaska		
Arizona	X	
California		
Hawaii		
Indiana		X
Iowa		
Kentucky	X	
Maryland		
Michigan		X
Minnesota	X	
Nevada	X	
New Mexico		
North Carolina		
Oregon	X	
South Carolina		
Tennessee	X	
Utah		
Vermont		
Virginia		
Washington	X	
Wyoming		
Total	**7**	**2**

Of the seven states that fund the entire portion of their program through employer assessments, five assess (1) employers who are self-insured and (2) private insurance carriers. Four of those five states—Arizona, Kentucky, Oregon, and Tennessee—assess a surcharge to private insurers and self-insured employers based on workers' compensation premiums. For example, Kentucky assesses a 23.3 percent surcharge on the workers' compensation premiums paid to all insurance carriers and self-insured employers. The fifth state, Minnesota, assesses a surcharge to private insurance carriers and self-insured employers based on workers' compensation paid claims during the previous year.

The funding approaches in Washington and Nevada differ from these other states. In Washington, the state-operated workers' compensation program funds the safety and health program from a portion of workers'

compensation premiums paid by employers and assessments collected from self-insurers. Nevada relies primarily on payroll assessments charged to all employers, regardless of workers' compensation or injury and illness history. This program is also funded, in part, by employers' penalties assessed for workplace violations and by licensing fees. Two states, Indiana and Michigan, fund only the education and training activities of their safety and health programs from an assessment based on workers' compensation paid claims.

Conclusions

OSHA and state-operated safety and health programs share similar approaches based on the statutory requirement that states be at least as effective as OSHA. However, certain components of state programs differ from OSHA as a result of state initiatives to improve their programs. These initiatives, based on OSHA and state program officials' opinions and research, appear to have a positive impact on workplace safety and health and some warrant further consideration and study by OSHA and other states.

State requirements for employers to develop and implement comprehensive worksite safety and health programs and committees have reportedly resulted in numerous benefits including (1) better use of limited inspection resources, (2) improved injury and illness rates at the worksite level, and (3) improved financial performance for some companies. Those companies implementing safety and health committees have reported improved productivity and employee morale.

State access to worksite-specific data has produced multiple benefits for state-operated safety and health programs, including (1) better targeting of inspections and education and training programs to the most hazardous worksites and (2) more efficient use of limited inspection and training resources. We agree with program officials in 14 states and OSHA that access to worksite-specific data could improve the safety and health program. However, along with gaining access to worksite-specific data, OSHA needs to take additional steps to ensure that these data are being accurately recorded and reported by the employer.

In cases of imminent danger, giving inspectors authority to shut down operations helps ensure the protection of workers until employers take corrective action. This authority serves as an incentive to abate hazards in the workplace. Giving OSHA jurisdiction for state and local government workers could ensure some 7 million workers safety and health protection

and respond to concerns that other federal agencies with jurisdiction are not covering. These two program features, although adopted in several states, may warrant further study by OSHA and other states to assess whether they should be adopted.

Recommendations

We recommend that the Secretary of Labor require the Assistant Secretary for Occupational Safety and Health to (1) develop procedures for OSHA to obtain worksite-specific injury and illness data from employers, and (2) implement its procedures for ensuring that employers accurately record occupational injuries and illnesses.

To determine what, if any, changes are needed regarding coverage for state and local government employees and protections for workers in imminent danger situations, we recommend that the Secretary of Labor require the Assistant Secretary for Occupational Safety and Health to assess the need for change to (1) extend OSHA's coverage to state and local government employees in states without OSHA-approved safety and health programs and (2) give OSHA greater authority to protect workers in imminent danger situations.

Agency Comments and Our Evaluation

Both OSHA and BLS officials agree that procedures are needed for OSHA to obtain worksite-specific data from employers. On October 21, 1993, OSHA and BLS reached agreement that worksite-specific data is needed to enhance OSHA's targeting of inspections to the most hazardous employers and its education and training efforts. We believe that along with gaining access to these data, however, OSHA needs to address the related issues of (1) developing the specific procedures for obtaining worksite-specific data and (2) ensuring the accuracy of the records at the worksite. In addition, OSHA officials agreed that procedures are needed to ensure the accuracy of the records at the worksite.

OSHA officials agreed to further review the issues of extending coverage to state and local government employees and providing additional authority to inspectors in imminent danger situations during their consideration of the OSHA reform legislation.

Survey of State Officials on OSHA's Monitoring and Evaluation Process and the Combined Federal-State Approach

Through a questionnaire, we surveyed state officials in the 21 states that have responsibility for private-sector occupational safety and health programs to (1) obtain their opinions about OSHA's routine and "special" evaluations of state programs and (2) collect information about the way the states ensure workers' safety and health. State officials completed our questionnaire between July and August 1992. In addition, we followed up with the state officials in February 1993 to confirm information about their state programs.

Our questionnaire had two parts. Part I consisted of a mail-out questionnaire containing closed-ended and open-ended questions about OSHA's routine and special monitoring and evaluation process. Part II provided a description of each state's safety and health program which we developed from information received from OSHA's Office of State Programs and other sources. We then surveyed state officials by telephone to (1) confirm information we had provided in part II; (2) collect, as necessary, supplementary program information; and (3) identify program components or features that differed from the OSHA program and, in the officials' opinions, were particularly noteworthy or successful.

All of the 21 states responded to our survey. The questionnaire with summaries of responses to closed-ended questions is shown as follows.

PART (1)

U.S. GENERAL ACCOUNTING OFFICE

OSHA Monitoring and Evaluation of
State-Operated Worker Safety and Health Programs

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state code

INTRODUCTION

At the request of the United States Congress, the U.S. General Accounting Office is conducting a study of the Occupational Safety and Health Administration (OSHA) monitoring and evaluation process, including its "initial" special 1991 evaluation of state programs*, and the combined federal and state approaches to ensure workers' safety and health. We are interested in getting the opinions of state officials about OSHA's monitoring and evaluation process in preparation for testimony before the Congress planned for later this year, and a final report to be issued in early 1993. To obtain this information we are sending this questionnaire to the officials responsible for state-operated safety and health programs for the private sector.

Please complete and return this questionnaire within **ONE WEEK** of receipt to the:

U.S. General Accounting Office
NGB/Education and Employment (E & E)
441 G Street, NW
Washington, DC 20548
Attn: Linda Stokes

A preaddressed postage-paid business reply envelope is enclosed for your convenience. You may also return your completed questionnaire by FAX on (202) 336-6607.

When answering these questions, you may want to seek assistance from members of your staff. If you have any questions please call Linda Stokes on (202) 512-7040. She will be pleased to help you.

Thank you for your prompt response.

Please enter the following information about the person responsible for completing this questionnaire.

Name: ______________________________

Title: ______________________________

Address: ______________________________

Phone: ______________________________
area code number

* By "special evaluation" we are referring to the OSHA evaluation conducted during 1991 of all 18B states other than North Carolina, the results of which were submitted to the Congress on January 31, 1992.

I. OSHA'S SPECIAL EVALUATIONS

The items in this questionnaire only relate to the special evaluation of state occupational safety and health programs that OSHA conducted in 1991 and not to the followup to this special evaluation that OSHA is now conducting. Please consider **ONLY** the initial special evaluation process when responding to these questions.

1. Based on your state's experience, to what extent did the special evaluation that OSHA conducted in 1991:
(CHECK ONE FOR EACH.)

	To a very great extent (1)	To a great extent (2)	To a moderate extent (3)	To some extent (4)	To little or no extent (5)
. . .use performance measures that were valid indicators of the effectiveness of a state's program? ***(n=21)***	*1*	*1*	*8*	*9*	*2*
. . .base its conclusions on information (from IMIS, case files, etc.) that was complete and accurate? ***(n=21)***	*0*	*7*	*5*	*9*	*0*
. . .reach conclusions that were supported by the data? ***(n=20)***	*0*	*5*	*6*	*8*	*1*
. . .produce a complete and balanced report from your regional office to OSHA? ***(n=21)***	*2*	*3*	*9*	*4*	*3*
. . .produce a complete and balanced report from OSHA to the U.S. Congress? ***(n=19)***	*1*	*1*	*8*	*4*	*5*

2. Consider the performance indicators used for OSHA's special evaluation. Are there any other performance indicators that you believe should have been used either in addition to or in lieu of any of these?
(n=21)

1.[*11*] Yes

2.[*10*] No-->**(SKIP TO 4.)**

3. Please list the other performance indicators that you believe should have been used.

____

____

____

____

II. COMPARISON OF OSHA'S ROUTINE AND SPECIAL EVALUATIONS

The items in this section refer to OSHA's **ROUTINE** evaluation and monitoring process as well as the **SPECIAL** evaluation of state occupational safety and health programs

that OSHA conducted in 1991. Once again, consider the initial special evaluation process when responding to these questions, not the followup to this special evaluation that OSHA is now conducting.

4. Now consider the **ROUTINE** evaluation and monitoring that OSHA conducted in your state for fiscal year (FY) 1990. In your opinion, did this produce an accurate or inaccurate picture of the effectiveness of your state program at that time? (CHECK ONE.) ***(n=21)***

1.[*0*] Completely accurate

2.[*16*] Mostly accurate

3.[*4*] About half accurate, half inaccurate

4.[*1*] Mostly inaccurate

5.[*0*] Completely inaccurate

5. Compared to its FY 1990 **ROUTINE** evaluation and monitoring, did OSHA's **SPECIAL** evaluation in 1991 produce a more accurate, about as accurate, or less accurate picture of the effectiveness of your state program? (CHECK ONE.) ***(n=21)***

1.[*1*] Far more accurate than routine evaluation/monitoring

2.[*1*] Somewhat more accurate than routine evaluation/monitoring

3.[*10*] About as accurate as routine evaluation/monitoring

4.[*5*] Somewhat less accurate than routine evaluation/monitoring

5.[*4*] Far less accurate than routine evaluation/monitoring

6. Compared to its FY 1990 **ROUTINE** evaluation and monitoring, did OSHA's **SPECIAL** evaluation in 1991 require more, about as much, or less in terms of time and effort expended by your state? (CHECK ONE.) ***(n=21)***

1.[*11*] Far more than routine evaluation/monitoring

2.[*6*] Somewhat more than routine evaluation/monitoring

3.[*4*] About as much--->**(SKIP TO 8.)**

4.[*0*] Somewhat less than routine evaluation/monitoring

5.[*0*] Far less than routine evaluation/monitoring

7. Please briefly describe what accounted for this difference.

____

____

____

III. OSHA OVERSIGHT OF STATE PROGRAMS

Please concisely summarize your views and experiences, if any, related to each of the following open-ended questions. If you need more space to respond, you may attach additional sheets.

8. Based on your state's experience, what were the advantages or strengths of OSHA's **SPECIAL** 1991 evaluation?

9. What were its disadvantages or weaknesses?

10. What are the advantages or strengths of OSHA's **ROUTINE** evaluation and monitoring?

11. What are its disadvantages or weaknesses?

12. What administrative or legislative changes, if any, could improve OSHA's oversight of state programs?

administrative changes:

legislative changes:

IV. COMBINED FEDERAL AND STATE APPROACH

13. In your opinion, what administrative or legislative changes, if any, would encourage or improve cooperation between the federal and state governments in ensuring worker safety and health?

administrative changes:

legislative changes:

V. OTHER COMMENTS

14. If you would like to elaborate on your response to any of the previous questions or provide any other information about OSHA routine or special evaluations, please write your comments below.

You may also attach a copy of any correspondence that your state has sent to OSHA regarding their routine or special evaluation, that you believe would be useful to us.

THANK YOU FOR YOUR TIME AND EFFORT.

PART (2)

STATE PROGRAMS:

DESCRIPTION OF STATE ACTIONS TO OPERATE A SAFETY AND HEALTH PROGRAM
(As of February 1993)

Note: Part II of our questionnaire was developed to obtain a description of state policies and procedures in the following areas:

- Standard setting
  - administrative process
  - legislative process
  - periodic review/update of standards,
- Enforcement
  - targeting inspections (priorities, sources of data, special emphasis programs)
  - hazard abatement procedures (corporate-wide agreements, imminent danger provision, shut down authority
  - citation structure (civil and criminal sanctions)
- Program evaluation
  - impact studies
  - review of performance indicators
  - resources (staffhours and funds)
- Education and training
  - consultation program
  - voluntary protection program
  - special emphasis programs
- Ways to encourage employer and worker involvement in safety and health (require or encourage)
  - worksite safety and health programs
  - joint labor-management committees
- Sources of program funding

Appendix II

OSHA Actions Taken in Response to Prior GAO and OIG Recommendations

About 5 years after GAO and the Department of Labor's Office of the Inspector General issued studies identifying significant weaknesses in OSHA's performance measurement system[1], OSHA has taken mostly interim steps to address the recommendations of the OIG and GAO.

OSHA Has Made Little Progress in Responding to GAO Recommendations

The 1988 GAO study included recommendations that OSHA (1) establish desired performance levels for use by state programs, (2) require states to develop quality assurance programs and internal program audits, and (3) help states develop and implement plans for evaluating the impact of their programs. As shown in table II.1 below, OSHA has made little progress to address the major weaknesses we identified.

Table II.1: Status of OSHA Actions Taken in Response to GAO's 1988 Study Recommendations

Recommendation	Agency response(s)	Agency action(s)
OSHA should establish performance levels for use by state programs and consider providing incentives for states to attain them.	OSHA agreed to establish specific performance levels where they are provided in OSHA policy, but disagreed with providing incentives for states to attain.	OSHA agreed to incorporate some specific performance levels based on federal OSHA policy in its (routine) evaluations as of June 1988; first included them in its special evaluations.
OSHA should require that states establish quality assurance programs and conduct periodic review of these efforts.	OSHA agreed to consider requiring states to implement internal audit programs.	An OSHA task force submitted four draft proposals to require states to develop and conduct annual assessments of their safety and health programs (September 1990, January 1993, February 1993, and August 1993).
OSHA should work with the states to implement plans to evaluate their programs' impact on workers' safety and health.	OSHA agreed to develop policy requiring regional offices to evaluate and report on impact studies performed by state program officials.	OSHA issued a memorandum to its regional directors requiring them to obtain information on state-directed impact studies and include the results in state evaluations (January 1990). OSHA's national office, as of February 1993, received no information on these state-directed studies.

In 1990, OSHA organized a federal-state task force to conduct a comprehensive review of its monitoring and evaluation system. The task force, representing both state and federal officials, comprised five task groups responsible for developing a conceptual framework to revise OSHA's routine monitoring and evaluation system. The task force was also responsible for incorporating changes that would address the system weaknesses in OSHA's performance measurement system and oversight role.

[1] OSHA's Monitoring and Evaluations of State Programs (GAO/T-HRD-88-13, Apr. 20, 1988), and OSHA's Monitoring of State Programs, Final Report No. 05-89-029-10-105 (Jan. 30, 1989).

OSHA, in early 1990, took additional actions to (1) clarify basic monitoring principles and performance activity measures, (2) incorporate OSHA enforcement policies as criteria in a few performance activity measures, (3) require states to use state and other computerized reports to help verify state databases and daily program operations, (4) develop draft guidelines for states to conduct annual internal program audits of their safety and health programs, and (5) encourage field staff to gather and distribute information about state-directed efforts to conduct impact assessments of their programs.

Although OSHA has taken some interim actions, many proposals of the five task groups remain incomplete, and others await further review and comments of the OSHA field staff. Three of the five task groups submitted their proposals for revision in April 1991, recommending that OSHA (1) streamline its program activities measures, (2) incorporate grant-based monitoring, and (3) assess the adequacy of states' internal audit procedures as part of OSHA's evaluation of states' performance. In February 1993, a fourth task group, responsible for recommending changes to OSHA's monitoring policies and procedures (including guidelines for internal audits), submitted its third draft proposal for review and comment by OSHA's national office and field staff. The fourth task group also issued a fourth draft in August 1993. As of January 1994, OSHA had acted on only one of the four proposals of the four task groups: OSHA officials agreed to reduce the number of program activity measures used to assess state programs' performance from 115 to 48, but this decision had not been implemented in January 1994. In addition, the fifth task group, responsible for revising the occupational injury and illness activity measures, had not submitted a report for OSHA's review and comment.

OSHA Has Made Little Progress in Its Response to the OIG

OSHA has also made little progress to correct weaknesses in its monitoring policies and procedures identified in a 1989 report by the OIG. As of January 1994, OSHA had fully implemented only one of the OIG recommendations: to require uniform data collection of states through their participation in OSHA's data information system. Recommendations not implemented by OSHA included requirements for (1) improvements in data use and reporting quality, (2) onsite reviews of critical enforcement program activities, (3) improved tracking and follow-up procedures, and (4) strengthened internal audits of regional and area office monitoring activities. OSHA headquarters officials plan to respond to the remaining OIG recommendations once the revisions to its routine monitoring and evaluation system are completed. OSHA's Director of the Office of State

Programs and a task force representative told us that higher priorities and limited staff and funds have delayed any further actions in this area; however, OSHA expects to complete all revisions to its routine monitoring and evaluation system by September 30, 1994.

OSHA Performance Measures Used in the Special Evaluations

		Comparison		
		Federal performance		Absolute performance level (percent)
Category	Measure	Initial	Follow-up	
Safety & Health Standards	1. Percent of five standards adopted within 6 months after OSHA promulgation			100[a]
Compliance Staffing Levels	2 & 3. Percent of benchmark positions allocated			
	Safety			100[b]
	Health			100[b]
	4 & 5. Percent of allocated compliance positions filled			
	Safety			80[a]
	Health			75[a]
	6 & 7. Number of covered workers (public and private) for every inspector			
	Safety	*84,322[c]*	*84,322[c]*	
	Health	*127,463[c]*	*127,463[c]*	
Enforcement/productivity	8 & 9. Number of inspections for every compliance officer			
	Safety	66.5[d]	39.5[d]	
	Health	23.2[d]	14.1[d]	
	10 & 11. Number of inspections for every 1,000 covered workers			
	Safety	.60[d]	.31[d]	
	Health	.16[d]	.09[d]	
Targeting	12 & 13. Total percent of programmed targeted inspections (construction and nonconstruction)			
	Safety	47.4[e]	55.2[e]	
	Health	14.3[e]	20.4[e]	
	14 & 15. Total percent of programmed targeted inspections not in compliance			
	Safety	72.5[e]	61.6[e]	
	Health	76.6[e]	63.5[e]	
	16 & 17. Total percent of programmed targeted inspections (nonconstruction) in high-hazard industries			
	Safety	*65.6[e]*	*68.4[e]*	
	Health	*76.4[e]*	*71.7[e]*	
Right-of-entry	18. Percent of cases where entry was obtained after initial denial	94.7[e]	88.4[e]	
Complaints	*19. Percent of valid complaints in backlog status at end of period*	*5.7[f]*	*17.1[f]*	

(continued)

Category	Measure	Comparison: Federal performance		Comparison: Absolute performance level (percent)
		Initial	Follow-up	
Identify/cite hazards	20 & 21. Average number of violations for every not-in-compliance inspection Safety Health	 4.6[e] 5.6[e]	 5.0[e] 7.0[e]	
	22 & 23. Average percent of serious violations Safety Health	 64.2[e] 57.2[e]	 66.5[e] 62.2[e]	
	24 & 25. Average percent of serious, willful, repeat, and combined violations *Safety* *Health*	*Safety[e]:* *64.1* *1.7* *2.4* *68.2* *Health[e]:* *57.2* *2.3* *1.9* *61.4*	*Safety[e]:* *66.5* *.5* *2.1* *69.1* *Health[e]:* *62.2* *.6* *2.0* *64.8*	
Abatement	26. Percent of not-in-compliance inspections resulting in follow-up	6.2[e]	4.1[e]	
	27. Percent of case files where abatement evidence was adequate and timely			*90[e]*
Penalties	28. Average initial penalties for serious, willful, and repeat violations Safety Health	Safety[g]: $670 16,090 2,184 Health[g]: $702 8,888 1,862	Safety[g]: $1,105 25,938 4,084 Health[g]: $1,208 15,406 4,795	
Public sector	29. Percent of total inspections in the public sector			3-17[h]
Review	30. Percent of contested violations upheld	82.7[e]	77.1[e]	
	31. Percent of penalty retained in settlement agreement after employer contest	52.2[e]	48.3[e]	
Discrimination	*32. Percent of discrimination cases in backlog at the end of the fiscal year*			*35[i]*
Funding	*33. Percent of past 3 years when state was able to match federal funding*			
	34. Percent of funds reverted to OSHA over past 3 years (deobligated and lapsed)			

(continued)

Category	Measure	Comparison: Federal performance – Initial	Comparison: Federal performance – Follow-up	Comparison: Absolute performance level (percent)
Voluntary compliance	35. Percent of total funds allocated to voluntary compliance activity (consultation, training, and education activities)			5-15[j]
Injury rates	*36. Percent of change in the Bureau of Labor Statistics' Lost Workday Injury Rate (over the past 5 years)*	*11.8*[k]	*11.8*[k]	
Seven-Fold Penalty	Enactment of OSHA's seven-fold penalty increase			Yes

Note: Words in boldface type are the five priority program areas. New performance measures used in only the special evaluations are shown in italics.

[a]Further Review Level (FRL): not less than this amount.

[b]FRL: not less than this amount, except for states without final approval, for which comparison is 80 percent.

[c]FRL: not above federal level.

[d]FRL: no more than 20 percent above or below federal level.

[e]FRL: no more than 20 percent below federal level.

[f]FRL: no more than 20 percent above federal level.

[g]FRL: no more than 20 percent below federal level for four of the six items.

[h]FRL: not outside this range.

[i]FRL: not more than this amount.

[j]FRL: not outside this range for states with final approval; for others, acceptable range is between 10 and 20 percent.

[k]FRL: no more than 10 percent above federal OSHA's level.

Results of OSHA's Special and Follow-Up Evaluations of State Occupational Safety and Health Programs

Between October 1991 and January 1992, OSHA conducted special evaluations of all 21 states that have responsibility for workers' safety and health in both the public and private sector. OSHA then conducted follow-up evaluations during August 1992 to assess states' progress in correcting performance considered unacceptable, with the intention of withdrawing approval from any state program not providing adequate safety and health protections.

In October 1992, OSHA released its final follow-up evaluation reports.[1] As your Committee requested, a summary of OSHA's conclusions (at the time of the special and the follow-up evaluations) regarding the states' performance and our observations follow.

OSHA's Special and Follow-Up Evaluations of State Programs

In the special evaluations of state programs—the most recent evaluation reports available for all states at the time of our review—OSHA considered all 21 states unacceptable in one or more of the areas assessed. In the follow-up to the evaluations, OSHA found substantial improvement in state performance but still found at least one area of unacceptable performance in 19 states. Seven of those states had performance that OSHA still considered unacceptable in one or more of the five areas identified by OSHA as high priority, but OSHA did not withdraw approval for any state to continue operating its own program.

OSHA's Assessment of States' Performance in Priority Program Areas

As we discussed in chapter 2, OSHA identified five priority program areas in its special evaluations: (1) adoption of safety and health standards within 6 months after OSHA promulgated them, (2) adequate compliance officer (inspector) staffing levels[2], (3) adoption of the 700 percent penalty increase mandated by the Congress in 1990 and implemented by OSHA in March 1991, (4) adequate (complete) and timely evidence that employers abated hazards for which they had been cited, and (5) procedures for right-of-entry. As figure IV.1 shows, OSHA initially considered 20 of the 21 states, all except South Carolina, to be unacceptable in one or more of the priority areas.

[1]OSHA released its final conclusions about the North Carolina occupational safety and health program on March 30, 1993.

[2]To comply with a court order, OSHA requires states to maintain the number of safety and health inspectors considered necessary to operate a "fully effective" program. This number, called the "benchmark," is based on a formula that considers data such as the number of inspections, average number of workers at each worksite in each industry, and percentage of inspector hours spent conducting different types of inspections. Using the formula on state-specific data generates the benchmark level of safety and health inspectors for that state.

Figure IV.1: Areas in Which OSHA Concluded State Performance Was Unacceptable in Special and Follow-Up Evaluations—Five Priority Areas

State	Initial Special Evaluation: Timely Standard Adoption[a]	Initial Special Evaluation: Adequate Inspector Staffing Levels	Initial Special Evaluation: Adoption of the Seven-fold Penalty Increase	Initial Special Evaluation: Adequate and Timely Abatement Evidence	Initial Special Evaluation: Right of Entry[b]	Follow-up Evaluation: Timely Standard Adoption	Follow-up Evaluation: Adequate Inspector Staffing Levels	Follow-up Evaluation: Adoption of the Seven-fold Penalty Increase	Follow-up Evaluation: Adequate and Timely Abatement Evidence	Follow-up Evaluation: Right of Entry
Alaska	•		•	•						
Arizona	•		•	•						
California	•	•	•							
Hawaii	•		•							
Indiana	•			•					•	
Iowa	•	•	•	•			•		•	
Kentucky			•							
Maryland	•			•						
Michigan	•	•		•		•	•		•	
Minnesota				•						
Nevada				•						
New Mexico	•	•	•	•						
North Carolina	c	•								
Oregon				•						
South Carolina										
Tennessee		•		•					•	
Utah	•			•					•	
Vermont	•	•		•			•		•	
Virginia			•	•						
Washington	•			•						
Wyoming			•	•					•	
Totals	12	7	9	16	0	1	3	0	7	0

● Program areas that OSHA considered unacceptable.

[a]Five standards not implemented within 6 months after OSHA promulgates them.

[b]Percent of cases where the state compliance inspector obtained entrance to the worksite after the employer initially denied entry.

[c]OSHA initially considered the state unacceptable in this area, but later agreed that its initial assessment was in error.

The area in which the most states (16 of the 21) were unacceptable was abatement evidence. As appendix III, which lists the specific measures

used to assess performance in each area, shows, a state could be unacceptable in this area either because it conducted 20 percent fewer follow-up inspections to confirm abatement than OSHA did or because fewer than 90 percent of the case files examined showed adequate and timely evidence of abatement. It was a comparison with a 90-percent standard for adequacy in the case files, which was used for the first time in the special evaluations, that caused most states to be considered unacceptable.[3]

In the follow-up evaluations 6 months later, OSHA concluded that 13 of the 20 states had resolved program inadequacies. In the seven states where OSHA still found state performance unacceptable, (1) all seven[4] states lacked adequate and timely procedures for verification of abatement or follow-up inspections, (2) three states were below their required compliance inspector staffing levels, and (3) one state had not adopted OSHA standards within 6 months of OSHA's date of issuance. Regarding the timely adoption of federal standards, 11 of the 12 states completely met OSHA's requirement, even though 10 of the 11 had been unacceptable in the fiscal year 1990 evaluations as well. For example, California enacted a provision to enforce the federal standard if an equivalent state standard were not adopted within 6 months. Michigan, the only state still considered unacceptable, had initiated action that, when fully implemented, will bring its process into compliance.

OSHA's Assessment of States' Performance in Nonpriority Program Areas

In addition to the 5 priority areas, OSHA also assessed states' performance in 11 other areas, usually comparing them with comparable statistics for OSHA in the same time period. OSHA initially considered all states unacceptable in one or more of these areas. Most of the states were acceptable in the areas of program funding, funds spent to encourage voluntary compliance, and review of contested cases. OSHA found that 10 states had shown a greater 5-year increase in injury rates than OSHA had, but, as discussed in chapter 2, concluded that there were reasons other than the program itself that generally explained the discrepancy. In addition, OSHA could not assess improvement on that measure at the

[3]For further discussion of the way OSHA confirms abatement, and our criticism of its policies, see Occupational Safety and Health: OSHA Policy Changes Needed to Confirm That Employers Abate Serious Hazards (GAO/HRD-91-35, May 8, 1991).

[4]GAO reported this number during OSHA oversight hearings (October 20, 1993) as six states lacking adequate and timely procedures for verification of abatement or follow-up inspection, but OSHA headquarters officials later concluded that the performance of one other state—Vermont—also remained unacceptable at the follow-up evaluation.

follow-up because of the short time interval. Table IV.2 shows state performance in the other seven areas.

Figure IV.2: Areas in Which OSHA Concluded State Performance Was Unacceptable in Special and Follow-Up Evaluations—7 of the 11 Nonpriority Areas

	Initial Special Evaluation							Follow-up Evaluation						
State	Productivity (Number of Inspections)	Inspection Targeting Procedures	Percent of Valid Complaints in Backlog	Adequate Violation Classification and Citation	Penalty Assessment (Serious, Willful, and Repeat)	Public-Sector Inspections	Investigation of Discrimination Complaints[a]	Productivity (Number of Inspections)	Inspection Targeting Procedures	Percent of Valid Complaints in Backlog	Adequate Violation Classification and Citation	Penalty Assessment (Serious, Willful, and Repeat)	Public-Sector Inspections	Investigation of Discrimination Complaints[a]
Alaska				●							●			
Arizona				●	●						●	b		
California		●		●	●				●		●	b		
Hawaii				●	●						●	b		
Indiana	●		●	●		●		●			●			
Iowa		●												
Kentucky	●	●		●	●				●		●			
Maryland				●			●							●
Michigan	●	●	●	●			●	●			●			
Minnesota				●	●						●			
Nevada				●							●			
New Mexico	●	●		●	●				●		●	b		
North Carolina		●	●	●			●		●	●	●			
Oregon	●													
South Carolina	●	●		●	●			●	●		●			
Tennessee	●			●	●	●		●			●		●	
Utah	●			●			●	●			●			
Vermont				●							●			
Virginia			●	●										
Washington	●			●			●	●			●			
Wyoming	●	●		●	●			●			●			
Totals	10	8	4	19	9	2	5	7	5	1	17	0	1	1

● Program areas that OSHA considered unacceptable.

[a] Percent of discrimination cases in backlog at the end of fiscal year 1991.

[b] OSHA could not evaluate state performance in this area due to recent adoption of the seven-fold (700 percent) penalty increase.

At the time of the follow-up evaluations, three states—Iowa, Oregon, and Virginia—had completely resolved the problems identified by OSHA; OSHA continued to consider the other 18 states unacceptable in one or more of the same program areas. The three nonpriority areas in which the most states continued to be considered unacceptable were (1) procedures for classifying violations and issuing citations, (2) productivity (number of inspections for each compliance inspector and per 1,000 covered workers, taking into consideration as well the number of violations cited for each inspection), and (3) procedures for targeting inspections. In addition, 10 of the 21 states had occupational injury rates that OSHA considered unacceptable.

Classifying Violations and Issuing Citations

In the special evaluations, OSHA compared states' performance in this area with its average performance of citing 64.2 percent of its total safety and 57.2 percent of its total health violations as serious.[5] States' performance was expected to be no more than 20 percent below OSHA's performance in each category, that is, OSHA expected a state's performance to be no lower than 51.4 percent for safety violations and 45.8 percent for health violations.

Nineteen of the 21 states did not meet OSHA's performance levels in the average percentage of violations classified as serious. In the follow-up evaluations, all but four states—Iowa, Maryland, Oregon, and Virginia—continued to perform at levels OSHA considered unacceptable. For example, at the time of the special evaluations, the Tennessee safety and health program classified 26 percent safety and 28 percent health violations as serious. At the time of OSHA's follow-up evaluation, Tennessee continued to fall short of OSHA's performance (which was then 67 percent for serious safety and 62 percent for serious health) by classifying 30 percent of its safety and 40 percent of its health violations as serious.

State officials identified several factors as reasons for differences in the percentage of total violations cited as serious. Some of these were differences in inspection procedures: (1) different procedures used in citing violations, (2) the experience of compliance inspectors, and (3) more frequent inspections of worksites, which might lead to fewer serious violations being found. Others, however, reflect differences in the worksites, not in the inspection procedures; examples are smaller size of employers and industry mix.

[5]OSHA defines a serious violation as a condition (accident or injury) that could most likely cause death or serious physical harm from one or more practices, means, methods, operations, or processes that have been adopted or are in use in a workplace.

OSHA officials believe that classifying a low percentage of total violations as serious is one indication that a state may be operating an ineffective safety and health program. Further, OSHA's Director of the Office of State Programs told us that numbers and percentages of violations are merely indicators that lead to further analysis of a state's actual practice of classifying violations. It is worth noting, however, that there have been significant increases over time in the number of serious violations OSHA has cited. A 1993 Department of Labor study[6] of the trends in OSHA's enforcement data points out, for example, that 2 percent of all violations were serious in fiscal year 1976, compared with about 62 percent in fiscal year 1991.

Productivity

As measures of productivity, OSHA uses the average number of inspections conducted per safety and health compliance inspector for each 1,000 covered workers, but it combines that measure with another one (average number of violations cited during inspections in which there were some violations) to draw its conclusion about whether a state's performance is acceptable. (See app. III for more details on the measures.)

It was the number of inspections for each compliance inspector, combined with the violations cited, that led OSHA to conclude that 10 states were unacceptable at the time of the special evaluation and 7 remained unacceptable at the follow-up. OSHA considered a state unacceptable if its numbers differed too much from OSHA's statistics. (OSHA, at the time of its special assessments, averaged 67 safety and 23 health inspections for each compliance inspector compared with a state average of 118 safety and 40 health inspections a year for each compliance inspector during the same period.) For example, at the follow-up evaluations, OSHA found that seven states conducted more inspections for each compliance inspector than OSHA but found fewer violations than OSHA. As a result, OSHA considered the performance in these seven states unacceptable.

State program officials maintained, however, that there were reasonable explanations for their performance. For example, the Wyoming compliance inspectors performed more safety inspections and over twice as many health inspections as OSHA, but the state inspectors identified and issued citations for fewer violations during their inspections. A state program official explained that the large number of smaller employers—approximately 80 percent of the employers have fewer than

[6]Frederic B. Siskind, "Twenty Years of OSHA Federal Enforcement Data: A Review and Explanation of the Major Trends," U.S. Department of Labor/Office of the Assistant Secretary for Policy (Washington, D.C.: Jan. 1993), pp. 12-14.

10 employees—allows each state compliance inspector to do considerably more inspections than each OSHA compliance inspector. At the same time, one would not expect a smaller worksite with fewer employees to have as many violations as a larger one.

Procedures for Targeting Inspections

Another program area in which states remained unacceptable during OSHA's follow-up evaluations was the use of inspection targeting procedures. At the time of OSHA's follow-up, five of eight states were still considered unacceptable in their inspection targeting procedures. States conducted fewer targeted inspections than OSHA and those that were done were not targeted to the high-hazard industries identified by OSHA. For example, the California program was considered unacceptable in its inspection targeting approach because they did too many inspections of complaints and accidents compared with OSHA. The California program conducted 61 (5.9 percent of total targeted) safety and 4 (11.8 percent of total targeted) health inspections of high-hazard industries compared with OSHA's 1,034 (65.6 percent of total targeted) safety and 34 (67.9 percent of total targeted) health inspections. Although the state's procedures for inspection targeting comply with OSHA's priorities for inspection of worksites, the California Labor Code requires certain additional investigations, for example, investigation of accidents, that are not required of OSHA by the Occupational Safety and Health Act. OSHA's major concern is that many high-hazard employers and industries in California are not being inspected because their employees do not file complaints. OSHA has concluded that the state's inspection targeting system does not adequately protect employees in high-hazard industries.

OSHA also considered the New Mexico program to be unacceptable in the percentage of programmed inspections conducted in the high-hazard manufacturing industry. The manufacturing industry, however, accounts for only 8.2 percent of the jobs in New Mexico compared with 20 percent of the jobs nationwide. New Mexico has a higher concentration of construction than manufacturing worksites.

Required Comprehensive Worksite Safety and Health Programs and Committees

As of February 1993, nine states had legislative requirements for some or all employers to have worksite safety and health programs, and six states also required them to have safety and health committees. This is an increase from the six states with required programs and three states with required committees that we reported in May 1992. Table V.1 summarizes state employer requirements for comprehensive worksite safety and health programs and committees.

Table V.1: State Requirements for Comprehensive Worksite Safety and Health Programs and Committees

	Requirements	
State/(date of law)	**Programs**	**Labor-management committees**
Alaska (1973)	All employers	Employers in pulp, paper, and paperboard mill industries
California (1989)	All employers	None, but state encourages all employers to have them
Hawaii (1982)	All employers	None
Minnesota (1990)	Employers with specific injury and illness rates[a]	None
Nevada (1991, but not yet enforced)	Employers with specific injury and illness rates[b]	Employers with specific injury and illness rates[b]
North Carolina (1992)	Employers with 11 or more workers and specific workers' compensation experience[c]	Employers with 11 or more workers and specific workers' compensation experience[c]
Oregon (1991)	Employers with 11 or more employees and high-risk employers with 10 or fewer employees[d]	Employers with 11 or more employees and high-risk employers with 10 or fewer employees[d]
Tennessee (1993)	Employers with specific workers' compensation experience[e]	Employers with specific workers' compensation experience[e]
Washington (1960)	All employers	All employers[f]

[a]Employers in industries with lost workday injury rates or injury and illness rates (or both) at or above the state average for all industries.

[b]Employers with injury and illness incidence rates in the top 25 percent in the state for that industry. However, Nevada has not enforced its requirement pending the state's clarification of legislative intent.

[c]Employers with experience rates (factor for calculating workers' compensation premiums) of 1.5 or more.

[d]High-risk employers are defined by their workers' compensation premium rates or lost workday incidence rates.

[e]Employers, including those self-insured, with experience rates in the top 25 percent of all covered employers.

[f]Employers with 10 or fewer employees may have foreman-crew meetings that address the required committee responsibilities.

OSHA's Options for Obtaining Worksite-Specific Injury and Illness Data

Two kinds of worksite-specific injury and illness data that OSHA might use are (1) workers' compensation records and (2) employer records required by the Occupational Safety and Health Act. For the most part, states are relying on workers' compensation data or other private insurer data for their worksite-specific targeting. Although these data may be adequate for state purposes, they would be inadequate for OSHA to develop a nationwide targeting system because of the variations from state to state in workers' compensation coverage and confidentiality rules. For example, reportable injury definitions and reporting time frames can vary significantly from one state to another—21 states require that all injuries occurring on the job be reported, while other states require that injuries resulting in 1 or more lost workdays be reported.[1] Thus, the only nationally consistent source of worksite-specific data available to OSHA is the OSHA log (OSHA 200) and supplemental records. OSHA regulations require all employers to maintain this log documenting recordable injuries and illnesses.

Options for Collecting Worksite-Specific Data From Required Employers' Records

If OSHA is to target its resources based on worksite-specific data, it has two options: (1) devise a procedure to share employer-specific data with BLS or (2) collect OSHA log data directly from employers. Any decision regarding the best way to obtain such data will rest on an analysis of the costs and benefits associated with each option.

OSHA could obtain data from the BLS annual survey in a variety of ways. For example, OSHA could obtain the data directly from BLS or from the state agencies collecting this data for BLS. In either case, BLS would have to modify or eliminate its confidentiality requirement. In addition, although the survey covers most high-hazard worksites with 100 or more employees, some changes to the BLS sample would be required. For example, OSHA officials have estimated that if they were to use data for manufacturing firms with 100 or more employees, 10,000 to 15,000 more employers would have to be added to the current BLS survey.

An alternative would be to have employers send their survey data to OSHA where it could be processed and forwarded to BLS. Both the Mine Safety and Health Administration, part of the Department of Labor, and the Federal Railroad Administration have negotiated a similar arrangement with BLS ensuring their access to worksite-specific data. By collecting and processing these data themselves and then forwarding it to BLS, they are able to access the worksite-specific information prior to its becoming

[1]See Child Labor: Work Permit and Death and Injury Reporting Systems in Selected States (GAO/HRD-92-44FS, Mar. 16, 1992).

confidential. To do this, OSHA would have to implement and operate a data processing system similar to that operated by the state collection agencies under the current system.

Alternatively, employers could be required to send their survey data to the state agencies, BLS, and OSHA. This would avoid the problem of confidentiality, which comes into play when the data reach the state agencies. However, this alternative would cause extra burden to employers, and require OSHA to implement and operate a duplicative data processing system, as mentioned above. A slight change to this alternative would be for OSHA to collect information from high-hazard employers, while BLS continues to collect information for its survey. This would also require duplicative data processing systems and increased burden on employers, many of whom would be required to respond to two separate surveys.

Comments From the Occupational Safety and Health Administration

U.S. Department of Labor

Assistant Secretary for
Occupational Safety and Health
Washington, D.C. 20210

NOV 15 [illegible]

Linda G. Morra, Director
Education and Employment Issues
U.S. General Accounting Office
Washington, D.C. 20548

Dear Ms. Morra:

This is in response to your letter of October 14 to Secretary of Labor Robert Reich submitting for our review and comment the proposed report of the General Accounting Office (GAO) entitled, Occupational Safety and Health Administration: Changes Needed in the Combined Federal-State Approach. The Occupational Safety and Health Administration (OSHA) appreciates the opportunity to comment on the GAO draft report.

OSHA has enjoyed working closely with you to complete your study. GAO has presented a complete review of the challenges confronting this Administration in strengthening the federal-state approach to worker safety and health. While the report describes some policies and procedures that predate this Administration and does not fully acknowledge the significant progress OSHA has made in revising the State plan monitoring system, it will provide a base from which the Agency can build.

Secretary Reich and I are deeply committed to charting a new course that will nourish our partnership with the states. As a former state official, I learned firsthand that states can be laboratories for innovation. With better communication, the coordination between federal and state OSHA programs can be enhanced to provide better working conditions for the American worker.

To strengthen the federal-state approach, OSHA plans to launch significant changes to its operations. We will strive to become a mission driven, results oriented organization. While we will preserve the best of our current program, we will examine new approaches to provide measurable improvements in the workplace. To this end, OSHA has solicited innovative ideas and approaches from stakeholders, such as the states, to meet this challenge. We welcome the assistance of GAO in this endeavor.

GAO makes a number of recommendations. First, GAO suggests that OSHA emphasize measures of program outcome and evaluation as it assesses its own activities and those of the state-operated programs. We agree with this recommendation. OSHA, with the states, has geared its Fiscal Year (FY) 1994 goals toward focusing many Agency tools such as enforcement, consultation and training on maximizing its impact on workplace hazards.

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As one of our goals, we will implement a performance measurement system that will allow us to assess quantifiable measures. As such, we will be better able to more effectively evaluate and monitor the performance of the states. States will be required to respond to any major federal changes that result from the implementation of these goals in order to remain as effective as federal OSHA.

Second, GAO suggests that OSHA revise its state program monitoring and evaluation approach by setting improved outcome measures and goals to eliminate the "moving target" criteria. As noted above, we agree that the development of outcome measures and goals is desirable. Once federal OSHA has developed ways to measure its effectiveness through outcome measures and goals, we could use that approach to enhance our system for gauging the performance of the states. Eliminating the "moving target" aspect of state plan monitoring is a somewhat different matter because the Occupational Safety and Health Act requires direct comparisons between the effectiveness of state programs and federal OSHA. Federal OSHA continually seeks to refine and improve the effectiveness of its program, and the states are required to keep pace with these improvements.

Consistent with our response to the 1988 GAO study, we have addressed GAO's concern about the "moving target" criteria by establishing absolute measures whenever possible. We have also responded to concerns about the number of state plan activity measures by reducing these measures from 115 to 48. Of these, 14 are in the form of absolute criteria. We continue to believe, however, that some level of activity measurement will continue to be necessary for proper grant administration and oversight purposes.

Third, GAO recommends that OSHA require states to conduct annual internal audits and establish more effective procedures to obtain state corrective action on significant issues. Since early 1990, a federal-state task force has been working exclusively to revise OSHA's monitoring and evaluation procedures. The revised draft procedures include both an internal audits component and specific procedures for tracking state corrective actions. We expect to fully implement these procedures in FY 94.

Fourth, GAO recommends that OSHA assess the need for legislative change to extend coverage to state and local government employees, and to give OSHA greater authority in imminent danger situations. These issues and others are contained in proposed OSHA reform legislation that is currently under active review by the Administration.

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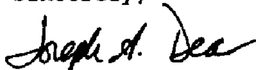
Finally, GAO suggests that OSHA develop procedures to obtain worksite-specific injury and illness data from employers and implement its procedures for ensuring that employers accurately record occupational injuries and illnesses. OSHA is moving forward on both recommendations. The increasing complexity of the OSHA mission has necessitated a reexamination of our data needs. Following our review, OSHA has concluded that the use of worksite specific data will vastly improve its effectiveness in targeting inspections, education, training, consultation, and evaluations.

Accordingly, OSHA and the Bureau of Labor Statistics (BLS) signed an agreement on October 21 that provides for a formal understanding between both agencies of their respective data needs. Drafted to clearly delineate roles, this agreement outlines OSHA's needs as a regulatory agency to collect better data for targeting individual employers and BLS's needs as a statistics-producing organization to provide only statistical aggregates for purposes of independence and confidentiality.

OSHA believes that with the use of worksite specific data, it is essential that employer records are accurate. OSHA is developing a Quality Assurance Program that will provide the Agency with procedures to ensure this accuracy. Once these procedures are completed, they will be implemented nationwide.

OSHA appreciates the information provided in this report. The Agency welcomes the opportunity to discuss ways to improve the federal-state approach to workplace safety and health.

Sincerely,



Joseph A. Dear
Assistant Secretary

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Related GAO Products

Occupational Safety and Health: Differences Between Program in the United States and Canada (GAO/HRD-94-15FS, Dec. 6, 1993).

Occupational Safety and Health: Changes Needed in the Combined Federal-State Approach (GAO/T-HRD-94-3, Oct. 20, 1993).

Occupational Safety and Health: Uneven Protections Provided to Congressional Employees (GAO/HRD-93-1, Oct. 2, 1992).

Occupational Safety and Health: Improvements Needed in OSHA's Monitoring of Federal Agencies' Programs (GAO/HRD-92-97, Aug. 28, 1992).

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Occupational Safety and Health: Options to Improve Hazard-Abatement Procedures in the Workplace (GAO/HRD-92-105, May 12, 1992).

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Occupational Safety and Health: Options for Improving Safety and Health in the Workplace (GAO/HRD-90-66BR, Aug. 24, 1990).

Occupational Safety and Health: Assuring Accuracy in Employer Injury and Illness Records (GAO/HRD-89-23, Dec. 30, 1988).

OSHA's Monitoring and Evaluation of State Programs (GAO/T-HRD-88-13, Apr. 20, 1988).

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