The Future is Now

Developing Effective Workplace Inspection in the United States

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In 1970, the Occupational Safety and Health Act (OSHA) held great promise for worker health protection. It proposed to remedy the problems that were present in the fragmented and unequal enforcement that resulted from a state-based system. Many expected that the Act would herald a new era, that there would be dramatic reduction in the number and distribution of work-related accidents and illnesses among U.S. workers. In many respects OSHA's impact has been substantial, and benefits have accrued even where a direct role is not identifiable. Workers and employers are more aware of risks and the need for their control, and structures now exist in plants, corporations, and unions that are a positive response to the existence of OSHA.

But any new agency must struggle to determine the manner in which it will fulfill its mandate. This includes creation of an administrative structure, employment and training of staff, and development of rules and regulations through which to function. OSHA experienced these developments with the expected false starts, failures, and slow evolution of a new national program. Even though most interested people were aware of the politically sensitive nature of regulations that apply to the workplace, no one appears to have guessed just how sensitive an area it would prove to be. This was borne out when OSHA made the political decision to set the initial asbestos standard without regard to cancer risk. Even so, this standard had to be demanded by legal petition, taking advantage of the requirements that existed for special emergency rule-making procedures. This experience was followed by the intensive battle over a new standard for vinyl chloride, another emergency standard. In fact, almost all of the original new substance-specified standards and the majority of the existing ones were set using the emergency and not the routine standard-setting procedures. These, and other battles, took place against the backdrop of four different administrations, seven directors of OSHA, and a number of changes in Congressional committees providing oversight.

To date, then, the picture that OSHA presents to the public is comprised of conflicts between various interest groups, several new occupational standards, and little evidence that there has been a substantial change in risks experienced by the worker in the factory or the office. Is this evidence of an agency that has failed? I would suggest rather that it is evidence that real change is generally slow, often painful, and inconstant. As an optimist I propose that today the task is to consider what should be done so that we can observe the evolution of OSHA into an effective and forceful regulatory agency.

This panel is confronted, in particular, with the task of examining where OSHA should direct its attention in the sphere of inspection as the agency strives

for adulthood. This examination is of particular interest to OSHA watchers, because so little public attention has been directed to the role of inspection in regulating the risks in the work environment. For the most part the public battles regarding OSHA have been around standards. To the extent that they have addressed inspection they have been focusing on which industry is, or should be, subject to inspection. But little attention has been paid to the objectives of the actual inspection including targeting, level of detail, possible penalties, effective followup, and appropriate monitoring by workers, management, and government.

It is presumptuous for this panel to actually suggest a blueprint for inspection. But it is not presumptuous for the panel to identify key areas to consider in developing inspection programs. We should recognize that it is unlikely that OSHA could ever have as comprehensive an inspection program as that discussed earlier by Jim Weeks concerning coal mine health and safety. Therefore, we will attempt to focus our attention on the key issues in maximizing the impact of OSHA's inspection effort within reasonable expectations.

Les Boden will address the importance of and means to greater worker involvement in the inspection process. Peg Seminario will address considerations for how OSHA can and should refocus and redefine the task of inspection. Had Joe Canella been able to attend, as originally planned, I would have asked him to characterize those areas where inspection might best be left to voluntary compliance and those that should be emphasized or newly created as requiring the special attention of government enforcement. I would like to take a moment here, however, to address issues included in two related areas: information needs and inspection targets.

To examine OSHA's inspection experience and what OSHA might wish to accomplish in the next 5 years, there is an obvious need to turn to data on the impact of inspections to develop the answer. This includes determining the magnitude of the different disease and hazard problems in industry as well as developing information on trends in these problems. This information could then be placed in the context of inspection practices to identify where inspections have made a difference and where they need to be improved or redirected.

What is striking is that such a search would lead to the discovery that there is essentially no reliable information for such an evaluation. Barney Frank's Congressional oversight committee decried this fact and called for immediate action to change the situation.[1] The response of the administration to this call led to an intensive effort by the National Institute for Occupational Safety and Health (NIOSH), the Bureau of Labor Standards (BLS), and the National Center for Health Statistics (NCHS) to respond to the need. The recent National Academy of Science (NAS) report, "Counting Injuries and Illnesses in the Workplace," proposed some ways to address the problem and it should prove useful reading to those who have not yet seen it.[2] In the main, however, it focuses on injury. It was unable to address the problem of disease at anywhere near the depth that it addresses injury.

The NCHS has responded by incorporating questions in several of the different national survey systems planned for the near future. These should give some improved estimates on work-related problems in the general population but without regard to the source of the problem. NIOSH embarked on a renewed effort at developments in disease surveillance and should be reporting on these efforts and proposing a number of new initiatives in the near future as well. Although this effort is expected to enhance recognition and reporting of disease, the problem of assigning actual cause to a specific case remains and will always be quite difficult.

A proposal in both the NAS report and the NIOSH effort suggests that devel-

opment of hazard surveillance information may offer a means to estimate disease burden, to monitor changes in that burden, and, most importantly, to target specific areas that should receive priority attention for inspection and control of hazards. It is hoped that special attention can be paid to this area because it should provide significant and useful information on risks and how to target control of future disease burden for regulators, health professionals, planners, and the public as a whole.

Even if the knotty problem of estimating and monitoring disease and injury burden were to be solved, there remains the major task of determining how actually to carry out inspections. To this end it is important to consider the purpose of an inspection and the expected outcome. Much discussion of inspections is directed at the need to identify and punish infractions. Many complaints about OSHA identify the failure to do this. But OSHA will never have enough inspectors to accomplish even this end. Furthermore I suggest that this is not the appropriate way to characterize the task. For if it were, then attention would be directed at the inspection to *accomplish* the control rather than to *verify* its presence.

How might the latter objective be made more central to OSHA's efforts? One way is to design a program so that inspections are directed toward increasing the *risk* of inspection. In this way the deterrent nature of an inspection can be better utilized. For example, if 1,000 inspectors are given the task of visiting three workplaces a day with employment of 25 or more and of being in the field three quarters of the time, then 600,000 workplaces of this size can be visited each year. The result is that an employer of 25 or more can expect to be visited more than once a year.

This accomplishes the end of increasing "risk" of inspection and promotes voluntary compliance. It would be short-lived in actual effect, however, unless the inspection actually presents a risk of penalty and if workers are not included as integral to the abatement process. The inspection needs to be designed so that if an infraction is found, a penalty assessment is highly likely, the penalty is substantial enough to be a deterrent, and the workers are carefully informed of the circumstances, the abatement plan, and their rights under the process.

To accomplish this goal several steps need to be taken. Most of these will be the topics of other panel members. Suffice it to say here that without a plan to increase inspection numbers by improved targeting and reduced paper work, and the willingness to readily impose penalties after initial warning (and to penalize to the maximum, not the paltry average $200 at present), compliance inspections can at best be considered cheap consultant visits.

An often forgotten step, however, is that some substantially improved monitoring system must be developed together with record keeping designed for rapid and efficient perusal. It would be possible, in fact, to require standardized record keeping on exposure assessment, medical monitoring, worker training, and ventilation effectiveness which are forwarded regularly to an OSHA area office so that these could be perused prior to a visit. The visit, in turn, could review basic compliance, examine recognized problem areas, and carry out a walk-through in search of new or unrecognized problems.

For example, if an OSHA area office is responsible for a secondary lead smelter, then there should be blood lead monitoring, air lead monitoring, a medical surveillance program, a respirator program, and a worker educational program all directed at the one substance—lead. Similar information would be available on other hazards, carbon monoxide for instance. If there were rules on keeping and forwarding of records to OSHA on these items (using forms and data management

systems designed to focus attention on sentinel events or trends), then the OSHA compliance officer would be well informed and properly oriented to accomplish the maximum when entering the plant for a quick walk-through.

The record review and the walk-through would provide the basis for immediate compliance action, for a decision to call for a more complete evaluation, or for a decision that there was sufficient evidence that the plant was in compliance. Such an approach would miss some problems that were not readily evident, were purposely hidden, or were intermittent. These would be susceptible to a separate program designed to improve worker input to problem identification and compliance. Even still, the approach briefly mentioned could greatly increase the coverage of OSHA inspections, reduce some of the unfocused detailed industrial hygiene activities that are expensive in time and dollars, and also permit the construction of a data system that would provide much better estimation of the distribution and magnitude of potential risk and the success in its control.

Experience in the coal mine compliance activity suggests that privately collected data needs to be considered with care and not always taken at face value. However, such data are far superior to no data, and can be randomly checked by OSHA compliance officers to identify evidence of misleading reports.

Inspections in the future, in any event, must include consideration of a data base that permits surveillance of compliance activities, an inspection plan that greatly increases coverage, and a targeting system that is flexible and directed at both important acute and long-term risks.

REFERENCES

1. U.S. CONGRESS, HOUSE OF REPRESENTATIVES. 1984. Report on Occupational Illness Data Collection: Fragmented, Unreliable, and Seventy Years Behind Communicable Disease Surveillance. Subcommittee of the Committee on Government Operations, 98th Congress, 2nd Session. Washington, DC. U.S. Government Printing Office.
2. POLLACK, E. S. & D. G. KEIMIG, Eds. 1987. Counting Injuries and Illnesses in the Workplace: Proposals for a Better System. National Academy Press. Washington, DC.