

STATUS OF OCCUPATIONAL HEALTH PROGRAMS  
IN STATE AND LOCAL GOVERNMENTS

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## STATUS OF OCCUPATIONAL HEALTH PROGRAMS

### IN STATE AND LOCAL GOVERNMENTS

#### INTRODUCTION

The 1969 summary of the status of occupational health programs in State and local governments is based on information submitted by State and local agencies for the January 1969 issue of the Directory of Governmental Occupational Health Personnel, and supplemented by observations made by the Regional Consultants for Occupational Health during their visits to all the States the latter part of 1968 and early part of 1969. Included in this year's report is a brief summary of trends in growth patterns of these programs.

#### JURISDICTIONS WITH OCCUPATIONAL HEALTH UNITS

As of January 1969, 82 units with responsibility for occupational health or in combination with radiological health, air pollution or other activities functioned in 42 States, District of Columbia, Puerto Rico and in 32 local health departments, with total staffs of 702 professional personnel (see Table 1). In four States (New York, Massachusetts, Illinois, Washington) the occupational health programs are the total responsibilities of departments of labor. In California, Ohio, Oregon and Puerto Rico, programs varying in size and scope operate in both health and labor departments or industrial commissions. The remaining units are in State and local health departments.

In the District of Columbia and Georgia, industrial hygiene and occupational health are independent administrative programs and are counted as such. The number of local health departments with identifiable occupational health activities shows no growth. In California, the Administrative Code now makes it mandatory for local health departments to offer at least a minimum occupational health service as one of their basic public health services.

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The eight States with no identifiable programs in occupational health are Alabama, Arkansas, Arizona, Delaware, Iowa, Nebraska, North Dakota, South Carolina. Some interest in initiating occupational health programs in either health or labor departments has been reported in four of these States.

The total of 702 persons reported in 1969 includes at least 44 persons on a part-time basis, 9 medical and 2 radiological health consultants. State health departments employ 62 percent of the personnel; local health departments, 24 percent; and State labor agencies, 14 percent. The proportions continue to remain roughly the same as reported over the last several years.

Eight State and four local units are under the direction of physicians; 33 State and 11 local units are directed by engineers or industrial hygienists. In the remaining 26 units, occupational health activity is not a separate administrative unit, and personnel so assigned are responsible to the directors of divisions or bureaus of environmental health, sanitary engineering, industrial safety, etc.

With respect to size of units (Table 2), 10 are one-man units, 31 employ 2 to 4 persons and 21 employ 5 to 9 persons. The 20 units with staffs of 10 persons or more account for 471 persons or 67 percent of the 702 persons reported by all units. At least 40 percent of the staffs in the 10 persons and over units are designated for radiological health, air pollution control, employee health services or other miscellaneous functions.

### PROFESSIONAL STAFFING PATTERN

The State and local staffs continue to be mainly composed of environmental industrial hygienists and specialists. They account for 82 percent of the total professional staffs and include industrial hygienists, industrial hygiene engineers and chemists, industrial sanitarians, health physicists, and air pollution

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specialists. The proportion has not changed materially for the past 20 years.

Some indication of the numerical trend in professional staffing patterns since 1960 is shown in Table 3. The changes over the ten-year period have been relatively minor for most professional categories. The drop from a high of 50 to a low of 35 physicians (full-time, part-time, and consultants) in 1969, and from 36 to 22 nurse consultants is serious, however, and the future outlook holds little promise for improvement. For instance, between January 1968 and January 1969, five State units lost their physician-directors (Colorado, Minnesota, Oregon, Pennsylvania and Tennessee).

The number of industrial hygienists and engineers as well as laboratory staff reached a high of 290 and 108 respectively in 1969. These increases were spread among a large number of units with no unit showing a net increase of more than two persons. Proportionately, the largest increases have been for personnel specifically designated for radiological health and more recently for air pollution activities. The number of State and local staffs actually involved in these program components is much greater, but they could not be separated on basis of job titles.

### ADMINISTRATIVE ASPECTS

The trend to locate occupational health units in an environmental health setting continues as a result of reorganizations within health departments and loss of medical personnel. Presently, 29 of the 50 State units are in environmental health bureaus or divisions; five function in preventive health, three are associated with other bureaus; and five are administratively separate divisions. Six of the units in labor agencies are located in divisions of safety and two (Massachusetts and New York) are separate administrative units. Local units generally operate out of bureaus of environmental health or sanitation. Insofar as it could be determined, some five could be considered separate administrative divisions or bureaus.

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### PERSONNEL TURNOVER

The problem of personnel turnover continues to be relatively substantial, despite increasing trends in total personnel employed in recent years. For instance, comparison of the Directory listing for 1969 with 1968 disclosed that 46 State and 15 local units experienced some turnover in personnel during this interval. The actual number of persons who left for other employment or were separated because of reorganizations or transfers was 97 in State units and 19 in local units. Replacements or additions of new staff, half of whom were for other than occupational health services, totalled 116 in State and 33 in local units. The net gain in 1969 over 1968 was 33 persons.

### FUNCTIONS

#### ENVIRONMENTAL SERVICES

The extent to which the 82 State and local units provide environmental services for the prevention and control of occupational health hazards varies tremendously with size of staff, geographical coverage and scope of activities, as well as other responsibilities assigned to them. With but few possible exceptions, the resources and emphasis placed on industrial hygiene services are totally inadequate in terms of coverage of industries and scope of technical assistance.

Based on facts already known, and on general observations of the Bureau's Regional Consultants for Occupational Health, it was determined that in 13 State and 8 local units minimal or only the part-time services of one or at most, two persons, are available for industrial hygiene activities which consist essentially of investigating complaints. Examples of States classified in this category are South Dakota (1 person for industrial hygiene and radiological health); Wyoming (2 persons for industrial

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hygiene, radiological health and air pollution); and West Virginia (2 persons for industrial hygiene laboratory support for Division of Sanitary Engineering and supervision of radiological health and air pollution activities).

In 11 State and 16 local units, emphasis on environmental control can be considered borderline in that industrial hygiene problems are handled by a small but full-time staff primarily on a request or referral basis. This group includes State units in Minnesota, Colorado, Georgia, Ohio, and Utah.

In 16 States, industrial hygiene services receive relatively substantial emphasis through additional conduct of self-initiated studies or routine visits to industries and adequate laboratory support. (Examples of States in this category are New Hampshire, North Carolina, Virginia and Indiana.) Seven States (Connecticut, Massachusetts, New Jersey, New York, Pennsylvania, Michigan and California) and 3 local units (Baltimore City, Detroit and Los Angeles) all of which have better staffed programs, could be rated as being relatively above average in their attention to environmental phases or in broader scope of occupational health services provided.

## RADIOLOGICAL HEALTH AND AIR POLLUTION CONTROL ACTIVITIES

In 1969, radiological health and/or air pollution control activities were associated as staff activities within the units or as separate sections under the supervision of the unit director in 26 State and 14 local units. A breakdown of the program elements by jurisdiction follows:

	<u>Total</u>	<u>State Health</u>	<u>State Labor</u>	<u>Local Health</u>
Occupational health essentially	42	19	5	18
Occ. health and radiological health	21	12	2	7
Occ. health and air pollution	8	2	-	6
Occ. health, radiological health, and air pollution	<u>11</u>	<u>9</u>	<u>1</u>	<u>1</u>
TOTAL	82	42	8	32

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The scope of radiological health and/or air pollution control activities may be limited to industrial and occupational aspects or may encompass community aspects as well. The combining of these activities as program elements of occupational health units has had varied effects on the traditional work of these units. In the smaller staffed units, these activities have definitely diminished the amount of effort expended in providing industrial hygiene services. For example, 10 of the 13 State units referred to earlier as providing token services in industrial hygiene, also have total or some responsibility for radiological health and/or air pollution control. Even when separate personnel are employed, the program direction in traditional occupational health services is apt to suffer. In several State and local units, the number of personnel designated for radiological health and/or air pollution is far in excess of those designated for occupational health. As an example, the State program in Texas embraces radiological health, air pollution, and occupational health. Of the 43 persons on the staff, 40 are assigned to the first two areas. The other 3 persons provide occupational health support on a part-time basis. However, the unit has budgeted vacancies for industrial hygienists for which recruitment is underway.

It should be remembered that until Congress passed legislation in these areas and appropriated separate funds, the occupational aspects of these programs were considered part of the State occupational health programs to control hazards associated with the working environment. It is not surprising, therefore, with availability of Federal funds and enactment of State legislation in these areas that responsibility for initiating or directing these programs should fall to the State occupational health units.

The trend in delegation of these functions to State units is shown in Table 4 for the years 1960 through 1969. Responsibility for radiological health (State units only) has been decreasing slightly as a result of separations of this element from the occupational health unit while that for both radiological health and air pollution control has increased from 3 units in 1960 to 10 units in 1969.

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Air pollution control activities were separated from most occupational health units prior to the 1960 decade. For example, in 1958 some 30 State units were involved in air pollution control to some degree. Current trend in increasing responsibility is due to the Clean Air Act and subsequent amendments in the 1960's which make it mandatory that State and local areas do something about air pollution control.

### MEDICAL AND NURSING SERVICES

The need for balanced medical-environmental programs has always been recognized, but the fulfillment of this goal continues to be hampered by diminishing medical and nursing personnel resources. Medical activities for the prevention and control of occupational health hazards currently receive relatively substantial attention in only four State (California, Connecticut, New York and Pennsylvania) and one local unit (Santa Clara County)\*. The several other units that employ physicians do so on a part-time basis or retain them for occasional consultant services. A few units are directed by physicians who have other responsibilities within the health department. The occupational health units in Georgia and District of Columbia are headed by physicians, but are concerned essentially with employee health programs for State employees.

Twelve State and 6 local units employ 22 consultant occupational health nurses, most of whom work directly with nurses in industry. Five of these consultants are assigned for part-time work in these areas.

### OTHER FUNCTIONS

In addition, employee health services are currently associated with occupational health units in States of Georgia, Pennsylvania, and the District of Columbia. The California State Department of Public Health was given late in 1968 responsibility for

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\* Since the publication of the 1969 Directory, physician-director of this unit has left.

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environmental epidemiology which was accompanied by transfer of 12 professional staff for this activity. The Oregon unit in the State Board of Health also operates the Migrant Health Project and the Implied Consent Program.

### PROBLEMS AND NEEDS

The factors and situations responsible for lack of growth in occupational health activities in most States are many. No single unit is without its own variety of problems. The better staffed units are more capable of overcoming them, whereas the smaller, weaker units tend to retrogress.

The Comprehensive Health Act which appeared to hold much promise for the future appears to have had no demonstrable effect on the strengthening of State and local occupational health programs. Funds appropriated under Section 314 (d) of the Act have been essentially the same as the combined totals appropriated under the former categorical grants. Relatively few States designate Federal funds for their occupational health programs, and the already committed block grants leave little promise for Federal support for such activities. Occupational health monies are already being used in some instances to match Federal funds for other environmental programs. The potential for taking on new activities under Section 314 (e) for project grants has likewise been frustrating. Of the several applications submitted, about four have been approved but not funded.

Following are some of the problems and needs reported to the Regional Consultants for Occupational Health on their recent visits to the States. These problems do not apply consistently to all units and some may be applicable to only one or to a few.

1. Lack of funds and personnel for occupational health activities.
2. Low salary scales still prevailing in a number of States remain as obstacles to recruitment of new staff.

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3. Inability to fill existing vacancies because of high qualifications for personnel required by merit systems.
4. Lack of administrative and legislative support and concern with health problems of workers.
5. Lack of resources to identify statistically, the nature, and extent of industrial hygiene problems for use in budget justifications and for documenting the need for more personnel and needed legislation.
6. Assignment of other responsibilities to the occupational health unit such as for radiological health and air pollution control activities has had a gross effect on the amount of industrial hygiene services provided. Their eventual separation from the unit was often accompanied by loss of experienced personnel.
7. Reorganizations within the State departments of health have resulted in transfer of occupational health activities to other administrative components. The splitting of environmental and medical and/or nursing functions has been accompanied by loss of personnel and at times, discontinuance of activities, especially medical and nursing.
8. Restrictive policies and lack of funds for out-of-State travel to national meetings or for short-term training of new as well as old personnel; restrictive policies regarding travel allowances within the State (e.g. staff must use public transportation for field work).
9. Prospective retirement of older and experienced staff with little or no provision for replacements.
10. Centralization of laboratory services which has resulted in curtailing laboratory work in industrial hygiene.
11. Failure to maintain working relationships with State labor agencies or local health departments.
12. Lack of adequate enabling legislation and rules and regulations for prevention and control of occupational health hazards.

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13. Inadequate support from the Public Health Service, Bureau of Occupational Safety and Health.
14. Poor motivation and leadership in many State and local units.
15. Absence of program visibility such as is associated with radiological health and air pollution control.

### COMMENTS ON TRENDS

Occupational health as a responsibility of State and local governments (as well as of the Federal government) has been subject to criticism or concern of many groups and individuals throughout the country during the past several years. In 1968, this concern was further brought to light by the report of the Committee on State Programs, ACGIH, entitled "A Look at Occupational Health as a State Activity". A group of States was visited by the Committee members who summarized their observations in this report and outlined recommendations directed at the Public Health Service and State governments.

The recent visits of the Bureau's part-time Regional Consultants in Occupational Health corroborated many of the general impressions regarding the inadequacy of State and local resources for occupational health services. Another current indication of the inadequate attention to health problems of workers is reflected by the bills introduced in Congress in 1968 and 1969 dealing with Federal responsibilities in these areas, and with workmen's compensation benefits particularly for the pneumoconioses.

Occupational health as a function of State and local governments is no longer a fledgling activity. Some 55 years have elapsed since the first State programs were established in the New York State Department of Labor and the Ohio Department of Health. Despite the evidence of poor health status of industrial workers in the early years, the development of official programs was slow and erratic. It was precipitated by such universal events

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as the passage of Social Security Act which made funds available for expansion of public health programs including industrial hygiene, and by World War II which forcibly brought to light the importance of conserving manpower in order that production could be maintained. Further stimulus was provided from 1947 to 1950 when Federal grants-in-aid funds were designated for industrial hygiene. The withdrawal of the funds, coupled with State austerity movements, resulted in a retrogression of occupational health activities reflected in a loss of personnel and the discontinuance of some programs. In some instances, financial situations were stabilized through appropriation of State air pollution funds for studies in which industrial hygiene units cooperated extensively.

The growth trend in the number of State and local units and their staffs since 1950, a peak year in their development up to that time, is presented in Table 5. The number of States with no identifiable occupational health programs has remained about the same for the past 15 years. The gross number of personnel has almost doubled over this period, but most of the increases can be attributed to staffs employed for related environmental health services.

As has been brought out in this summary, major problems center about lack of funds and personnel, inadequate leadership and support on a national as well as State and local level, and the lack of resources to define the extent of health problems of workers.

TABLE 1

PROFESSIONAL STAFFS OF STATE AND LOCAL GOVERNMENTAL OCCUPATIONAL  
HEALTH UNITS BY FUNCTIONAL CATEGORY 1/

	All Jurisdictions	State Units		Local Health Depts.
		Health Depts.	Labor Agencies	
With programs:				
States <sup>2/</sup>	42	38	7	16
D.C. & Puerto Rico	2	2	1	--
Total - Jurisdictional Units	82	42	8	32
<u>Total Personnel</u>	<u>702</u>	<u>432</u>	<u>98</u>	<u>172</u>
<u>Physicians - Total</u>	<u>35</u>	<u>21</u>	<u>7</u>	<u>7</u>
Directors of Units	12	7	1	4
Staff	14	7	6	1
Consultants	9	7	0	2
<u>O.H. Nurse Consultants</u>	<u>22</u>	<u>11</u>	<u>2</u>	<u>9</u>
<u>Engineers, Industrial</u>				
<u>Hygienists - Total</u>	<u>290</u>	<u>167</u>	<u>52</u>	<u>71</u>
Directors of Units	44	30	3	11
Staff	246	137	49	60
<u>Chemists, Lab. Tech.</u>	<u>108</u>	<u>75</u>	<u>19</u>	<u>14</u>
<u>Sanitarians</u>	<u>45</u>	<u>5</u>	-	<u>40</u>
<u>Employee Health Services</u>	<u>32</u>	<u>32</u>	-	--
Physicians	10	10	-	--
Nurses & Technicians	22	22	-	--

TABLE 1 CONTINUED

	All Jurisdictions	State Units		Local Health Depts.
		Health Depts.	Labor Agencies	
<u>Rad. Health Staff</u> 3/	<u>71</u>	<u>46</u>	<u>17</u>	<u>8</u>
<u>Air Pollution Staff</u> 3/	<u>69</u>	<u>48</u>	-	<u>21</u>
<u>All Other</u> 4/	<u>30</u>	<u>27</u>	<u>1</u>	<u>2</u>

FOOTNOTES

1/ Analysis is based on 1969 Directory of Governmental Occupational Health Personnel, and includes full and part-time personnel. Excluded are administrative heads other than occupational health under which the activity is carried on.

Included are personnel designated for radiological health, air pollution control, employee health services and other miscellaneous activities when part of or associated with formal occupational health programs.

2/ There are programs in both State health and labor agencies in States of California, Ohio, Oregon and Puerto Rico.

3/ Includes only persons specifically identified for radiological health or air pollution activities.

4/ Includes 12 persons in California Bureau of Occupational Health and Environmental Epidemiology designated for environmental epidemiology, and 6 persons in the Oregon State Occupational Health Section assigned to Migrant Health and Implied Consent activities.

TABLE 2

STATE AND LOCAL GOVERNMENTAL OCCUPATIONAL HEALTH AGENCIES

BY SIZE OF UNIT FOR TOTAL STAFF REPORTED

Jurisdictions	Total	Size of Staff			
		1 Person	2 to 4 Persons	5 to 9 Persons	10 Persons and over
<u>Total - all jurisdictions</u>					
Units	82	10	31	21	20
Persons	702	10	88	133	471
<u>State Jurisdictions</u>					
Health Departments:					
Units	42	4	12	15	11
Persons	432	4	32	92	304
Labor agencies:					
Units	8	-	3	2	3
Persons	98	-	9	13	76
<u>Local health dept. units</u>					
Units	32	6	16	4	6
Persons	172	6	47	28	91

TABLE 3

TRENDS IN PROFESSIONAL STAFFING PATTERNS  
OF STATE AND LOCAL OCCUPATIONAL HEALTH UNITS

<u>Professional Category</u>	<u>Number of Personnel</u>		<u>Range</u>
	<u>1960</u>	<u>1969</u>	<u>1960-1969</u>
<u>Total</u>	<u>465</u>	<u>702</u>	<u>465-702</u>
Medical	43	35	35-50
Nurse Consultants	36	22	22-36
Industrial Hygienists	233	290	233-290
Laboratory Staff	84	108	84-108
Industrial Sanitarians	28	45	28-54
Rad. Health Staff	13	71	13-87
Air Pollution Staff	10	69	5-69
Employee Health Services	6	32	6-41
All Other	12	30	12-30

TABLE 4

TRENDS IN RADIOLOGICAL HEALTH AND AIR POLLUTION  
CONTROL ACTIVITIES DELEGATED TO STATE OCCUPATIONAL HEALTH UNITS

<u>Year</u>	<u>Number of State Units with Responsibility or Activity</u>			
	<u>Total</u>	<u>Radiological Health</u>	<u>Air Pollution</u>	<u>Radiological Health and Air Pollution</u>
1969	26	14	2	10
1968	27	17	2	8
1967	28	19	2	7
1966	26	18	2	6
1965	27	20	1	6
1964	26	19	1	6
1963	26	23	1	2
1962	26	22	1	3
1961	21	16	1	4
1960	20	14	3	3

TABLE 5

TRENDS IN NUMBER OF OCCUPATIONAL HEALTH UNITS  
AND PERSONNEL IN STATE AND LOCAL GOVERNMENTS

Year	Number of States With No Programs	All Jurisdictions		States, D.C. & Puerto Rico		Local	
		Units	Personnel	Units	Personnel	Units	Personnel
1969	8	82	702	50	530	32	172
1968	8	82	670	50	511	32	159
1967	8	82	667	50	526	32	141
1966	8	90	694	50	529	40	165
1965	9	86	691	48	540	38	151
1964	9	82	681	46	519	36	162
1963	9	81	615	46	471	35	144
1962	9	80	609	45	461	35	148
1961	9	82	584	47	457	35	127
1960	9	78	510	46	393	32	117
1959	9	75	484	42	377	33	107
1958	9	69	425	42	333	27	92
1957	8	66	360	43	282	23	78
1956	8	62	377	43	299	19	78
1955	8	61	370	43	295	18	75
1954	8	62	371	43	299	19	72
1953	6	58	375	45	319	13	56
1952	5	58	389	46	334	12	55
1951	4	59	412	47	355	12	57
1950	3	59	425	48	369	11	56