Workers at Risk:

Regulatory Dysfunction at OSHA

By CPR Member Scholars Thomas McGarity, Rena Steinzor, and Sidney Shapiro, and CPR Policy Analyst Matthew Shudtz

CPR CENTER FOR PROGRESSIVE REFORM

CENTER FOR
PROGRESSIVE REFORM
WHITE PAPER #1003

February 2010

About the Center for Progressive Reform

Founded in 2002, the Center for Progressive Reform is a 501(c)(3) nonprofit research and educational organization comprising a network of scholars across the nation dedicated to protecting health, safety, and the environment through analysis and commentary. CPR believes sensible safeguards in these areas serve important shared values, including doing the best we can to prevent harm to people and the environment, distributing environmental harms and benefits fairly, and protecting the earth for future generations. CPR rejects the view that the economic efficiency of private markets should be the only value used to guide government action. Rather, CPR supports thoughtful government action and reform to advance the well-being of human life and the environment. Additionally, CPR believes people play a crucial role in ensuring both private and public sector decisions that result in improved protection of consumers, public health and safety, and the environment. Accordingly, CPR supports ready public access to the courts, enhanced public participation and improved public access to information. The Center for Progressive Reform is grateful to the Public Welfare Foundation for funding this report, as well as to the Deer Creek Foundation, the Bauman Foundation, and the Open Society Institute for their generous support of its work in general.

This report is a collaborative effort of the following Member Scholars and staff of the Center for Progressive Reform: **Thomas McGarity**, University of Texas—Austin School of Law; **Sidney Shapiro**, Wake Forest University Law School; **Rena Steinzor**, University of Maryland School of Law; and **Matthew Shudtz**, CPR Policy Analyst.

For more information about the authors, see page 31.

www.progressivereform.org

For media inquiries contact Matthew Freeman at mfreeman@progressivereform.org

or Ben Somberg at bsomberg@progressivereform.org.

For general information, email info@progressivereform.org

Acknowledgments

The Center for Progressive Reform is grateful to the Public Welfare Foundation for its generous support of this project.

Printed in the U.S.A.

Cover Photo: Courtesy WikiCommons.

Executive Summary

The Occupational Safety and Health Administration was born with a heavy load to bear – the obligation of ensuring that every worker in America has a safe and healthful workplace for his or her entire working life. In its early years, OSHA acted with great vigor, establishing important standards for occupational health and safety that have prevented hundreds of thousands of injuries and illnesses. But the agency has not aged gracefully. Today its enforcement staff is stretched thin and the rulemaking staff struggle to produce health and safety standards that can withstand industry legal challenges. In short, OSHA is a picture of regulatory dysfunction.

Regulatory dysfunction in the federal government is manifest in administrative agencies that lack the resources, statutory authority, leadership, and affirmative help from the White House to accomplish the goals Congress has set out for them. OSHA's current leadership – Assistant Secretary David Michaels and Deputy Assistant Secretary Jordan Barab – are committed to revitalizing the embattled agency by turning it into a professional regulator and competent enforcement agency. But Michaels and Barab have inherited a resource-starved agency operating under a statute that has been enfeebled by 30 years of troubling appellate court decisions and White House initiatives that substantially increase the time and effort needed to implement a proactive regulatory agenda.

This white paper explores the causes of OSHA's regulatory dysfunctions and describes their negative impacts on OSHA and America's workers. With the decreasing power of unions to organize and press employers to implement strong health and safety programs, employees in every occupation rely on OSHA to protect them from occupational hazards. Yet, in the last decade, OSHA has dropped more standards from its regulatory agenda than it has finalized, largely due to insufficient budget authority. And the agency's enforcement program has assessed such paltry fines for even fatality-related violations of the law that many employers see no incentive in addressing hazards, much less developing precautionary health and safety programs.

After describing OSHA's problems in detail, this paper outlines a number of reforms that could enhance the agency's performance. Although certain aspects of the Occupational Safety and Health Act could use improvement, the recommendations in this paper focus on regulatory reform – that is, administrative actions that OSHA could implement in the short term. A subsequent white paper will address legislative reform.

TABLE 1. Recommendations for OSHA Regulatory Reform

Enforcement	• Use the General Duty Clause to protect workers who are exposed to chemicals that lack OSHA-derived Permissible Exposure Levels. • End the practice of regularly discounting penalties before they're even proposed. • Publish all negotiated settlement proposals for public comment. • Conduct a rigorous analysis of what resources would be required to make the OSHA inspection program a credible threat for employers chronically out of compliance, restoring the efficacy of deterrence-based enforcement throughout the agency. • Based on that analysis, request substantial increases in funding from the White House. • Redesign the scope and priorities of National Emphasis Programs, seeking advice of inspection staff. • Improve training to promote criminal referrals. • Work with state and local prosecutors to prompt criminal indictments in certain cases. • Rethink the proper balance between traditional enforcement (inspections) and "compliance assistance."
Rulemaking	• Seek additional resources to increase rulemaking staff. • Ask the Solicitor of Labor for a new analysis of risk assessment burdens imposed by the *Benzene* decision. • Use generic standards to combine multiple hazards or agenda items into a single rulemaking. • Avoid the use of negotiated rulemaking. • Conduct peer reviews, when necessary, concurrently with public comment periods and hearings. • Improve transparency with respect to the White House Office of Management and Budget's interaction with the agency.
Recordkeeping	• Update IMIS (OSHA's Integrated Management Information System). • Work with the Bureau of Labor Statistics to improve the quality of injury and illness statistics. • Develop a strategy for eliminating employer prizes and disciplinary actions that lead to incorrect injury and illness reporting.

Introduction

In 2005, the Government Accountability Office (GAO) released a report on the state of occupational safety and health programs in the meat and poultry industry that painted a picture eerily reminiscent of the images described in Upton Sinclair's 1906 masterpiece, *The Jungle*. GAO's account of conditions endured by newly immigrated workers in the slaughterhouse industry provides a shocking reminder that occupational hazards are not confined to heavy industry.

> The type of work performed and the plant environment expose workers to many hazards. The work is physically demanding, repetitive, and often requires working in extreme temperatures—such as in refrigeration units that range from below zero to 40 degrees Fahrenheit—and plants often have high turnover rates. Workers often stand for long periods of time on production lines that move very quickly, wielding knives or other cutting instruments used to trim or remove portions of the carcasses. Conditions at the plant can also be loud, wet, dark, and slippery. Workers responsible for cleaning the plant must use strong chemicals and hot pressurized water to clean inside and around dangerous machinery, and may experience impaired visibility because of steam. … While the most common injuries are cuts, strains, cumulative trauma caused by repetitive cutting motions, and injuries sustained from falls, more serious injuries, such as fractures and amputation, also occur. For example, according to OSHA data, a worker died when he attempted to replace his knife in the scabbard hanging from his belt, missed the opening, and pushed the knife into his leg, severing his femoral artery. In addition, some workers become ill because of exposure to chemicals, blood, and fecal matter, which can be exacerbated by poor ventilation and extreme temperatures.[1]

What differentiates the workers in today's meatpacking industry from the workers in the early 1900s is the existence of a law – the Occupational Safety and Health Act (OSH Act) – and an agency – the Occupational Safety and Health Administration (OSHA) – that were designed to ensure modern workers would have a safe and healthful workplace. The OSH Act paved the way for federal regulatory standards that are "reasonably necessary or appropriate to provide safe or healthful employment and places of employment."[2] And it worked. OSHA's health and safety standards have been credited with a significant decrease in work-related illness and injury where those standards have been created and enforced. The "lockout/tagout" standard, which required the installation of devices to ensure that heavy machinery was not turned on while repairs were being made, for instance, was credited with 30-percent annual reductions in lockout-related fatalities in the auto industry in its first eight years and a 55-percent reduction in lockout/tagout-related fatalities at ten basic steel-producing companies between 1990 and 1997.[3]

However, in more recent years, illness and injury rates have stopped declining, and today's injury and illness rates are virtually the same as 15 years ago, suggesting that OSHA is not utilizing new and evolving knowledge about managing occupational hazards to foster improvements in U.S. workplaces.

Observing OSHA in its struggle to implement and enforce the OSH Act is a study of regulatory dysfunction. OSHA and its state partners employ fewer than 2,100 inspectors to keep tabs on more than 8 million U.S. workplaces.[4] OSHA must meet so many analytical requirements that it takes more than a decade to implement a single new standard. By one count, OSHA is subject to 18 different statutory, court-created, and administrative limits on its rulemaking process.[5]

Organizational structures that separate enforcement staff, rulemaking staff, researchers, and agency lawyers prevent OSHA from operating as efficiently as possible. This paper describes, in detail, how these sources of regulatory dysfunction have serious implications for workers' health and safety and lists a series of legal and regulatory reforms that could reinvigorate the troubled agency.

Resource Shortfalls

Regulatory dysfunction at any agency, and in particular at OSHA, begins with resource constraints. Often, the most difficult and most important work for a regulatory agency is the most resource-intensive. Enforcement that has a meaningful deterrent effect is the prime example. Inspectors must be trained and deployed across the entire country. OSHA must develop fair and effective mechanisms for targeting the most dangerous worksites for inspection by trained personnel. If conducted properly, a compliance assessment at a very large worksite might take 2,000 employee-hours. The accompanying legal proceedings can drag on for months or years. In Fiscal Year 2010, OSHA will spend about $227 million on federal enforcement programs, but will only have the capacity to inspect 40,000 of the nation's more than 8 million workplaces.

Proactive rulemaking to manage emerging hazards, such as lung disease linked to diacetyl, and other flavoring chemicals used in the popcorn industry, can also be a huge resource drain. Every type of OSHA employee – economists, engineers, occupational health specialists, lawyers – is involved in the development of new health and safety standards. Coordinating their work is difficult and costly.

Yet, OSHA operates on a shoestring budget. OSHA's budget climbed steadily in the 1970s, funding the agency's growing capacity to develop new rules and enforce the OSH Act, which in turn triggered a backlash from the business community. Under the Reagan and George H.W. Bush administrations, OSHA's budget was first cut and then held roughly even with inflation. The Clinton administration gave OSHA a boost, and the agency's budget reached an historic high in 2001. But that was the same year that the agency published its ill-fated ergonomics standard, and, like OSHA's aggressive enforcement in the late 1970s, the ergonomics standard elicited a backlash in the business community and a subsequent whittling-away of the agency's budget under George W. Bush.

FIGURE 1: FY 2010 Proposed Budget

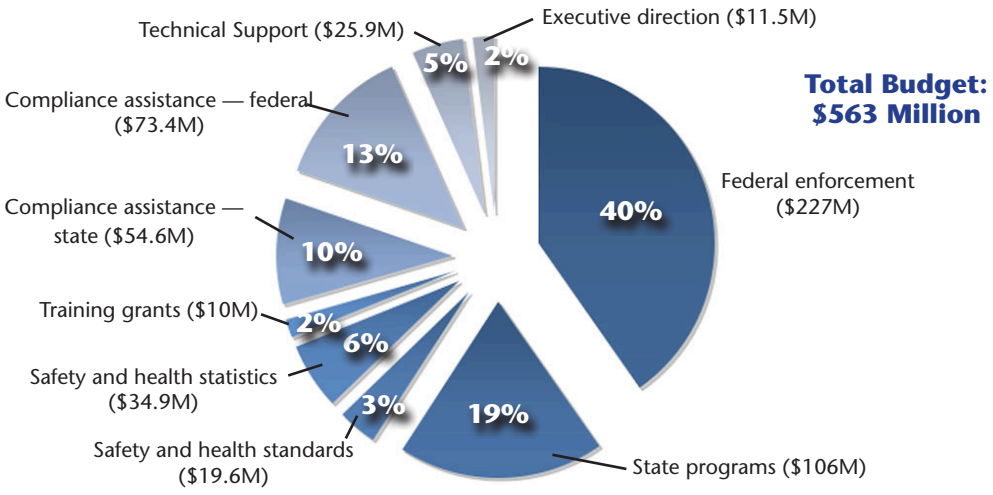
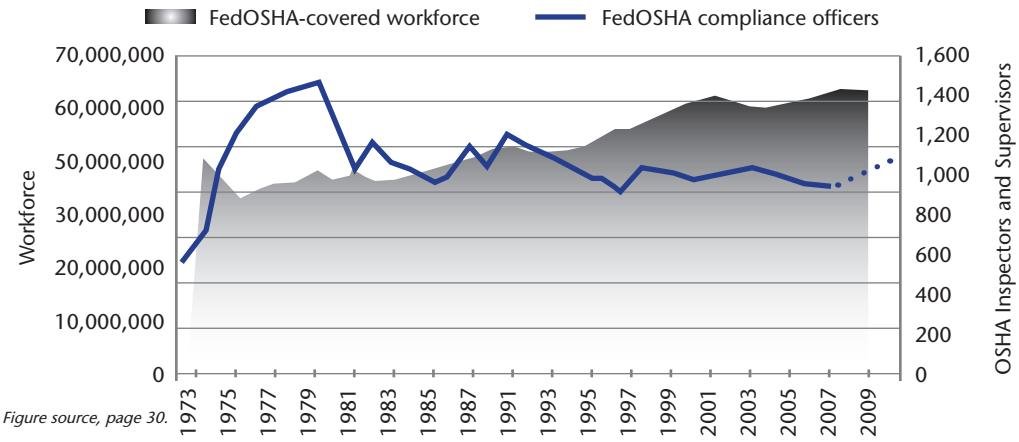


FIGURE 2: Historical Comparison: Workforce vs. Compliance Staff *



** Figure source, page 30.*

One important feature of OSHA's budget is the part of OSHA's annual budget authority that is distributed to various states. Under the OSH Act, individual states can assume responsibility for protecting workers' health and safety by creating state-level laws, institutions, and resources that are at least as effective in providing safe and healthful workplaces as OSHA and the OSH Act.[6] The Secretary of Labor has approved 27 such "state plans," although in five states the state's jurisdiction only covers public employees. When a state plan is approved, OSHA generally relinquishes responsibility for inspecting worksites in the state but provides the state with significant funding to carry out its occupational safety and health program. States may receive up to 50 percent of their occupational safety and health budgets in the form of federal grants. For the last ten years (prior years' breakdowns were not readily available), about one-fifth of OSHA's proposed budget has been distributed to state-plan states.

OSHA's $513 million budget for FY 2009 is less than 0.02 percent of the year's $3.1 trillion total federal outlays.

Of the remaining 80 percent of the agency's budget, half is spent on federal enforcement activities (worksite inspections and accident and whistleblower investigations), and half is spent on all of OSHA's other activities. This last 40 percent of OSHA's budget is where the priorities are the most skewed. Almost a quarter of OSHA's total budget is directed to compliance assistance programs that have a weak track record. A mere 2 percent of the budget goes to worker training programs, and just 3 percent of the budget goes to improving health and safety standards. The small percentage of OSHA's budget spent on rulemaking only begins to tell the story. Claiming that insufficient resources stand in the way, OSHA has withdrawn more rules from its regulatory agenda than it has finalized in the last decade.[7]

OSHA's $513 million budget for Fiscal Year 2009 is less than 0.02 percent of the year's $3.1 trillion total federal outlays, such an infinitesimal portion that funding the agency at adequate levels would not affect the country's capacity to reduce the deficit in any meaningful manner. Adequate funding for the agency would mean improving the ratio of inspectors to workers. In the late 1970s, the ratio of federal inspectors to federally protected workers was about

1 to 30,000. Today, an OSHA inspector covers more than 60,000 workers. Increasing the number of federal inspectors, along with a corresponding increase in funding to state programs would yield obvious improvements in workers' safety and health. In recent years, OSHA has been able to increase enforcement staff at a cost of about $125,000 per full time staff person. Doubling the enforcement staff would obviously involve significant other costs (infrastructure, etc.), so at a minimum, OSHA would need another $125 million per year. We recommend that OSHA initiate an objective and critical analysis of what resources are necessary to conduct inspections with a frequency that employers once again are concerned about becoming the target of deterrence-based enforcement.

An Outmoded Rulemaking Process

The foundation of any successful regulatory program is effective regulations. They provide a starting point for enforcement programs, predictability for the regulated community, and – most importantly – protection from hazardous conditions. In the nearly 40 years since its enactment, the OSH Act has been exposed as a virtually useless tool for establishing occupational health and safety standards. As interpreted by the courts, the OSH Act requires such extensive analysis of hazardous conditions and potential regulatory interventions before OSHA can regulate that the agency has only been able to set standards for the most obvious and egregious problems (e.g., machines that could accidentally begin operating while employees are servicing them). Occupational hazards that can cause less obvious injuries – for instance, lung cancer that does not manifest for decades or developmental problems in a pregnant worker's child – are left unabated or are regulated only through limits set in the early 1970s by private and quasi-public standard-setting organizations relying on science from the 1940s and '50s. The OSH Act's standard-setting provisions are the second major source of OSHA's dysfunction.

OSHA standards come in two forms – health standards and safety standards. Health standards address hazards like lead, chromium, asbestos, or other toxic substances that cause illnesses when employees are exposed to them either for short or long durations. Safety standards are designed to prevent injuries caused by harmful physical agents, like stairs or raised platforms without railings or industrial machinery without guards around moving parts. The distinction is important because the courts have interpreted the rulemaking requirements for the two types of standards differently. The legal requirements for setting health standards are more stringent. In practice, however, OSHA must navigate a political gauntlet that makes development of any standard an arduous process. Since updating the exposure limits for methylene chloride in 1997, OSHA has revised just one other health standard (hexavalent chromium) and created two new safety standards (vertical tandem lifts at marine terminals and fire protection in shipyards). OSHA has made revisions to a number of other standards, but it has not finalized any new health standards related to chemicals that were not already covered by OSHA standards.

OSHA's inability to establish new health standards more efficiently can be traced, in large part, to a Supreme Court decision that gave the agency analytical burdens not intended by Congress. In *AFL-CIO v. American Petroleum Institute*,[8] commonly known as the *Benzene* decision, the Supreme Court held that OSHA must determine that workplace exposure creates a "significant risk" before it can regulate. The OSH Act's rulemaking requirements do not use the term "significant risk," leading legal scholars to criticize the decision as an example of judicial over-reaching.

The practical problem with *Benzene* is that the high court failed to provide useful guidance as to what analysis OSHA should undertake to prove a significant risk. The Supreme Court famously said that a one-in-a-thousand cancer risk would clearly be a "significant" risk, but a one-in-a-billion risk might be considered "insignificant." With little else to build on, OSHA

staff must undertake extensive quantitative risk assessments for any hazard they believe needs to be controlled through regulation. To get a sense of the burden, a mere summary of OSHA's risk assessment on the 2006 hexavalent chromium standard took up 117 pages of the *Federal Register*.[9] The entire rulemaking process took more than a decade and was only completed under court order.

Although the "significant risk" requirement does not apply to safety standards, OSHA is required to prove that safety standards are economically "feasible." A feasibility determination includes an analysis of the costs of compliance in relation to consumer prices and the financial health and profitability of the industry.[10] However, the Supreme Court has also held that OSHA need not determine that costs bear a "reasonable relationship" to benefits, the issue at stake in traditional cost-benefit analysis, because the feasibility analysis required by the OSH Act is intended to be a significantly less demanding test.[11] Nonetheless, feasibility analyses can result in regulations that are less protective then they might be otherwise. For example, like other federal agencies, OSHA is overly dependent on the regulated industry for data regarding the costs of compliance, but industry's estimates often exceed actual compliance costs, sometimes by orders of magnitude.[12] Moreover, OSHA is overly focused on demonstrating the feasibility of controlling hazards using existing technology, neglecting to analyze emerging or cutting-edge technologies, process changes, or other options that are more cost-effective but might lack data on the economic costs of implementation. The agency's excessively cautious interpretation of the statute is the primary reason why the OSH Act, while clearly intended by Congress to be technology-forcing, has failed in that regard. OSHA policymakers tend to be gun-shy about using regulation to force new technologies because they fear that the lack of historical economic data will prevent the new standard from standing up to the courts' "hard look" review.[13]

"Hard look" review, a general standard for judicial review of regulatory decisionmaking under the Administrative Procedure Act (APA), is uniquely stringent in the context of the OSH Act. Typically, courts review administrative actions by taking a "hard look" at the record of evidence the agency has developed to ensure its completeness, and then examining the agency's decision to ensure that it is not arbitrary, capricious, or contrary to law. But the OSH Act includes an instruction about judicial review not found in other statutes. Section 6(f) states that OSHA rules "shall be conclusive if supported by substantial evidence in the record considered as a whole."[14] Congress's requirement that OSHA's rules be supported by "substantial evidence in the record" signals to the courts that the legislature wanted more searching review than is applied to regulations issued by other agencies. As a result, OSHA staff spend large amounts of time and resources developing the data needed to support significant risk determinations and economic feasibility analyses.

As if the burdens found in the OSH Act were not enough, Congress and the Executive Branch have devised additional hurdles for OSHA to overcome before it can regulate occupational hazards. As noted, 18 different statutory, court-created, and administrative procedural limits slow the OSHA rulemaking process. Executive Orders on regulatory

impact and flexibility analyses are some of the most problematic, because they give White House officials significant sway over the shape of new rules, to the detriment of OSHA's experts. The White House Office of Management and Budget (OMB) has even mandated external peer review of certain scientific documents, which might do more to delay new rules than it does to improve their quality. Congress, too, has established a number of impediments to development of new occupational safety and health standards, through statutes that have failed to achieve their "good government" objectives. Examples include the Regulatory Flexibility Act, Paperwork Reduction Act, Congressional Review Act, and Information Quality Act.

18 different statutory, court-created, and administrative procedural limits slow the OSHA rulemaking process.

The Small Business Regulatory Fairness Act (SBREFA) is often the largest obstacle in the standards-development process. Before OSHA can even publish a proposed rule in the *Federal Register*, it must convene and gather input from a Small Business Advocacy Review Panel. These panels comprise several Small Entity Representatives, officials from the Small Business Administration's Office of Advocacy, and officials from OMB's Office of Information and Regulatory Affairs. While OSHA officials have expressed appreciation for SBREFA panels' input, suggesting that they bring to light issues not originally realized by agency staff, it is not clear that these panels provide any information that could not have simply waited until the notice of proposed rulemaking was published in the *Federal Register*. The panels create delays in the rulemaking process without producing any intrinsic benefits.

Over the years, there have been a number of attempts to devise new ways to prioritize and conduct OSHA rulemaking, but each has come up short. Unions and public interest organizations have attempted to use the OSH Act's provision for emergency temporary standards to force the agency to act. When employees are exposed to "grave danger," the OSH Act empowers OSHA to issue emergency temporary standards as direct final rules, without having to go through the normal OSH Act or APA procedures. Following publication of the direct final rule, OSHA must go back and start a standard rulemaking for the hazard at issue. Though OSHA has issued a few emergency temporary standards, it has more often denied requests to do so from outside groups.

In 1988, OSHA Administrator John Pendergrass tried to update more than 300 health standards in one fell swoop, only to have those updates thrown out by a federal court. From 1970 until 1972, Congress had given OSHA the power to adopt certain occupational health standards without undertaking the normal rulemaking procedures. Through the expedited process, OSHA adopted more than 400 standards based on recommendations from quasi-public standard-setting organizations like the American Council of Governmental Industrial Hygienists (ACGIH), the American National Standards Institute (ANSI), and the National Fire Protection Association (NFPA). OSHA failed to update those standards in the intervening years, so Pendergrass attempted a single rulemaking in which 212 of the original PELs would be updated and 164 new substances would be regulated, largely based on recommendations from ACGIH and NIOSH. This generic approach was thrown out by the 11th Circuit because OSHA had not adequately analyzed the risks and feasibility for each

hazard, which the court understood was required by the Supreme Court's *Benzene* decision and the D.C. Circuit's *Lead I* decision.[15]

OSHA has tried to use negotiated rulemaking ("Neg/Reg") to speed up its production of standards, but this has proven to be no solution. Through negotiated rulemaking, OSHA brings together the stakeholders who would normally stand at loggerheads and asks them to negotiate a rulemaking proposal that the agency will then use as the basis for regulation. OSHA proposes the general contours of the proposed standard and the stakeholders are given broad leeway to craft its content in the expectation that they will agree on a standard, paving the way for OSHA to enact it and eliminating judicial challenges by stakeholders. The Neg/Reg process has been attempted several times, yet it has produced little progress. Either the groups cannot come to agreement (*e.g.,* benzene negotiations in 1983-84) or, even when they do, unanimous consensus is not reached and the standard ends up at the center of the same battles it would have been absent the Neg/Reg process (*e.g.,* cranes and derricks negotiations proposal, under review with the Secretary of Labor for over five years now).

OSHA's rulemaking process is in need of drastic reforms. At the same time chemical manufacturers are creating about 700 new chemicals each year, OSHA is drafting new health standards at a rate of about two per decade. And out of the tens of thousands of chemicals that are already on the market, OSHA has set standards for only about 400. Those standards are almost 40 years old already, and based on science from the 1940s and 1950s. Congress, to its credit, has occasionally set strict deadlines for promulgation of new standards (e.g., lead, hexavalent chromium) and OSHA has been able to meet them. But OSHA still operates under heavy burdens imposed by the courts and the White House, and Congress must consider changes to the OSH Act that will free the agency to set standards more easily.

Enforcement

When OSHA first began enforcing the consensus standards it adopted in the early 1970s, the agency's inspectors made the strategic mistake of strictly enforcing even the most trivial facets of the standards. Employers were appalled by what they perceived to be a heavy-handed and adversarial new federal agency and they took their case to Congress and the Reagan administration, which slashed OSHA's funding in the early 1980s. Since then, OSHA has struggled to design a broadly effective enforcement program that properly balances traditional enforcement proceedings with voluntary programs. OSHA's difficulty in designing an adequate enforcement regime is reflected in the national injury and illness statistics, which, as noted earlier, are virtually the same as fifteen years ago. Resources, both money and staff, are a significant problem, of course. But another major impediment to a more effective enforcement regime is the agency's failure to collect adequate data to determine which programs are working and which programs are not.

With more than 8.6 million workplaces in the United States, 2,400 federal and state inspectors cannot inspect even a small fraction in any given year.

Traditional Enforcement

OSHA employs about 1,100 inspectors and state-plan states employ another 1,300 inspectors. With more than 8.6 million workplaces in the United States., and some inspections demanding more than 2,000 hours to complete, federal and state officials cannot be expected to inspect even a small fraction of U.S. worksites in any given year. OSHA's inspection of the BP Texas City oil refinery, for instance, delivered a record $87 million fine proposal, but it took six months to complete.

Instead, OSHA has adopted a number of different programs to prioritize its work so as to have the most significant impact on reducing occupational injury and illness rates. OSHA inspectors' primary focus is on "unprogrammed" inspections, i.e., investigations of fatalities, catastrophes, reports of imminent danger, worker complaints, and referrals from other inspectors or other government officials. Unprogrammed inspections make up about a third of OSHA's annual inspections. With their remaining time, inspectors work on programmed inspections. OSHA's three main programs for identifying worksites in need of inspection are the Local and National Emphasis Programs (LEPs and NEPs), the Site-Specific Targeting program (SST), and the Enhanced Enforcement Program (EEP).

'Unprogrammed' Complaint Inspections

Inspections conducted in response to complaints make up a majority of OSHA's unprogrammed inspections. When OSHA receives a complaint about a workplace hazard, the complaint is categorized and prioritized based on the severity of the alleged problem. Allegations of serious violations (those that could result in death, permanent disability, chronic or irreversible illness, amputation, blindness, or third degree burns) elicit on-site inspections, as do written and signed complaints from current employees that provide reasonable grounds for believing that a specific OSHA standard is being violated. Other-

than-serious allegations are investigated by OSHA employees over the telephone or using faxed letters of inquiry in order to conserve agency resources and maintain a less adversarial relationship between the agency and regulated employers. Between 2000 and 2002, two-thirds of complaint inspections were conducted by phone or fax.

The Government Accountability Office (GAO) studied several years of inspection data and discovered problems typical of the dysfunctions that run throughout the agency.[16] For one, GAO found wide non-compliance with the requirement that regional administrators annually conduct audits of their area offices' operations. With only five of ten regional offices conducting the required audits, OSHA headquarters cannot properly assess whether complaint response programs are working well. GAO also found that when inspectors go out to worksites to investigate serious complaints, they only discover violations in about 50 percent of their visits, raising an issue of whether this type of investigation is the best use of OSHA's resources. This result, however, may be tied to the fact that, under current policies, inspectors who go to worksites to investigate complaints are limited to only investigating violations alleged by the complainant. Blatantly obvious violations observed in the course of an inspection will be considered, but inspectors may only expand their work into a comprehensive inspection if doing so would comport with the OSH Act, "Area Office priorities," and "pre-determined criteria from their offices [used] to determine the necessity for expanding the scope of an investigation."[17] This approach, which is undoubtedly driven by OSHA's chronic lack of resources, defeats efforts to build a credible, deterrence-based enforcement program because it robs OSHA of the opportunity to make the most out of its inspection process.

Local and National Emphasis Programs (LEPs and NEPs)

The starting point for OSHA's programmed inspections is a complex scheme that ranks industries by nationwide injury and illness rates, groups them according to hazard type (safety hazard versus health hazard) and relative injury rates, and then generates randomized lists of workplaces for inspection. Since this system does not always ensure inspection priorities that reflect administration policy or emerging occupational safety and health concerns, OSHA uses special emphasis programs – NEPs and LEPs – to target specific industries and hazards. LEPs are chosen by regional and area office staff based on their experience with local employers, and the programs are subject to approval by the national office. NEPs are designated at the national level. While designation of an NEP by the national office ensures that each regional and area office adopts a parallel local plan, regional and area office staff retain significant flexibility in choosing worksites for inspection within the industries covered by the NEP. OSHA has approved more than 140 LEPs, eleven NEPs, and one pilot NEP.

Local and regional enforcement staff, the OSHA personnel most intimately involved in day-to-day enforcement proceedings with employers, have voiced support for LEPs because they believe that professional experience is a better guide in choosing inspection targets

NEPs for FY 2010
- Trenching Hazards
- Petroleum Refinery Process Safety Management
- Shipbreaking
- Amputations
- Crystalline Silica
- Lead
- Combustible Dust
- Chemical Facility PSM (Pilot in Regions I, VI, X)
- Diacetyl and other Food Flavoring Chemicals
- Primary Metals
- Occupational Asthma
- Recordkeeping

than a neutrally oriented computer program. NEPs garner less support from the rank-and-file because of the perception that they are defined by beltway politics instead of field experience.

Site-Specific Targeting (SST)

The SST program complements the normal programmed enforcement system and emphasis programs by identifying and targeting for inspection the most dangerous worksites in high-hazard industries. However, this program excludes the construction industry, which has become notorious for excessive injuries, especially because it relies on migrant laborers who are not well-trained. An analysis by *The Texas Observer*, for example, estimated that a construction worker in Texas dies every two and a half days, including such avoidable incidents as collapsing trenches. Like the standard programmed enforcement system, SST utilizes a nationwide database to randomly select worksites for inspection. However, the SST program selects only worksites within industries that are considered "high-hazard," a designation linked to high injury and illness rates and high levels of employment. Each year, OSHA sends out an information request to about two-thirds of the 140,000 worksites in the United States with more than 40 employees, asking them for information about how many employees worked for them in the previous year, how many hours they worked, and for a summary of the data from their injury and illness logs. OSHA then computes injury and illness rates and creates lists of worksites with relatively high rates. OSHA's regional offices then log into a system that randomly selects for inspection worksites in their geographical jurisdiction from the master lists. In total across the country, OSHA conducts 2,000 to 4,000 SST inspections each year.

Despite all of the work OSHA puts into data gathering and analysis to support the SST program, GAO concluded – and some officials at OSHA's regional and area offices agreed – that the program does not effectively identify hazardous worksites.[18] GAO found "that for about half the worksites identified through this process, inspectors were unable to do an inspection or, if they did, cited no serious violations." OSHA staff have expressed concern that these success rates are not a large enough increase over the NEP/LEP system to justify the considerable resources that go into collecting and analyzing the data needed to run the SST system. One problem is that the SST system relies on a single year's injury and illness data to target inspection sites, a flaw in the model that fails to recognize trends and could put too much emphasis on outlier years. In addition, the data is not always reliable, which means SST inspections have been triggered by employers' poor recordkeeping rather than their inability to ensure workers' health and safety. Finally, the data that drive the SST program might be useful for identifying worksites with serious safety hazards, but they are relatively useless for identifying noncompliance with health standards because the impacts of these failures will take many years to manifest themselves.

Enhanced Enforcement Program (EEP)

Following a *New York Times/Frontline* investigation into a spate of deaths and injuries at McWane Pipe, OSHA established the EEP to supplement the NEP/LEP system and the SST program. EEP was designed to target recalcitrant employers in high-risk industries, in particular, employers that have multiple worksites with similar potential hazards. EEP is a program that is triggered after an OSHA inspection. When an incident triggers an EEP, OSHA uses a number of enhanced enforcement techniques, including: notifying the company's corporate headquarters (to give them notice and opportunity to correct similar hazards at other sites), imposing more stringent requirements for settlement negotiations, carrying out follow-up inspections, raising the priority of inspections of the company's other worksites under SST, and obtaining enforcement orders if the company fails to abate the hazard and holding the company in contempt if it still does not abate.[19]

Five years after EEP began, OSHA's inspector general (IG) found serious flaws with OSHA's implementation of it in three regions.[20] Not only did the OSHA staff fail to designate appropriate cases for the EEP, thereby hampering the program's effectiveness from the start, but the staff also failed in every aspect of the follow-up procedures. Furthermore, the IG found that revisions to the EEP program requirements in 2008 substantially limited the number of cases that could be designated for EEP follow-up procedures.

Other problems with the EEP include an unduly high bar for initiating action. OSHA recognizes six triggers for EEP designation, but three of them require that the inspection was prompted by a fatality. Even when there has been a fatality, there may not be an EEP designation. OSHA will only designate a firm for EEP if, in addition to the fatality, a number of other criteria are met. Those criteria focus on the type of violation that led to the death and the employer's compliance history. But compliance history is only a useful measure of a firm's concern for its workers' health and safety if the firm has been the subject of regular inspections over the years. Given OSHA's resource constraints and the vast number of covered worksites, it is unlikely any individual firm has a significant inspection history. If the EEP is worth doing, it is worth doing right. And OSHA still has a long way to go in putting into place a program that severely punishes egregious violators and effectively discourages future scofflaws.

Fine Assessment

The failings of the EEP only affect OSHA's ability to deal with the most recalcitrant violators of the OSH Act. The larger problem with OSHA's post-inspection procedures is a weak system for administering penalties after finding violations at *any* workplace. Beginning with penalties that have low statutory limits, inspectors and then supervisors in OSHA's area offices, regional offices, and national headquarters regularly exercise their discretionary power to reduce penalties to levels so low that they have little deterrent effect on employers.

TABLE 2. Comparison of Statutory Penalties

OSH Act	Endangered Species Act	Clean Air Act
• Serious violation: $7,000 • Falsifying records: $10,000 • Willful violation: $70,000 • Willful violation that results in death: $250,000 (indiv.) or $5,000 (corp.), plus imprisonment for 6 months.	• Knowing violation of the ESA: $25,000 • Knowing violation of ESA regulations: $12,000 or $25,000 (depending on regulation) • Criminal penalties: $50,000 and 1-year imprisonment for knowing violation of ESA or certain regulations; $25,000 and 6 mos. for other regulations.	• Civil penalty: $25,000 *per day, per violation* • Criminal penalties: up to 5 years' imprisonment for some violations, up to 15 years' for others

A study by the majority staff of the Senate Committee on Health, Education, Labor, and Pensions (HELP) shows that OSHA's internal policies regarding penalty determination effectively transform the OSH Act's allowance for penalty reductions into a mandate.[21] Inspectors' template worksheets for calculating fines require discount calculations from the start. Then, area directors, regional administrators, and Department of Labor attorneys can reduce penalties further – and often do, after informal conferences with cited employers. Finally, OSHA officials can reduce penalties if the cited employer challenges the citation and enters into settlement negotiations with the agency. Looking at all fatality investigations in 2007, the Senate HELP committee staff found that the median penalty initially assessed by OSHA investigators ($5,900 after calculating discounts) was reduced by 38 percent over the course of the internal review and conference with the cited employer. Even in cases of more derelict conduct – willful violations of the OSH Act that led to an employee's death – the report found that, in 2007, there was a 58-percent decrease from the initial to the final penalty. The median final penalty in fatality cases in 2007 was just $3,675.

OSHA claims that penalty reductions are necessary to spur settlements. OSHA feels compelled to settle cases because it lacks the resources to litigate. But no deterrence-based enforcement scheme can function properly unless the economic consequences of committing violations are considerably higher than the costs of avoiding compliance in the first place discounted by the probability of detection. The interminable cycle of imposing minimal penalties may in fact create perverse incentives to ignore the law because getting caught is so much less expensive than steadfastly assuring compliance with OSHA standards. Until very recently, OSHA has made reducing fines to pennies on the dollar its normal policy, even in cases involving willful violations leading to fatalities. Its failure to pursue strong penalties, even in appropriate cases, suggests undue deference to the business community. These enforcement failures are among the most important reasons why the agency needs more adequate funding.

OSHA's Cooperative Enforcement Programs

OSHA has developed a number of voluntary and cooperative programs to complement its traditional enforcement programs and foster a more symbiotic relationship between

the agency, regulated industry, and workers. Employers and some agency officials tout the programs as highly effective tools, but independent analysis by GAO and others suggests that OSHA lacks the hard data that would enable it to prove any of the cooperative programs are truly effective.[22]

Voluntary Protection Program (VPP)

OSHA established the VPP in 1982 to recognize worksites that have comprehensive safety and health management programs designed to maintain a safe workplace and below-average injury rates as compared to the rest of their industry. The program got off to a slow start, taking twenty years to attract the first 1,000 worksites. But the Bush administration made it a priority to expand the program and, between 2002 and 2008, it doubled in size. There are now so many participants that the regional OSHA administrators who are responsible for primary administration of the program have complained that they do not have the resources to continue adding new worksites.[23]

The huge growth in VPP worksites can be attributed to the fact that participation in the program immunizes a worksite from all programmed inspections. Immunity from programmed inspections can be a significant benefit for any worksite that might fall within a local or national emphasis program, as evidenced by reports on the first year of implementation of the petroleum refineries NEP. Across the country, OSHA started 65 inspections at petroleum refineries and inspectors have issued citations at each of the 48 worksites where inspections have concluded. Inspectors have found alarming numbers of violations at some sites. At just 14 refineries, OSHA inspectors uncovered 1,517 violations, including 1,489 violations for process safety management.[24] Yet, OSHA will not inspect 20 percent of the petroleum refineries under federal jurisdiction because they participate in the VPP and therefore enjoy exemptions from inspection under the NEP. The exemptions would be acceptable if the VPP program actually works to protect workers, but OSHA does not know whether this is true. A GAO report found that OSHA had continued to expand the VPP program without collecting any data, much less analyzing any, to show that the program has produced any measureable impact on worker health and safety.[25] Following that report, OSHA's acting head under President Obama, Jordan Barab, instituted a comprehensive review of the VPP.

GAO's report had examples of how OSHA's failure to vet its program endangered workers. The investigation found 30 VPP sites at which 32 fatalities occurred between January 2003 and August 2008. At the time of GAO's investigation, five sites had voluntarily withdrawn from the VPP, five had been given a one-year conditional status, and three had not yet been reviewed by regional staff because enforcement investigations were ongoing. Seventeen were allowed to remain in the VPP. Incredibly, one of those 17 retained its VPP status despite having had three separate fatalities over the five-year period GAO investigated. In the same report, GAO "found that, for 12 percent of the sites, at least one of their three-

year average injury and illness rates was higher than the average injury and illness rates for their industries."

State Consultation Programs

OSHA's other longstanding voluntary compliance program is the state consultation program. Created in 1975, the consultation program funds state-based entities to provide free occupational safety and health consultations to businesses that request them. The occupational health and safety professionals who conduct the consultations are generally employed by state agencies or universities, and they are responsible for identifying hazards and potential violations, suggesting means for abating the hazards, and working with employers to implement abatement techniques as well develop broader health and safety programs. The consultation program is intended to benefit small employers in high-hazard industries, although "small" is defined for this program as a worksite with up to 250 employees run by a company with up to 500 employees companywide.

Much like the VPP, participation in a consultation program can immunize employers from OSHA programmed inspections. In addition, hazards uncovered during consultation visits, even if they rise to the level of a serious violation, will not result in penalties. In an employer's worst-case scenario, a serious violation will only be referred to OSHA enforcement staff after the state consultant has proffered a remedy and the employer has failed to implement the remedy within a reasonable time. By offering these incentives for participating in the program, OSHA has undermined, to some extent, its emphasis programs, since small employers in industries covered by emphasis programs often request consultations to forestall inspections.

As with the VPP, OSHA does not collect enough data to determine whether the consultation program is having any positive impact on employees' health and safety. OSHA did not formally study the issue until 2002 – almost 30 years after the program began – when GAO suggested that it do so. The researchers commissioned by OSHA to assess the state consultation programs' effectiveness found some potential benefits, but determined that the benefits might actually be the result of other factors, such as employer motivation (if employers who have a penchant for helping their employees are more likely to request consultations, the program might be getting undue credit).[26] Ultimately, they concluded that additional data were necessary if OSHA wants to properly evaluate the consultation programs. Unfortunately, the White House Office of Management and Budget (OMB), through its Paperwork Reduction Act powers, prevented OSHA from gathering data from a large number of companies that participated in the consultation programs. OMB rejected OSHA's request to collect information from any firm employing less than 40 people, a restriction that eliminates "a significant portion" of program participants and contributes to OSHA's inability to fully assess the effectiveness of its voluntary programs, according to GAO.[27]

Divided and Conquered

When Congress passed the OSH Act in 1970, it opted for a separation of policymaking functions that has had significant consequences for the development of federal occupational safety and health policies. Congress divided the responsibility for protecting workers among three agencies – OSHA, NIOSH, and the Occupational Safety and Health Review Commission (OSHRC). NIOSH was tasked with researching causes of, and solutions to, occupational safety and health problems. OSHA, of course, was given the power to promulgate and enforce safety and health standards. And OSHRC was put in charge of adjudicating disputes between OSHA and employers who wanted to challenge a citation for failure to comply with the agency's standards. Not only did Congress divide occupational safety and health policymaking authority between the three agencies, it set up administrative barriers between them. OSHA was placed in the Department of Labor, NIOSH was set up in the Department of Health, Education and Welfare (now Health and Human Services), and OSHRC was established as an independent commission made up of three commissioners appointed by the President for staggered terms.

The Research Divide

Because NIOSH's research agenda does not always track OSHA's research agenda, NIOSH's research is unused or underused by OSHA's regulatory staff, who end up doing or commissioning research that could have been done by NIOSH. In the mid-1990s, some members of Congress found the NIOSH-OSHA coordination problems to be so severe that they attempted to eliminate NIOSH, "claiming NIOSH duplicates the research of OSHA, the EPA, the National Safety Council, and private industry."[28] A bifurcated leadership structure is partly to blame. With no specific person or office in charge of coordinating NIOSH research and OSHA's needs, it is inevitable that their paths would stray. Further, NIOSH, in response to calls for its dissolution, made the strategic choice to adopt two new programs that effectively detached NIOSH from OSHA completely. First, NIOSH established a new research prioritization program called NORA (National Occupational Research Agenda) that marginalized OSHA's input into NIOSH's future direction. Second, NIOSH began emphasizing a "research to practice," or "r2p," mission, in which the primary target for NIOSH's research is not OSHA, but employers, employees, and their representatives.

NORA operates under a committee structure that includes such a wide variety of stakeholders that it marginalizes OSHA's role in setting NIOSH's agenda. Granted, the NORA sector programs are not the sole determinant of NIOSH's research agenda. NIOSH's work is also organized into 24 "cross-sector" programs that are linked to specific adverse health outcomes, statutory programs, and global efforts. The cross-sector programs include, for example, musculoskeletal disorders, exposure assessment, and

TABLE 3. NORA Council Structure

Sector Council	Number of OSHA Staff on Council
Agriculture, Forestry, and Fishing	0 of 61
Construction	4 of 133
Healthcare and Social Assistance	1 of 34
Manufacturing	1 of 56
Mining	n/a
Services	1 of 70
Transportation, Warehousing, Utilities	0 of 60
Wholesale and Retail Trade	0 of 35

nanotechnology. But, as with the NORA sector councils, the cross-sector program agendas are not developed through consultation with OSHA as a matter of standard practice, thereby limiting their utility for OSHA.

At NIOSH's request, the National Academies of Science undertook a systematic review of several NORA and cross-sector research programs to assess their relevance and effectiveness in relation to occupational health. Tellingly, NAS scored the relevance of the different programs' research agendas on two factors: (1) whether research focused on high-priority research areas (not necessarily priorities for OSHA); and (2) whether NIOSH appropriately transferred its research results to employers and employees (transfer to OSHA was essentially an afterthought). So, for example, NIOSH's respiratory disease (cross-sector) research program received a top score for relevance even though NAS concluded that "[c]urrent institutional silos [between NIOSH and other relevant federal agencies] obstruct the efficient use of resources and development of knowledge."[29]

Congress intended that NIOSH be the scientific arm of OSHA, which clearly has not happened. Congress separated NIOSH from OSHA to protect the integrity of its scientific enterprise, but this separation comes at a high price—its output is of limited utility to OSHA. Other agencies, such as FDA and EPA have their scientists in house, proving that this divide is unnecessary.

The Enforcement Divide

While the NIOSH-OSHA division of power slows the development of new health and safety standards, the OSHA-OSHRC split creates complicates the enforcement of what few standards OSHA develops. Congress adopted the split-enforcement model in the OSH Act in response to claims from industry that employers' rights to due process are best preserved when the prosecuting agency (OSHA) is institutionally separated from the adjudicating agency (OSHRC).[30] But there is little evidence that these perceived benefits outweigh problems with efficiency and policy coordination. Employers' challenges to OSHA citations can take many years to resolve and, in the meantime, the employer can delay abatement of the cited hazard. At times, OSHRC has been without its full complement of commissioners because of disputes between the President and the Senate over certain nominees. A partial commission can be responsible for significant delays in the appellate process. OSHA, however, has no means of insisting that OSHRC do a more efficient job of resolving claims. Moreover, OSHRC works as a one-way ratchet: employers can challenge OSHA citations, but employees and their representatives have no power to challenge the terms of settlement agreements between employers and OSHA. Unlike settlement agreements negotiated under the Clean Air Act and other public health-related statutes, OSHA's settlements are not subject to public review and comment.

Another problem with the split-enforcement model is its effect on OSHA's ability to interpret the OSH Act and its regulations to protect workers. For years after Congress

passed the OSH Act, OSHRC took the position that Congress, by granting the Commission the power to adjudicate disputes about OSHA citations, gave it the power to make broad policy determinations. OSHA, on the other hand, argued that OSHRC should accept OSHA's interpretations of the OSH Act and simply engage in case-specific fact-finding to affirm, modify, or vacate individual OSHA citations and penalties. In 1991, in *Martin v. OSHRC*, the Supreme Court sided with OSHA in holding that reviewing courts must defer to OSHA's interpretation of the OSH Act contained in its regulations when confronted with conflicting, but reasonable, interpretations held by OSHA and OSHRC.[31]

Notwithstanding the Supreme Court's unambiguous recognition of OSHA's fundamental supremacy in setting occupational safety and health policy, OSHRC keeps fighting to retain policymaking power by reading the Supreme Court's opinion in a narrow manner.[32] OSHRC's trick is to argue that OSHA's reading of its own standards or the OSH Act are unreasonable, allegedly making *Martin* inapplicable and giving OSHRC the power to decide the case based on its own interpretation.[33] In one case, OSHRC used that approach, was overturned by the Eighth Circuit, and drafted such a narrow follow-up decision that one prominent attorney for large employers suggested OSHRC's interpretation of the relevant law might apply everywhere but the Eighth Circuit.[34]

Until OSHRC is directed to defer to OSHA's policymaking decisions, disputes between the two institutions will continue to arise, sowing seeds of confusion for employers, employees, and OSHA inspectors. Only one other agency in the entire federal government is the subject of a similar arrangement – the Mine Safety and Health Administration (MSHA). In the rest of the government, the Administrative Procedure Act (APA) protects the rights of defendants without the problems that result from the split-enforcement arrangement.

Recordkeeping Woes

While we can say with certainty that too many workers contract illnesses, suffer injuries, and are killed in this country as a result of hazardous working conditions, recordkeeping problems at OSHA and the Bureau of Labor Statistics (BLS) prevent the detailed analysis of illness, injury, and fatality data that would enable OSHA's staff to determine the best targets for enforcement and the most effective regulatory tools. OSHA depends on three databases – BLS's Annual Survey of Occupational Injuries and Illnesses (SOII), BLS's Census of Fatal Occupational Injuries (CFOI), and OSHA's Integrated Management Information System (IMIS) – that need to be improved.

BLS – SOII

Each year, BLS surveys about 174,000 establishments to gather data from their OSHA-required injury and illness logs. BLS uses these data to estimate the total number of injuries and illnesses suffered by U.S. workers. Researchers have found that BLS likely misses between 20 and 70 percent of all injuries and illnesses.[35] The SOII will have some inherent uncertainty, since it is based on a sampling survey and not a comprehensive and precise count of injuries or illnesses, but the uncertainty could be minimized. There are three main reasons why the SOII data are incomplete:

1. BLS focuses only on occupations covered by the OSH Act, so injuries and illnesses suffered by the self-employed, household workers, workers on small farms (i.e., less than 11 employees), and federal government employees are not counted. State government employees are only counted for state-level statistics.
2. BLS's reliance on employers' OSHA logs reduces the likelihood that long-latency illnesses (e.g., cancer caused by air contaminants) will be counted. Employers do not track illnesses suffered by former employees.
3. Employers' safety programs include both disincentives for reporting work-related injuries or illnesses (disciplinary actions and mandatory drug testing following on-the-job injuries) and incentives for keeping quiet (prizes awarded for extended periods without reported injuries). The programs help employers minimize workers' compensation premiums and reduce the possibility for OSHA inspections.

BLS is currently working with OSHA and state agencies to figure out a way to count injuries or illnesses suffered by public employees. In addition, BLS is surveying individual employers to determine why some injuries and illnesses are reported to workers' compensation programs but not on OSHA logs. Finally, BLS is working with NIOSH on a pilot program that uses multiple databases – not just OSHA logs – to estimate injury and illness rates.[36]

BLS – CFOI

The strong point of the CFOI is that it uses a variety of data sources with the goal of developing a comprehensive census, rather than just a survey, of occupational fatalities.

Following a critical 1987 report by the National Academies of Science that suggested BLS had uncounted fatalities by up to 50 percent, it established a new system for obtaining data from a variety of sources. As a result, many occupational fatalities are counted in the CFOI database. But the CFOI only captures accurately deaths caused by occupational injury. Deaths caused by occupational illnesses, particularly long-latency illnesses, are not accurately captured, greatly reducing the CFOI's coverage and its utility for OSHA in setting health standards.

OSHA – IMIS

While the CFOI and SOII numbers are useful tools for setting rulemaking priorities or targeting industries and worksites for inspection, OSHA needs another database to analyze retrospectively the effectiveness of its inspection programs. Following each inspection, OSHA inspectors record the results of the inspection and all relevant information about penalties and settlements in the IMIS database. If the system functioned well, it would organize and make accessible large amounts of information that OSHA officials could use to determine the effectiveness of enforcement emphasis programs, consultation and voluntary programs, and other efforts to improve occupational health and safety.

However, the decades-old database has serious functionality issues, and gaps in the data it contains greatly limit its utility. IMIS was originally designed in the 1980s, and the basic software has not been updated since. Its obsolescence is well recognized, but OSHA currently has no plans to update the system. GAO has documented the fundamental flaws in IMIS that frustrate any formal analyses of OSHA inspections. For instance, individual worksites are not assigned unique identifiers, so inspections, consultations, worker injuries, and other key datapoints cannot be linked easily.

Recommendations for Reform

With its inadequate resources, outmoded statutory authority, misbalanced emphasis on voluntary compliance programs, imprecise understanding of injury and illness rates, and the almost complete failure to issue safety and health standards, OSHA was in dire straits when George W. Bush left office. Fortunately, President Obama has appointed a Secretary of Labor, Hilda Solis, and OSHA officials, David Michaels and Jordan Barab, all of whom have professional backgrounds that evidence a strong belief in OSHA's capacity to be an agent for positive change. To affect that change, OSHA will need more resources and an improved statute. But OSHA should also focus its attention on reforms that the agency can implement without the need to mobilize the broad resources necessary to accomplish legislative reform. CPR is in the process of convening a work group of national experts to develop a blueprint for overhauling OSHA, using all available tools, including dramatic increases in the agency's budget and new statutory authority. This paper, intended to be a threshold analysis of what makes OSHA so dysfunctional, will therefore confine itself to administrative reforms that are within the existing legal authority of the Obama Administration to implement.

Enforcement

For the first time in decades, OSHA's enforcement staff is growing. The 111th Congress and the Obama Administration provided OSHA with the funds to hire 130 new inspectors, many of whom will be bilingual.

As important as it is for OSHA to build its enforcement staff, it is more important that the enforcement program be properly designed to maximize the staff's effectiveness. OSHA's new leadership should reassess the scope and design of the special emphasis programs used to target inspections. Certain NEPs have broader implications than others. For instance, OSHA analysis of the chemical or petroleum refining industries' successes and failures in implementing process safety management (PSM) policies might help OSHA understand how PSM can be used effectively in other industries. But other NEPs – those focused on specific hazards or industries – might be targeting phantom problems or workplaces that are less hazardous than those that would be targeted through the SST program or through local and regional emphasis programs that do a better job of taking into account the professional experiences of inspection staff.

OSHA inspectors should expand their use of the general duty clause to better protect workers from health hazards. Hundreds of chemicals used by industry lack OSHA-derived permissible exposure limits (PELs), limiting OSHA inspectors' ability to protect workers through the use of citations. This failure to protect workers exists even for chemicals that have been identified as hazards by another government or standard-setting NGO. OSHA has the power to cite employers for general duty clause violations when an employee is exposed to a recognized hazard that has caused or is likely to cause death or

serious physical harm, and there is a feasible means of abating the hazard. Where an outside group has established an occupational health standard that is well-recognized and feasible, OSHA should use that standard as the basis for a general duty clause citation against any employer whose employees are exposed to the chemical above the standard.

OSHA's post-inspection procedures are also ripe for review. The statutory limits on penalties for violating the OSH Act are strikingly lower than limits under other public health and safety statutes, yet OSHA's standard practice is to discount proposed penalties before announcing them. This policy not only puts the agency in a poor negotiating position against the employer found to be in violation of the law, but also reduces the deterrent effect of OSHA's enforcement program on other employers. Following the 2009 inspection of BP's Texas City refinery, OSHA proposed full penalties for each of the 439 willful violations of the PSM standard that OSHA inspectors discovered, leading to a record fine of $87.4 million. OSHA should employ a similar "get tough" policy in appropriate cases, rather than automatically reducing fines to prompt settlements.

Further, OSHA should enhance its criminal enforcement arm. Between 2003 and 2007, OSHA inspectors referred just 21 percent of eligible cases to the Department of Justice for prosecution, and DOJ chose to pursue just 4 percent of the referred cases.[37] The Solicitor of Labor should work with OSHA's enforcement division to train inspectors to gather better evidence for criminal violations of the OSH Act. But in light of the weak criminal penalties in the OSH Act, the agency should also work with state and local prosecutors to prompt state criminal indictments of employers following the death of a worker in circumstances where such a penalty is warranted. OSHA could employ specially trained inspectors to assist local authorities in gathering the necessary evidence and the Solicitor of Labor could designate a lawyer in his office to serve as a liaison with state and local officials for this purpose. Cal-OSHA has employed this approach with some success.

In any enforcement case that OSHA chooses to settle with a cited employer, OSHA should allow the public an opportunity to comment on the consent order or other terms of the settlement. The public, especially employees, their representatives, and the victims or families of victims injured in an accident should have a chance to see the proposed terms of settlement and comment in writing to OSHA's attorneys. Other public health statutes (e.g., the Clean Air Act)[38] require government agencies to publish in the *Federal Register* a notice of settlement agreements. Even without an amendment to the OSH Act, OSHA has the power to involve stakeholders in the process of settling enforcement actions.

OSHA must also reassess the proper balance between traditional enforcement (i.e., inspections) and compliance assistance. With its current inspection force, OSHA only has the capacity to undertake formal investigations at a fraction of worksites in a given year. Compliance assistance programs – in particular, the consultation program – can provide a useful tool for ensuring that employers are fulfilling their duties under the OSH Act, but these programs are only suitable for some situations. Large employers do not fit the profile

of companies that need the free resources provided by the state compliance assistance programs. Large employers, for example, can presumably hire staff or consultants to assist them in complying with OSHA standards. The VPP may be more suitable for large employers, but OSHA should revise the standards for participation. To earn the recognition that comes with participation in the VPP, companies should be required to do more than establish that they have lower-than-average injury and illness rates. They should demonstrate a commitment to worker health and safety by voluntarily adopting more stringent health and safety controls than those minimally required by law (e.g., by adopting TLVs in place of PELs). And OSHA should drop employers that fail to maintain exemplary records from the VPP program. VPP participants are exempted from certain inspections, and they should have to earn that privilege.

OSHA has renewed its request with OMB to survey some smaller employers. OMB should approve OSHA's request or, better yet, expand it to cover a larger number of small employers so that OSHA can assess the effectiveness of its consultation programs. More broadly, OSHA should ask OMB for additional funding and authority to collect data that evaluates whether its consultation and other cooperative programs have a positive impact on employer's safety and health records.

Recordkeeping

In order for OSHA and stakeholders to properly assess the effectiveness of its rules, enforcement priorities, and other regulatory programs, the agency needs to significantly improve its recordkeeping policies. The most glaring problem is the agency's outdated Integrated Management Information System (IMIS), which was originally designed to link enforcement data with other agency resources. But IMIS has not been updated to take advantage of the vast improvements in computer hardware and software since it originally came on-line in the 1980s. To make IMIS a truly integrated system, OSHA should create unique identifiers for each employer and worksite and develop tools for linking the agency's enforcement records to employer injury and illness logs, workers' compensation records, and social security disability records. IMIS should also have a web-based interface (with adequate privacy protections) that would enable employers, workers, union officials, researchers, and other interested parties to access all records. The Obama Administration should ask Congress for a one-time appropriation to hire staff and/or consultants to modernize the IMIS system as suggested above.

OSHA also needs to work with the Bureau of Labor Statistics to improve the quality of national injury and illness statistics. Academic researchers have developed techniques for combining multiple data sources in a way that enables them to provide better estimates of the incidence of occupational injuries and illnesses than OSHA's and BLS's programs. Those researchers have uncovered systematic undercounting by OSHA and BLS that undermine OSHA's efforts to identify and eliminate occupational hazards.

Furthermore, OSHA needs to address the incentives (e.g., prizes) and disincentives (e.g., disciplinary actions and drug testing) that employers use to prevent employees from reporting all occupational injuries and illnesses. GAO has identified these tricks of the trade as one of the most significant causes of occupational injury and illness undercounting.[39] OSHA should consider the regulatory tools it could use to eliminate these programs.

Rulemaking

The OSH Act's § 6(b) standard-setting process is an abject failure. Of the more than 60,000 chemicals in commerce, OSHA has set standards for fewer than 1,000. The rulemaking process has essentially ground to a halt: In the past ten years, OSHA has finalized just a handful of new standards, one of them under court order. And to make matters worse, most of the health standards that OSHA has published are widely recognized as out-of-date and underprotective.

OSHA should seek from OMB additional resources to beef up its regulation-writing capacity. Far too often, OSHA has been unable to complete regulations, or has had to drop them, because it lacks the staff to do the necessary work. Now that the administration has expanded the number of inspectors at OSHA, it is time for the administration to expand OSHA's capacity to work on more than a few regulations at one time.

In the meantime, OSHA should seek ways of maximizing the impact of the few safety and health that it has the budgetary capacity and legal authority to promulgate. The Solicitor's Office could potentially speed up rulemaking by reassessing OSHA's burden of proof under the *Benzene* case. Although the Supreme Court required OSHA to demonstrate that exposure to the substance at issue poses a significant risk to workers, it also recognized that OSHA would lack sufficient evidence estimate workplace health risk precisely. The Solicitor should consider whether such language opens the door for OSHA to engage in a more truncated evaluation of risk evidence and if such a move would make it possible for OSHA to promulgate health regulations more quickly.

OSHA should also consider how it can avoid rulemaking delays caused by procedural hurdles imposed by other statutes.[40] The Information Quality Act (a/k/a "Data Quality Act")[41] instructed the Director of OMB to "provide policy and procedural guidance to Federal agencies for ensuring and maximizing the quality, objectivity, utility, and integrity of information (including statistical information) disseminated by Federal agencies." In 2002, the Department of Labor issued department-wide guidelines for implementing the Data Quality Act that may require OSHA to send its risk assessments and economic feasibility analyses out for peer review. The Data Quality Act itself does not require peer review and OMB's 2004 guidance on the subject leaves agencies with some discretion in selecting the appropriate timing and scope of any peer review. OSHA should therefore run

any peer reviews it deems necessary concurrently with public notice and comment periods specified in notices of proposed rulemaking.

Focusing rulemaking on generic standards that apply more broadly than single-chemical regulations has the potential to greatly improve OSHA's effectiveness. OSHA has experience with three types of broadly applicable, or generic, standards – industry-wide standards, multi-chemical standards, and work-practice standards. Utilizing generic rules to combine multiple hazards or agenda items into one rulemaking allows OSHA to engage stakeholders on a larger number of issues at each of these steps in the rulemaking process, eliminating the need to address smaller subsets of issues in a piecemeal fashion. While OSHA's follow-up analysis of stakeholders' input after each stage may take longer, at least the agency will be able to reduce the number of advisory committees it must convene, *Federal Register* notices it must publish, and hearings it must hold.

Moreover, the generic approach to rulemaking enables OSHA to address the full spectrum of risks that workers face. Rarely are workers exposed to a single hazard – more often, hazards exist in common combinations. OSHA's standards should reflect the realities of the workplace. As evidenced by the rise and fall of the ergonomics standard, however, the generic approach to rulemaking can be highly controversial, so OSHA must be judicious in its choice of rulemaking targets. Standards that apply to a single industry (e.g., refineries) or a specific health concern (e.g., chemicals that cross the placenta) might be good choices. OSHA should consider using a generic approach to update its PELs. By grouping PELs into sets of four or five chemicals that either pose similar hazards or are present in common work environments, OSHA might be able to move expeditiously through the hundreds of PELs that need to be updated based on new knowledge about risks and risk management.

The White House, too, has a role to play in speeding up OSHA's regulatory process. The White House's Office of Management and Budget should refrain from reviewing individual OSHA regulatory proposals, concentrating its energy instead on assessing longer-term issues. For instance, OMB's OSHA-focused staff could do an independent review of the efficacy of rulemaking versus voluntary compliance programs, in terms of occupational health outcomes, in an effort to help OSHA properly balance its limited resources. If OMB does not stop reviewing individual rules, OSHA should, at least, ensure better transparency regarding OMB's effect on the final rule by publishing all OMB comments in the relevant docket. Finally, the White House could amend the OMB peer review guidelines to clarify that agencies can conduct peer review during notice-and-comment periods.

Conclusion

The distinctive characteristics of a dysfunctional regulatory agency – a budget that is obviously inadequate for the agency's vast mission, a governing statute that has not been modified to keep up with a modern regulatory environment, political interference with regulatory policies, and a consequent failure to make ongoing improvements for the people the agency is supposed to protect – appear in virtual caricature at OSHA. Congress, the White House, and – most importantly – OSHA itself, must take steps to change course from the path OSHA is taking toward obsolescence. The Obama Administration has taken some steps in that direction, but more is needed to protect America's workers.

End Notes

[1] Gov't Accountability Office, *WORKER SAFETY AND HEALTH: Safety in the Meat and Poultry Industry, While Improving, Could Be Further Strengthened*, GAO-05-96, 3-4 (Jan. 2005).

[2] 29 U.S.C. § 652(8), OSH Act § 3(8).

[3] Occupational Safety and Health Admin., *Section 610 and Executive Order 12866 Review of the Control of Hazardous Energy Sources (Lockout/Tagout) Standard 29 C.F.R. 1910.147: Results of OSHA's Lookback Review of the Standard* (Jan. 2000).

[4] AFL-CIO, *Death on the Job: The Toll of Neglect, A National and State-by-State Profile of Worker Safety and Health in the United States*, 18th ed. (Apr. 2009).

[5] *See* Frank Mirer, *The Breakdown of OSHA Standard Setting*, Testimony before the Subcommittee on Workforce Protections, Committee on Education and Labor, U.S. House of Representatives, April 27, 2007.

[6] 29 U.S.C. § 667; OSH Act § 18.

[7] Testimony of Scott P. Schneider, Laborers' Health and Safety Fund of North America, before the Subcommittee on Workforce Protections, Committee on Education and Labor, U.S. House of Representatives, April 24, 2007; Cindy Skrzycki, *OSHA Withdraws More Rules Than It Makes, Reviewers Find*, Wash. Post, E-1, Oct. 5, 2004.

[8] 448 U.S. 607 (1980).

[9] Occup. Safety & Health Admin., *Occupational Exposure to Hexavalent Chromium; Final Rule*, 71 Fed. Reg. 10099, 10108-10225 (Feb. 28, 2006).

[10] *United Steel Workers v. Marshall,* 647 F.2d 1189, 1265 (D.C. Cir. 1980).

[11] *American Textile Mfrs. Inst. v. Donovan*, 452 U.S. 490 (1981).

[12] Thomas O. McGarity and Ruth Ruttenberg, *Counting the Cost of Health, Safety, and Environmental Regulation*, 80 Tex. L. Rev. 1997 (2002) (examining industry-produced cost estimates); *see also* Winston Harrington, Richard D. Morgenstern, Peter Nelson, *On the Accuracy of Regulatory Cost Estimates*, Resources for the Future Discussion Paper 99-18 (Jan. 1999) (assessing agency-produced cost estimates).

[13] U.S. Congress, Office of Technology Assessment, *Gauging Control Technology and Regulatory Impacts in Occupational Safety and Health: An appraisal of OSHA's analytic approach*, OTA-ENV-635, *at* 50-53 (Sept. 1995).

[14] 29 U.S.C. § 655(f); OSH Act § 6(f).

[15] *AFL-CIO v. OSHA*, 965 F.2d 962 (11th Cir. 1992).

[16] Gov't Accountability Office, *OSHA's COMPLAINT RESPONSE POLICIES: OSHA Credits Its Complaint System with Conserving Agency Resources, but the System Still Warrants Improvement*, GAO-04-658 (June 2004).

[17] Occupational Safety and Health Administration, *OSHA's Field Operations Manual*, CPL-02-00-148, *at* Chapter 3, § III. B. (Nov. 2009).

[18] Gov't Accountability Office, *WORKPLACE SAFETY AND HEALTH: OSHA Can Strengthen Enforcement Through Improved Program Management*, GAO-03-45 *at* 10-13 (Nov. 2002).

[19] Occupational Safety and Health Administration, *Enhanced Enforcement Program,* Directive CPL 02-00-145 (Jan. 1, 2008).

[20] U.S. Dep't of Labor, Office of the Inspector General—Office of Audit, *Employers With Reported Fatalities Were Not Always Properly Identified and Inspected Under OSHA's Enhanced Enforcement Program*, Report No. 02-09-203-10-105 (Mar. 31, 2009).

[21] Maj. Staff, Senate Comm. on Health, Education, Labor, and Pensions, *Discounting Death: OSHA's Failure to Punish Safety Violations That Kill Workers* (Apr. 29, 2009).

[22] *See* Sidney A. Shapiro & Randy Rabinowitz, *Voluntary Regulatory Compliance in Theory and Practice: The Case of OSHA*, 52 Admin. L. Rev. 1249 (2000) (noting the lack of evidence for the effectiveness of voluntary programs).

[23] U.S. Gov't Accountability Office, *OSHA'S VOLUNTARY PROTECTION PROGRAMS: Improved Oversight and Controls Would Better Ensure Program Quality* 11, GAO-09-395 (May 2009).

[24] Patricia Ware, *Process Safety Violations at Refineries 'Depressingly' High, OSHA Official Says*, BNA Occupational Safety & Health Daily, Aug. 27, 2009.

[25] U.S. Gov't Accountability Office, *OSHA'S VOLUNTARY PROTECTION PROGRAMS: Improved Oversight and Controls Would Better Ensure Program Quality* 14, GAO-09-395 (May 2009).

[26] John Mendeloff, Ph.D, and Wayne Gray, Ph.D, *Evaluation of the OSHA Consultation Program*, report prepared for the OSHA Office of Program Evaluation and Audits (July 2002).

[27] Gov't Accountability Office, *WORKPLACE SAFETY AND HEALTH: OSHA's Voluntary Compliance Strategies Show Promising Results, but Should Be Fully Evaluated Before They Are Expanded*, GAO-04-378, *at* 29-30 (March 2004).

[28] Cynthia Washam, *Working Toward a New NIOSH*, 104 Environmental Health Perspectives 484 (May 1996).

[29] National Academy of Sciences, *Respiratory Diseases Research at NIOSH: Review of Research Programs of the National Institute of Occupational Safety and Health* 149 (March 2008).

[30] George Robert Johnson, Jr., *The Split-Enforcement Model: Some Conclusions from the OSHA and MSHA Experiences*, 39 Admin. L. Rev. 315, 346 (1987).

[31] *Martin v. OSHRC*, 499 U.S. 144 (1991).

[32] *See* Benjamin W. Mintz, *Administrative Separation of Functions: OSHA and the NLRB*, 47 Cath. U. L. Rev. 877 (1998).

[33] *See, e.g.*, *Solis v. Summit Contractors, Inc.*, 558 F.3d 815 (8th Cir. 2009).

[34] Stephen Lee, "Summit Decision in Contractor Case Not Expected to Affect Major Employers," BNA Occupational Safety & Health Daily, Aug., 19, 2009.

[35] *See, e.g.,* K.D. Rosenman et al., "How much work-related injury and illness is missed by the current national surveillance system?" 48 J. Occup. Environ. Med. 357 (2006); J. Paul Leigh, J.P. Marcin, T.R. Miller, "An estimate of the U.S. Government's undercount of nonfatal occupational injuries," 46 J. Occup. Environ. Med. 10 (2006).

[36] *See* John W. Ruser, "Examining evidence on whether BLS undercounts workplace injuries and illnesses," Monthly Labor Review 20 (Aug. 2008).

[37] Maj. Staff, Senate Comm. on Health, Education, Labor, and Pensions, *Discounting Death: OSHA's Failure to Punish Safety Violations That Kill Workers* (Apr. 29, 2009).

[38] 42 U.S.C. § 7413(g).

[39] Gov't Accountability Office, *WORKPLACE SAFETY AND HEALTH: Enhancing OSHA's Records Audit Process Could Improve the Accuracy of Worker Injury and Illness Data*, GAO-10-10 (Oct. 2009); Greg Hellman, *AFL-CIO Says Survey Finds Evidence Of Practices Discouraging Injury Reporting*, 39 Occupational Safety & Health Reporter 1026 (Dec. 3, 2009).

[40] Chuck Gordon, personal communication, Jan. 4, 2010.

[41] Pub. L. No. 106-554, § 515, Dec. 21, 2000.

Figure 2, Page 6: OSHA compliance staff data from AFL-CIO, *Death on the Job: The Toll of Neglect – A National and State-by-state Profile of Worker Safety and Health in the United States* (April 2009).

About the Authors

Thomas O. McGarity holds the Joe R. and Teresa Lozano Long Endowed Chair in Administrative Law at the University of Texas in Austin. He is a member of the Board of Directors of the Center for Progressive Reform, and the immediate past president of the organization. Professor McGarity has published widely in the areas of regulatory law and policy. With Sidney Shapiro, he wrote *Workers at Risk: The Failed Promise of the Occupational Safety and Health Administration,* which was an instrumental part of OSHA's "reinvention" in the 1990s.

Rena Steinzor is a Professor of Law at the University of Maryland School of Law, with a secondary appointment at the University of Maryland Medical School Department of Epidemiology and Preventive Medicine. Among the courses she teaches are risk assessment, critical issues in law and science, and a survey of environmental law. Professor Steinzor received her B.A. from the University of Wisconsin and her J.D. from Columbia Law School. She joined the Maryland faculty in 1994 from the Washington, D.C. law firm of Spiegel and McDiarmid. From 1983 to 1987, Steinzor was staff counsel to the U.S. House of Representatives' Energy and Commerce Committee's subcommittee with primary jurisdiction over the nation's laws regulating hazardous substances. She is the President and a Director of the Center for Progressive Reform.

Sidney Shapiro holds the University Distinguished Chair in Law at the Wake Forest University School of Law and is the Associate Dean for Research and Development. He is a member of the Board of Directors of the Center for Progressive Reform. Professor Shapiro has taught and written in the areas of administrative law, regulatory law and policy, environmental policy, and occupational safety and health law for 25 years. Professor Shapiro has been an active participant in efforts to improve health, safety, and environmental quality in the United States. He has testified before congressional committees on administrative law and occupational safety and health issues. With Tom McGarity, he wrote *Workers at Risk: The Failed Promise of the Occupational Safety and Health Administration.*

Matthew Shudtz is a Policy Analyst at the Center for Progressive Reform, providing research, drafting, coordination and other staff assistance to CPR's Clean Science and Corporate Accountability Issue Groups. Prior to joining CPR, Mr. Shudtz worked as a legal intern for the Natural Resources Defense Council and as a legal/legislative intern for the Chesapeake Bay Foundation.

Related Publications

Available for download at www.progressivereform.org

Regulatory Dysfunction: How Insufficient Resources, Outdated Laws, and Political Interference Cripple the 'Protector Agencies'

By CPR Member Scholars Sidney Shapiro and Rena Steinzor, and CPR Policy Analyst Matthew Shudtz

CPR White Paper #906 describes the common causes of five federal regulatory agencies' inability to make continued improvements to public health and the environment after initial successes in the 1970s and 1980s. OSHA, along with EPA, FDA, NHTSA, and CPSC struggle to cope with changing regulatory burdens for three reasons: insufficient and imbalanced resources, outmoded laws, and centralized political decisionmaking.

A Return to Common Sense: Protecting Health, Safety, and the Environment Through 'Pragmatic Regulatory Impact Analysis'

By CPR Member Scholars Rena Steinzor, Amy Sinden, and Sidney Shapiro, and CPR Policy Analyst James Goodwin

Traditional cost benefit analysis pervades the modern regulatory system, despite its known shortcomings in accurately assessing either the costs or the benefits of regulation. In CPR White Paper #909, we outline a new methodology for evaluating regulatory action. "Pragmatic Regulatory Impact Analysis" is a more explicit and transparent multi-disciplinary, "weight-of-the-evidence" approach to decisionmaking.

The Hidden Human and Environmental Costs of Regulatory Delay

By CPR Member Scholars Catherine O'Neill, Amy Sinden, and Rena Steinzor, and CPR Policy Analysts James Goodwin and Yee Huang

Each year dozens of workers are killed, thousands of children harmed, and millions of dollars wasted because of unjustifiable delays in federal regulatory action. White Paper #907 uses three case studies—including OSHA's delayed rule on the use and operation of cranes and derricks—to identify the causes and costs of regulatory delay.

To see more of CPR's work or to contribute,
visit CPR's website at www.progressivereform.org.

455 Massachusetts Avenue, NW
150-513
Washington, DC 20001

202-747-0698 (phone/fax)

CPR CENTER FOR PROGRESSIVE REFORM

RETURN UNDELIVERABLES TO:

Center for Progressive Reform
455 Massachusetts Avenue, NW
150-513
Washington, DC 20001