

# LOCAL UNION HAZARD CONTROL HANDBOOK

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## GUIDES TO LOCAL UNION HAZARD CONTROL PROGRAMS

- Noise Hazards
- Silica and Dust Hazards
- Asbestos Hazards
- Controlling Health Costs

Substitute for Health PERSPECTIVES

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**LABOR SAFETY AND HEALTH INSTITUTE**

**LSHI**

*"To assure safe and  
healthful working conditions  
for working men and women..."*

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*COMMENTS BY UNION LEADERS WHOSE HAZARD CONTROL PROGRAMS ARE DESCRIBED IN THIS LOCAL UNION HANDBOOK*

Anthony J. Luisi,  
National Association of Broadcast  
Employees and Technicians, Local #16,  
111 West 50 Street,  
New York, New York 10020

Noise at the worksite is the most prevalent and nasty job hazard in our industrialized society. The program and strategy outlined in LSHI Guide #8 reflects the success of our local union in reducing offensive levels of noise. Coupled with worker awareness, the local union continues to strive for total noise abatement in view of management resistance and the costs involved.

The guide and handbook will serve as an excellent resource for every worker and local union faced with noise problems and the effective ways to stop them.

Edward Cross, Secretary-Treasurer,  
Local 147, Tunnel Workers Union,  
International Laborers Union

Even at this late date unions must still educate and by constant vigilance enforce existing rules relating to occupational diseases, since employers still put emphasis and priority on productivity, often at the expense of safety. Silicosis, while ever present in rock tunnels, is not limited to tunnel workers. Other industries and workers are also subject to silicosis. Guide #9 should be a valuable asset to any union where their workers will be or are exposed to rock dust or sand or similar mineral products where silica is present. Silicosis still takes a heavy toll, yet if the laws or rules were enforced, that toll could be cut. LSHI Guides can help by making workers aware of dangers and what they may be able to do to protect themselves.



Sam Meyers, President,  
Local 259, United Auto Workers (UAW)

Our Union has developed and recommended procedures in dealing with asbestos dust emanating from used brake linings.

We have recommended the use of vacuum cleaners and wet cleaning methods, which would minimize the asbestos hazard.

After some struggle, the Employers, by and large, have agreed to incorporate those steps in their shops. We must, however, constantly educate our members, so that those safety procedures continue to be utilized.

This Handbook, which contains the LSHI Guide #10 on asbestos control, should be used by all workers and unions to begin the process of protecting themselves, their families, and the community from asbestos hazards.

James H. Mitchell, President,  
Local 447 Printing Pressmen's Union

Due to misunderstanding and/or convenience by the membership, for years our health benefit and disability program was paying the bill for job-related diseases and/or accidents. This is not in keeping with Workers' Compensation procedures and was a severe cost to our health funds' finances. After two years of our screening disability claims and an intensive educational program, job-related injury and illnesses are now being paid by Workers' Compensation and our health and disability fund is on a sound, break-even footing.

In addition, the membership is receiving a two-fold benefit:

1. They are getting the higher benefit level from Workers' Compensation to which they are entitled.
2. *Their* fund finances are not being diluted by the payment of improper claims.

We hope this example, as described in LSHI Guide #12, will be useful to other unions.



## PREFACE

The Consumer Commission on the Accreditation of Health Services looks with pride on the contribution its affiliate, the Labor Safety and Health Institute, has made.

During a time when occupationally related factors are becoming increasingly recognized as major causes of ill health, the publications of the Institute are very important informational and strategic tools with which consumers can evaluate the safety of their workplaces and minimize threats to health. The 1977 *LSHI Occupational Safety and Health Workbook* was very well received by consumers. The publication of the *Local Union Hazard Control Handbook* takes prevention of occupational diseases to the workplace.

The importance of LSHI's contribution was recognized in 1978 when it was assigned a seat on the City-wide Board of Directors of the New York City Health Systems Agency. In this position, LSHI can have an even greater impact on the delivery of health services in New York City.

Health care consumers and providers will benefit by reading these practical guides and other materials to see where their programs and activities mesh with these local union hazard control programs.

Donald Rubin, President,  
Consumer Commission on the  
Accreditation of Health Services





## FORWARD

The passage of the Federal Coal Mine Health and Safety Act of 1969, as amended, and the 1970 Occupational Safety and Health Act brought hope to workers and unions that the workplace would soon be a safe and healthful place to work.

The past eight years has seen a very uneven administration of the OSHA Act. Few new federal standards have been established. The enforcement of all standards has been sporadic, often requiring aggressive worker and union participation to guarantee enforcement. Greater worker and union participation is required to bring about a more responsive OSHA Administration on the federal, regional and local level.

As the federal courts, Congress and the White House create narrower parameters for OSHA to work in, labor unions are devising their own strategies to detect, control and prevent workplace hazards.

This Local Union Hazard Control Handbook illustrates how four unions began to control noise, silica and other dusts, asbestos and health care costs. Additional Guides and related information will also be of value.

The combination of aggressive OSHA enforcement and the use of these strategies can begin to make the realities of the hopes which were aroused in workers by the 1970 OSHA Act.

Frank Goldsmith, M.P.H.  
Director

January, 1979

THE ABOVE IS A SUMMARY OF THE INFORMATION CONTAINED IN THE ATTACHED DOCUMENTS.

THE INFORMATION CONTAINED IN THIS DOCUMENT IS UNCLASSIFIED EXCEPT WHERE SHOWN OTHERWISE BY THE MARKINGS.



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Guide #7

FRANK GOLDSMITH, Director

## OSHA STANDARDS CAN SAVE LIVES:

### A GUIDE TO THEIR UNDERSTANDING

The purpose of this Labor Safety and Health Institute Guide is to acquaint union leaders and members with OSHA standards and to explain how to use them to save workers lives.

#### 4 + 400 = Lives

OSHA safety and health standards are federal laws enforceable by the U.S. Labor Department's compliance officers. Since the passage of the 1970 Occupational Safety and Health Act, only four new health standards have been promulgated. These new standards cover asbestos; vinyl chloride; a group of fourteen cancer causing chemicals; and coke oven emissions. These standards cover workplace hazards that can cause cancer.

Upon passage of the OSHA Act, the Occupational Safety and Health Administration "referenced in" threshold limit values (TLVs) for about 400 toxic substances\* and safety practices\*\* regarding work hazards. These 400 substances are under review and tougher TLVs are being considered. The OSHA safety practices are also being revised. The four new OSHA health standards and the 400 TLVs and safety practices are legally enforceable by the Labor Department OSHA compliance officers. But until they are revised, workers and their unions must seek strong enforcement. For example, the TLV for vinyl chloride was 500 parts per million (PPM) until it was revised by the Labor Department to one PPM after its cancer causing effects were discovered.

#### Standards Not Enforced

Employers have not been voluntarily complying with OSHA standards except for those covering exposure to vinyl chloride. After business leaders first contended

\* These standards were developed by the American Conference of Governmental Industrial Hygienists (ACGIH).

\*\* These standards were developed by the American National Standards Institute (ANSI).

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that no one could comply with the strict vinyl chloride (PPM) standard, the plastics producers and major plastic fabricators now claim to be in compliance. (The Labor Department has not validated this claim.)

It is generally agreed that the current 2 fibers (fibers longer than 5 micrometers) per cubic centimeter (cm<sup>3</sup>) asbestos standard is not being complied with by companies using or manufacturing that substance. It has been alleged that the Labor Department is not conducting strict enforcement programs to ensure that the asbestos standard is not exceeded. Evidence has shown that workers get cancer from exposure to asbestos at the present standard level. Because of this finding the government has proposed a new standard for asbestos of 0.5 fibers/cm<sup>3</sup>. There is little discussion concerning the package of 14 cancer causing chemicals which each carry a "no detectable level" exposure level. But even improved standards are meaningless unless they are enforced.

### Coke: Its the Real Thing.

The recently promulgated coke oven emissions standard is 150 micrograms per benzene soluble particulate air. The Labor Department does not claim that this standard will totally eliminate the cancer threat to coke oven workers. There has been strong criticism against OSHA for setting a standard which may not eliminate the risk of cancer caused by workplace hazards. Stricter enforcement must be coupled with an improved standard.

### 1,200 Inspectors Need You

Employers can not be expected to voluntarily comply with OSHA standards that save worker lives. OSHA standards are only enforced when the 1,200 nationwide OSHA compliance officers actually visit a workplace or when knowledgeable workers and their unions militantly seek enforcement. OSHA investigators are permitted by federal law to randomly inspect any workplace, but they are required to enter a workplace after a complaint is filed with the Regional OSHA Office.

### The Threshold is the Limit...

Health standards established under the OSHA Act are supposed to be designed to completely protect workers from the health effects of toxic substances, excessive noise and other workplace hazards. (The use of protective equipment is entirely temporary.) These standards should incorporate a definition of the threshold limit value (TLV), or permissible exposure level to which workers can be exposed averaged over an eight hour day. The TLV is stated in numerical terms as a quantity of the substance or noise (i.e. X decibels or parts per million). Even though the allowable levels of a chemical are measured in parts per million, a small amount per million or "no detectable level" is often required when dealing with dangerous, cancer-causing substances.

### Measurement Can Be Easy

OSHA standards also describe the method(s) of determining the amount of the chemicals in the air. Most of these monitoring methods are described in highly technical terms, thus often not easily understood by workers. However, equipment to measure air content has been developed which is easy to use. But in order to prove to an employer, OSHA, the courts or other union members that a danger exists any initial samples gathered by the union which indicate a dangerous level should be backed up by professional, scientific evidence. Workers and their unions can

request the employer to provide more sophisticated testing equipment and to test the air. The labor-management safety and health committee should be entitled by the union contract to validate the employer test results and confirm any suspicion of dangerous conditions through independent testing. Unions should consider the formulation of health and safety demands for inclusion in future contracts, while those with health and safety committees should consider demands to strengthen these union functions. (See LSHI Guide #5)

The workers and/or the union can request a "health hazard evaluation" by the National Institute for Occupational Safety and Health (NIOSH) to determine the extent of any hazardous condition. Tests by NIOSH are conducted at no cost to the employer or the union. No citation or penalty accompanies the test. When a dangerous situation is confirmed and workers or the union are not satisfied with the employer's corrective actions they can seek an OSHA citation by filing a complaint with the OSHA area office. The OSHA inspector then determines after an inspection, if a serious hazard exists and an OSHA standard is not met. If a violation is found, an OSHA citation is given to the employer and an abatement period (period of time to correct hazard) is established. The Regional OSHA Director can then assess a fine as a penalty. A new ruling curtails the impact of non-serious OSHA violations. This ruling states that a penalty can only be assessed when there are eleven or more citations made based on one OSHA inspection.

#### Compliance Methods Vary

There are specific methods of compliance with each OSHA standard. The OSHA Administration explicitly states how an OSHA health hazard is to be corrected. These methods of compliance are different for each standard. Each violation of OSHA standards must be corrected by modifying production techniques, providing adequate light, reducing noise levels, etc. For example: chemical vats must be properly enclosed and vented; asbestos production must take place without any fibers escaping into the air; and noisy machines must be reengineered to reduce the noise levels.

The use of personal protective equipment, (i.e., ear plugs and muffs, face masks and other breathing apparatuses) to protect workers from health hazards can only be used as a temporary remedy until the production method is corrected. The choice of corrective technique or equipment is usually left to the employer but they are suggested or specifically required by OSHA. The union should negotiate the right to use this equipment and to validate its performance and accuracy.

#### Hazard Posting is Assured; Medical Surveillance

The posting of hazards is another OSHA requirement. Posting is especially required when dealing with known cancer-causing substances as asbestos, vinyl chloride and coke oven emissions. All citations issued by OSHA must be posted for a required length of time. Each employer must also have a Labor Department notice posted which states that the OSHA laws are being observed. Posting is vital since it helps the union inform all workers of dangers. This often alerts workers of factual conditions while dispelling rumors and misunderstandings. OSHA health standards requires workers to be offered free annual medical examinations by their employers i.e., asbestos workers are required by law to have an annual exam. This medical surveillance requirement is probably the most weakly enforced OSHA regulation. Once workers are guaranteed, usually through the union contract or activity, that the results of workers' medical examinations will remain

confidential, worker support for this type of enforcement improves. An effective medical exam program (one which will provide incentives for worker participation) will include a salary or wage-rate retention guarantee. This provides workers with the security of knowing that a reassignment of work because of a job-related disease to a lower risk job does not mean less pay, loss of seniority or reduced benefits. In effect, a rate retention guarantee provides an incentive to high risk employees to participate in health exam programs. So far, only the OSHA asbestos standard contains a rate retention provision.

The storage of medical records for a defined period of time is associated with the medical examination program. The asbestos standard requires, in addition to the tests, that the medical records of workers be kept for 30 years. The vinyl chloride standard does not make this mandatory, but collective bargaining contracts can make it a union protected requirement. The stored medical records can be used for a variety of reasons including the documentation of actual morbidity (sickness) and mortality (deaths) of workers caused by working conditions.

### OSHA Training Important

OSHA regulations are usually written in language which can be understood by a shop steward and safety and health committees who have received adequate OSHA education and training. Without proper training workers and union officials, as well as management personnel, can not be expected to understand many OSHA technical materials. Section 18 of the OSHA requires health and safety education and training programs.

### Understanding Safety Standards

Safety standards used by OSHA are with few exceptions, generally taken from the American National Standards Institute (ANSI). OSHA safety standards refer to methods of guarding workers against the dangers of unsafe machinery; proper construction of scaffolding; and other safety measures to prevent accidents. Some safety standards are related to health hazards, but OSHA generally divides these areas into two groups - each with its own enforcement procedures. These standards are easy to understand and cost industry little. But, some important safety standards are difficult to understand or enforce. For example, the easiest and safest method to guard against the potential danger of most machines is to keep workers hands and bodies away from the dangerous parts of machines. One approach tried by OSHA in its regulations is known as the "No Hands In Dies". This simple meant no hands are to be placed in any machine where a cutting die is used. After the Labor Department promulgated this ruling an avalanch of industry reaction forced its revocation. In January, 1977 the Labor Department issued a large volume on approved methods of guarding workers against the dangers of power machinery. One method is the use of automatic eyes to indicate potential danger. The methods in this volume of regulations are difficult to understand and enforce. Workers and their unions can expect OSHA compliance officers to fully understand safety protection methods, however, and health and safety union representatives can learn safety principles and protection techniques from these officers, and through specially prepared educational and training programs.

### Fail Safe Machines

A machine must be safe especially when a worker errs, because everyone can make a mistake, but few people can grow another hand, arm, leg or return from the dead. Machines must be made so safe that even an occasional unsafe action by a worker will not result in injury or death.

### NIOSH "Criteria Documents"

The National Institute for Occupational Safety and Health (NIOSH) has the responsibility to develop "criteria documents" on job health hazards. These "criteria documents" become the major basis for promulgation of OSHA regulations. Workers and their unions can participate in the review and comment of these documents before submission to OSHAdm. The needs of workers and their unions must be incorporated into all OSHA standards. This can be accomplished by participation in the review and comment of "criteria documents". Each "criteria document" is prepared by staff experts under the guidance of an advisory committee. The names and addresses of the advisory committee members are listed in the front of each "criteria document". These advisors should be contacted so that broad worker opinions are available for consideration. At least one copy of each "criteria document" is available, free, on request from NIOSH, (see LSHI Guide #1).

### OSHA Standards Proposed First

Before finalizing a federal OSHA standard, a "proposed standard" is issued by the Labor Department for consideration. Public hearings are held so that workers, unions, industry and the general public may comment before the appropriate government officials. (The Labor Department will occasionally establish Special Advisory Committees e.g., special coke oven emission advisory committee, to seek more information before final hearings and proposal of standards.) These proposed standards are organized into provisions similar to the final standard based on the format of the OSHA standards previously described.

### One Step Forward, Two Back

Federal OSHA safety and health standards, however, are not solely promulgated for prevention, medical and safety reasons. While the law carefully states that standards must be feasible, the weight of the standards are assumed to be both technically and economically feasible.

The OSHA law was passed when U.S. engineering capability was seen at its apex (after the successful moon and other space shots). However, industry has repeatedly claimed it does not have the technical ability to achieve a safe and healthful standard at the workplace. OSHA officials have usually found industry claims of limited technology as unacceptable and forced improvements in safety. However, the recent coke oven emission standards may be a dangerous precedent. In this case, OSHAdm. accepted the steel industry's technical arguments that the correction costs and limited technology prevented reasonable safety standards. The OSHAdm. failed to aggressively demand information and action based on existing technology that would have made coke oven production safer for workers.



Ford Hadn't A Better Idea

The economic crisis of inflation and unemployment has brought the specter of economic feasibility into the limelight. The OSHA Act makes no mention of industry's ability to pay. However, Ford and Nixon by Executive Orders forced the Labor Department to prepare economic impact statements on each proposed OSHA standard. In the last two years of the Nixon/Ford administration Inflationary Impact Statements were also imposed. The requirement that Economic and Inflationary Impact Statements be made is now being challenged in court by the labor movement as illegal and not in keeping with the Act's mandate.

The current administration has indicated that the inflationary impact will not be a factor in establishing OSHA standards, but the economic impact would still play an important role in establishing standards.

Union Action Summarized

In summary unions and their members must:

- . seek tougher regulations;
- . participate in hearings on OSHA standards;
- . participate in the review and comment of NIOSH "criteria documents";
- . document workplace hazards that kill, or disable workers;
- . seek effective enforcement;
- . bargain in labor rights to safe and healthy working conditions;
- . demand better benefits for disabled workers;
- . support medical programs designed to detect illness caused by workplace conditions; with full rate retention rights and confidentiality guaranteed;
- . participate in joint labor-management health and safety committees.

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The Labor Safety and Health Institute Guides and Consumer Commission CCAHS Quarterlies are available upon request at \$1.00 per copy. The LSHI Workbook costs \$4.00.

Subscribers to the Labor Safety and Health Institute are entitled to future Guides at no extra charge. Membership is \$10 per year. Contributions are tax deductible. Use attached coupon.

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Guide # 8

FRANK GOLDSMITH, Director

## NOISE CONTROL PROGRAM

### IN A

#### LOCAL UNION

##### Broadcast Technicians

The National Association of Broadcast Employees and Technicians (NABET) represents workers at the American Broadcasting Company (and NBC) nationwide. The Executive Committee of NABET Local 16 decided to employ the services of a professional audiologist to provide hearing tests for its 600 members in New York City. This action came as a result of several complaints from union technicians that noise in various locations (studios, control rooms, etc.) was annoying, and perhaps dangerous.

Sound levels were never measured by company management or its consultants to learn if the current federal standard of 90 decibels had, in fact, been exceeded. However, the kind of noise and its persistence made it a great nuisance and potential health hazard.

Discussion of noise complaints during grievance sessions proved to be futile. No offer was made by the company to conduct audiometric (hearing) tests for the technicians nor sound level tests at worker stations. In the union program, workers were offered an audiogram or graph showing their level of hearing at a number of frequencies.

##### Union Confidentiality

Results of hearing tests were confidential due to the complete control by the union. Some workers feared the loss of income or, ultimately, dismissal if the company learned of their impaired hearing. The union assured each member that its purpose was to expose the work-site noise problem and that individual hearing tests would not be used. In addition, the hearing test for each worker was retained by the union and filed for future reference.

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### Worker Participation

The entire membership was informed of the noise control program via newspaper, etc. Specific procedures were outlined which included special hours and days for the union-financed tests. Members were advised to appear for ear tests prior to work time and not to use subways or motorcycles to travel to the hearing test studio. One hundred fifty-one members elected to take the ear test. The showing was considered a good one considering the fact that over one hundred members work out of state to cover sports and other events.

### Workers' Compensation

Although some workers had a prior hearing test, the union program established a "base-line" reference point illustrating a hearing level at a specific time. The importance of the "base-line" test cannot be over emphasized since hearing loss can be documented by future tests. Insurance companies invariably contest hearing loss cases on job-related claims--they rarely lose. While workmen's compensation is "no fault" in principle, the worker will need "base-line" data and other tests to show loss of hearing as being work-related.

### Use of OSHA

The union has not used the services of an OSHA inspector, but safety and health activists within the union have attended classes on OSHA and are very familiar with its provisions. On occasion the union has threatened the company with an OSHA inspection for noise and other occupational hazards.

### Use Of Collective Bargaining

The union, in using its own membership funds, did not use its collective bargaining agreement to achieve its noise control program. Union leaders did plan to use adverse test results as a club to get the company to correct the high noise levels. Future negotiations will be utilized on safety, etc., however.

### Results of Testing Program

Much to the surprise (and shock) of most of the NABET members the hearing tests proved that a noise hazard exists in the radio and television studios. At least 75 technicians showed hearing loss, and showed indications of hearing loss. Perhaps the most significant fact is the rapid hearing loss of 18-34 year-old workers. The full report was written and presented by the hearing specialists hired by the union. A union executive board meeting heard the report and the results were then given to the full membership. The final report contained no individual names but a series of graphs and tables showing the rate of hearing loss. An evaluation of the results accompanied the graphs and tables.

### Conditions Changed?

The union presented the results of their testing program to the company. The company yawned and made no response! In fact, the company was in the process of reorganizing some studios at the time of the union ear testing program. The union was never consulted on the new studio design. The result of one studio reorganization was higher audio levels with more complaints of hazardous noise levels. The purpose of the studio adjustments was to satisfy management desires

as seen by audio consultants. At no time did management mention or request evidence of hearing loss nor did they discuss the project with the union safety members.

### Did Union Give Up?

Most of the safety & health activists knew prior to the testing program that the company would give it little attention. It was a necessary step. The membership was not then aware that a problem existed. But the testing program that was accomplished and continuing education on noise, its health effects and safety made the membership aware of the danger of hearing loss because of work conditions.

### Some Hope

Recently, one union member used collective bargaining techniques and OSHA information at an arbitration. The worker escalated his complaints against noise levels with grievances and accident reports which resulted in an expedited arbitration. The arbitrator ruled on behalf of the worker that he should not be fired for demanding a safe workplace. The company agreed to technical changes so that studio monitors (speakers) would not be offensive to technicians and sound insulation is to be installed. The union is now considering a second round of audiometric (hearing) tests following the "base-line" tests by two to three years. The results should begin to document that hearing loss is job-related. Based on comparative tests, the union will determine if workers' compensation claims can be processed for partial permanent hearing loss. Whether this becomes an economic incentive to the company to change the studio remains to be seen.

### Some Lessons

The main lesson of this noise control program is that any union can be mobilized for a program of hearing conservation. The company has a more difficult time sowing discontent among workers not favorable to the program as it could if this phase of the program was not accomplished. This is a popular tactic on the part of management to stop union safety and health activities. And, the way is now paved for the collective bargaining of this issue since the fact of hearing loss has been scientifically established which would furnish evidence to future arbitrations which could fall against the company. This sequence of events usually results in corrective actions on the part of management to deflect union momentum. The union plans to use this opening to press for lower noise levels.

Another major lesson is that OSHA was of little or immediate use. The OSHA noise standard was not exceeded, but a noise problem still existed. This gap between a known occupational hazard and the OSHA standard was not bridged.

The current and OSHA proposed noise standard of 90 dBA exceeds the noise standard (85 dBA) of practically all industrialized nations. The labor movements' demand for a 85 dBA is still possible if action is taken immediately.

Hazard control programs in a local union should meet the following standards:

1. Maximum involvement of the whole local union membership;
2. Establishment of a permanent safety and health committee with a subcommittee on the particular hazard, in this case, a noise control committee; One shop steward per work area task may be sufficient;
3. Use of outside medical or scientific professionals in hazard detection, medical surveillance, and preventive measures;
4. Strategic use of collective bargaining clauses & procedures;
5. Maximum knowledge of the Occupational Safety and Health Act, its enforcement and other regulatory provisions;
6. Close monitoring of management initiated safety and health activities, especially those which require workers to use personal protective equipment;
7. Regular reports to the membership through the local newspaper; union shop steward notices; bulletin boards; special OSHA newsletters;
8. Investment of union dues monies in the hazard correction programs in addition to possible monies gained through negotiations with management during collective bargaining.

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GUIDE # 9

FRANK GOLDSMITH, Director

## SILICOSIS AND DUST CONTROL PROGRAM

### IN A

### LOCAL UNION

Tunnel excavation work is extremely hazardous work. Dynamiting, drilling and mucking out accompanied by working at great depths below sea level yield occupational hazards which place workers at increased risk to their health and lives. Tunnel workers ("sandhogs") constructed the Holland and Lincoln Tunnels; subways in Washington, D.C. and New York City; and were preparing to construct a tunnel under the English Channel. No city can exist without tunnels for its sewage and other vital necessities. Yet, few city residents are aware of tunnel workers and construction hazards they face.

#### The Environmental Water Tunnel

Fresh drinking water is brought into New York City via two tunnels from up-state New York reservoirs. These two tunnels were built in the 1910's and 20's and are in dangerous disrepair. Experts agree that these tunnels cannot be cleaned out, they are beyond repair. A third water tunnel was deemed necessary to replace them as a source of water supply. Thus in 1970, the New York City Board of Water Supply accepted bids and contracts were let to a group of five major tunnel construction companies to commence work on the "Third (Environmental) Water Tunnel". The tunnel is 800 feet below sea level.

A construction union, the Tunnel Workers Union Local 147, of the International Laborers Union, began recruitment of workers for the project and work commenced in 1971. Six years later, in 1977, a cruel toll has mounted in deaths and sickness from hazards in the tunnel. Eighteen workers have been killed, many have suffered crippling injuries, and many now have developed silicosis, a debilitating lung disease. This lung disease is caused mostly by silica (rock) dust.

The tunnel is now shut down due to lack of funds from the City of New York. The funds cut-off came as a result of structurally weak ceilings and walls of the tunnel which require steel supports to end dangerous rock falls which increase hazards and lead to the destruction of the tunnel before it is used. Without

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these steel supports the same conditions which now exist in the first two tunnels would result in the third within a very few years. Prior to the cut-off of funds, over 1,600 workers were employed.

Local 147, prior to this project, had established an excellent safety work record in construction of various city projects. Only one worker had been killed in the previous twenty years. The union's safety record came after suffering decades of illnesses and deaths in the construction of, for example, the Holland and Lincoln Tunnels. These tunnels were constructed under "compressed air" which has the job-related risk of an illness known as "caissons" (or decompression) disease, a crippling bone disease. The subways, sewage and water tunnels are fresh air tunnels.

### Safety Training

A major problem facing this new job resulted when the involved construction companies began hiring new workers who had no previous tunnel construction experience. The handling of explosives, working with an underground narrow gauge railroad, and other unique underground construction work require experienced workers. The companies provided no training programs. The union did not sit still in this situation. It invested its own money and sent union safety and health leaders to the Bureau of Mines in Pittsburgh for advanced safety training. Union training classes were held in New York City to up-grade the importance of working safely for the whole membership. Without this emphasis on safety, the death and injury toll in the water tunnel doubtlessly would have been greater.

### Tunnel Hazards Numerous

The membership of the union is aware of the health hazards associated with excessive noise exposure. Hard-of-hearing workers are very common because of the failure to take precautionary action to prevent ear damage. The smell of oil fumes from drilling machines cannot be escaped in the tunnel unless proper ventilation is installed and maintained. Workers are also very aware of the high dust levels in the tunnel. However, in the past, they were not as aware of the long term effects of breathing rock dust as they are now.

### Learns From History

The union leadership has informed all of the union members about the criminal story of Gauley Bridge, West Virginia in the early 1930's. In this tunnel project, the Union Carbide diverted the meandering New River from Hawks Nest to a power station to be built near Gauley Bridge. A book called Hawks Nest was written about this episode in labor history, but the company, to conceal the disaster, bought all the copies. Congressional hearings in 1941 heard the U.S. Public Health Service report of how 476 workers died of silicosis with as little as three months exposure to rock dust from the tunnel. The death toll was probably far higher. It usually takes at least fifteen years to show breathing impairment caused by silicosis. Thousands suffered permanent lung damage. A New York City member of Congress, Vito Marcantonio, lead the Congressional hearing into this carnage since many of the workers came from New York State seeking jobs.

This awareness of labor history and the mounting breathing problems faced by Local 147 membership brought the union into action to seek remedies against this

disabling disease. However, a major obstacle stood in the way of a medical program to protect tunnel workers from silicosis.

### Workers' Comp "Catch-22"

Up to July, 1974, the New York State workers' compensation system did not cover workers with permanent, partial disability from dust diseases. This prohibition has run through the whole history of the New York State law since its inception in 1914 with the exception on one year, 1934. This one year coverage came as a result of the public outcry from the Gauley Bridge exposé. However, the insurance companies and employers created a giant scare among companies, unions, and politicians at the time, saying that the workers' compensation system would be destroyed, run financially dry, if this provision was retained. In addition, thousands of construction and manufacturing workers who refused to submit to employer x-ray examinations by company physicians were laid off. They refused the test for fear of being found unhealthy, being laid off, and not hired by other employers. These examinations would have reduced the employer's liability if the worker applied for permanent, partial disability benefits in the future. Thus without one worker receiving permanent, partial disability workers' compensation, the New York State Legislature withdrew this provision.

But the "Catch-22" only begins here. To be able to collect for permanent, total disability under compensation law, a worker must report to the Compensation Board, within a 30 day time limit, any suspected or diagnosed silica damage even though they could not collect on a partial disability claim.

This seems a rather simple, innocuous, if not meaningless thing to do, however, workers justifiably fear that their employers, who must be informed of this report under law, will terminate their employment just as they feared 40 years ago. Employers do this to avoid a rise in their workers' compensation insurance premiums once the worker becomes totally disabled and receives an award. Under compensation law, only the last employer's insurance company pays. Thus the last employer of the compensated workers receives premium increases. Since July, 1974, under tremendous pressure from the labor movement, lead by Local 147, and against stiff employer resistance, the New York State Compensation Law was amended by the Legislature so that workers employed after that date can collect for permanent, partial disability for dust diseases. However, this provision does not cover workers working before that date. Protecting workers who are collecting permanent partial workers' compensation for dust diseases from employer discrimination (firing the workers before total disability set in) may still be a problem.

### Union Program Fills Gap

Local 147 leadership launched a special medical program for its membership which partially filled the loophole in the workers' compensation law. It is similar to medical screening programs which unions in similar situations utilize. (See Guide # 8 on Noise Control Programs).

The keystone of the Local 147 dust control program is to make a medical test available to the union member which reports the worker's health status, but at the same time protects the worker's confidentiality. It also guards against incriminating union officials who can be subpoenaed by the workers' compensation board to give evidence against the claiming worker and union member. Compensation hearing officers responding to the demands of the company's insurance carrier can



call union officials to testify that the official and the worker knew of the illness, but didn't inform the employer or compensation board within the prescribed 30 day time limit. This knowledge would make the claim invalid.

The union made arrangements with Mt. Sinai School of Medicine's Environmental Sciences Laboratory for workers to receive chest x-rays. A numbering system was used so that only the worker knows the chest x-ray results and diagnosis. A composite of all the chest x-rays are grouped together for analysis by the union and laboratory. Under this system, 1) only the worker knows the degree of lung impairment; 2) the union and the construction companies can know to what extent the dust is creating an occupational hazard problem in the tunnel; 3) the company and union do not know the health status of the individual workers; 4) union officials are protected against workers' compensation subpoena; 5) workers can judge for themselves at what point they will quit working in the tunnel and/or seek workers' compensation for permanent total disability, or since 1974, permanent partial disability.

### Dust Control in Tunnels

In order to test for dust concentrations and for proper ventilation, the union had to first settle a jurisdictional dispute between the Bureau of Mines, Interior Department (under the Coal Mine Health and Safety Act) which had the expertise, but no legal jurisdiction, to conduct these tests, and the Occupational Safety and Health Administration of the Labor Department (under OSHA law) which had no expertise, but had legal jurisdiction on this issue.

It took over two years to reach an agreement by which OSHA would use Bureau of Mines expertise to test for silica concentrations and ventilation effectiveness. In 1978, the Labor Department has taken over all legal and scientific apparatus under the Coal Mine Health and Safety Act. This reshuffling may result in more foot dragging in standard setting and enforcement programs on the short-run, but should be a positive step on the long-run.

### Tunnel Shutdown Ends Programs

The shutdown of work in the tunnel suspended the medical surveillance program with Mt. Sinai and the attempts to bring effective ventilation systems into the tunnel.

### The Solution

A solution to this complicated compensation problem is the revision of New York State Workers' compensation laws which will:

1. Award workers' compensation for permanent partial disability for all dust diseases, regardless of date of employment;
2. Take aggressive action against employers who discriminate against workers who have a permanent partial disability which may develop into a total disability;
3. Penalize worker'compensation insurance carriers who consistently and unnecessarily controvert every workers' claim for compensation for dust diseases and other job-related health problems.

In addition, proposed national health legislation must cover the whole cost of preventive and health screening, including periodic out-patient exams. Until that time, third-party payment insurance companies, (i.e. Blue Cross, Blue Shield, Group Health, Inc., and commercial carriers) should cover these exams with no increase in premiums.

Hospital out-patient, emergency, and in-patient facilities can utilize this added insurance coverage through revision of existing hospital procedures. (See Labor Safety and Health Guide # 2 for details.)

In addition, extensive training and education programs, at no cost to workers or the union, should be mandatory. These should be conducted on working time.

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Materials Available (\$1.00 each)

- 1. Guide #1 OSHA Local Union Library . . . . .
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- 10. CCAHS Quarterly OSHA and Health Care . . . . .
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## GUIDE # 10

FRANK GOLDSMITH, Director

### COMBATING ASBESTOS - RELATED DISEASES IN A LOCAL UNION

Local 259 of the United Auto Workers (U.A.W.) union represents over 5,000 workers in the New York-New Jersey area. The local negotiates contracts with several employers of its membership. While this local may utilize the contents of contracts negotiated by other U.A.W. locals in General Motors and the other auto companies, it cannot generally negotiate all of the more comprehensive benefits given its smaller membership and small auto repair shops and auto dealers with which it deals.

There are approximately 3,300 auto mechanics in the union. These workers perform the same on the job duties. Job responsibilities include mechanical work on engines, body work, and replacement of worn out brakes. Workers are paid by employers by two basic methods: production (incentive pay), and hourly (same hourly pay regardless of production).

The union is composed of almost all male workers with an equal distribution of Black, Puerto Rican and other Hispanic workers, and white workers.

Important characteristics of the shops are their size and the fact that many owners also work in the shop. The extent of exposure to job hazards affects the owners almost to the same degree that it affects the workers! The shops are small enough, the **short** distance between the brake repair areas and the management areas, to create a health hazard to anyone in the shop.

#### PRE-ASBESTOS PERIOD

The union, since its inception, has negotiated the right to question and up-grade working conditions on the job. All contracts negotiated by the union contain clauses allowing shop stewards and committees to conduct grievance proceedings toward hazard correction. Some of the common hazards associated with auto repair shops include: correct use of hydraulic lifts; ladders (fixed and portable); spray paint operations; compressed air equipment; machine guarding; welding, cutting, and brazing; electricity. Reportedly, many grievances brought by union members are about hazardous work conditions.

The union has negotiated a comprehensive health and welfare benefit plan which ensures the maximum amount of health and medical coverage given the limited contributions by employers. The health and welfare fund trustees have self-insured

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its hospitalization (dropping Blue Cross coverage) and uses Group Health Incorporated for its medical coverage. Major medical coverage is also self-insured. This aggressive program by the union has enabled the union to stretch its package for its membership to include drug, vision care, mental health, and other benefits.

In addition, the union substitutes its own negotiated (off-the-job) disability program for the New York and New Jersey programs.

An effective education program directed toward its membership includes: a newspaper, shop steward training, general education classes, and many social functions: this program has created a close relationship between the union leadership (including the union elected leaders and health benefit fund administrators) and its members.

#### Occupational Disease Latent Period Eludes Union's Records

Despite the union health program, the long latency period (20-30 years) prevented the detection of breathing and respiratory problems.

The main source of data on the prevalence of job-related health and safety data is the workers' compensation system reports on cases closed for a year. This method of data collection, however, was not the way in which occupational health problems were found. According to the 1977 Report the N. Y. State Workers' Compensation Board, less than 1 percent of all cases closed in 1974, were for occupational diseases. The national figures, according to the Employment Standards Administration of the U.S. Department of Labor, reflect only 2 percent for occupational health reasons.

While occupationally associated health problems were and are recognized by policy-makers and other OSHA leaders, workers' compensation boards rarely award claims after the insurance company for the employer controverts (challenges) the claim as not being job-related. The first successful claims for asbestos exposure did not come until well after the establishment of the federal standard. Up to that point, emphysema (asbestosis) was regarded as an off-the-job problem associated with smoking or other environmental factors. The cancer risks associated with asbestos were just recognized by the scientific community after passage of the OSHA standard. Yet in 1918, according to the U.S. Department of Labor, many U.S. and Canadian insurance companies refused to insure workers in the asbestos industry. Thus this combination of the difficulties in workers receiving compensation for job-related health problems and the non-recognition by employers, insurance carriers and workers compensation boards of job-related cancer, put Local 259 at a disadvantage when trying to associate the conditions at the workplace as the cause of cancer in many of its members.

The 1974 Academy of Sciences meeting on Occupational Carcinogenesis was instrumental in pointing the scientific finger at environmental and occupational factors as a major reason for the rapidly growing asbestos cancer threat in the United States. The Academy's meeting coupled with another cancer - the vinyl chloride liver cancer expose started an irreversible trend toward seeking the fundamentals reasons for cancer and not the existing trend toward seeking a vaccine for cancer similar to polio and measles.

### Federal Anti-Asbestos Action

The OSHA law was signed into law by President Richard Nixon on December 31, 1969. By the early months of 1972, the National Institute for Occupational Safety and Health (NIOSH) promulgated a "criteria document" on worker exposure to asbestos. Under Section 22 NIOSH is mandated to conduct medical and scientific studies on chemicals and substances to determine Threshold Limit Value (TLV), or time weight average over an eight work day, a worker can sustain without becoming injured or ill. The OSHA law clearly mandates that the law must, "assure safe and healthful working conditions for working men and women..." NIOSH recommended that 2.0 asbestos fibers/cubic centimeter of air based on a count of fibers greater than 5 micrometers in length be the standard to determine the safety of workplaces using asbestos. On June 7, 1972, the OSHA Administration promulgated a standard of 5 fibers. On July 1, 1976, the standard was reduced to 2 fibers. However, rising concern about the threat of asbestos, especially its carcinogenic risk has pushed the OSHA Administration to consider reducing the standard to 0.5 fibers. One reason for this new proposed reduction in the asbestos standard came as a result of epidemiological studies conducted with Local 259, United Auto Workers in New York City.

### Phone Call Alerts Union

When the OSHA Administration established its asbestos standard, in 1972, the primary investigators began the search for workers who were at risk from the hazard. The Mount Sinai School of Medicine's Environmental Sciences Laboratory, headed by Dr. Irving Selikoff, was chiefly responsible for the establishment of a new body of scientific knowledge on the latency of job-related diseases and up-to-date epidemiological studies, controlling for a 15 to 25 years period (not using workers with less exposure in the studies). The primary population at risk to asbestos was insulation workers on whom Mt. Sinai conducted landmark studies. There was little question after the OSHA standard was established and the data were accepted that workers with high exposure to asbestos, as insulation workers, faced the greatest risk. But, what about workers with other kinds of exposures?

The National Institute for Occupational Safety and Health preparation for its "criteria document" on asbestos conducted a research study on the number of types of workers who may face asbestos exposure. Brake repair workers were documented as high risk workers by that study.

In 1974, Dr. Selikoff called Sam Meyers, President, Local 259-UAW to discuss the possible asbestos exposure of the union members who worked in auto repair shops. Soon after Meyers and UAW-Local 259 health fund personnel developed a program to combat the dreaded cancer killer.

### First Stage Union Program

In October, 1974, the union turned its headquarters into a health clinic. Forty veteran UAW members were examined by a team of physicians from Mt. Sinai's Environmental Laboratory. The following was their printed in the Union newspaper:

"The results of the examinations were made available to each member by letter from Dr. Selikoff. Of the forty people who were examined about ten were shown to have some respiratory difficulty, and of the ten most were cigarette smokers. So

it can be stated that at this point the COMBINATION of cigarette smoking and the dusts found in the shops' air constitutes a health hazard to the membership."

In its initial screening program only workers with twenty or more years were asked to participate. Immediately following these tests and a phone call from Selikoff, the Trustees of the union welfare fund authorized an increase in the death benefit to the membership. Upon completion of this first round of tests, the union launched a full medical screening program for all workers in the auto repair shops. Under this medical surveillance program 2,500 workers received a medical examination. These tests indicated many clinical problems in the lungs of auto repair workers. Thus, the union, using the services of Mt. Sinai and its own programs was able to determine the dangers facing its membership. It now was in a position to launch a preventive program to protect their membership.

### Protective Activities

The first activity of the union was to inform its membership and their families of the health hazards associated with asbestos. This required the most effective means of communication since the union did not want to frighten its membership, yet at the same time, it wanted them to take their yearly medical examinations and to begin to initiate corrective actions at the workplace. The medical examinations are free under union contracts.

The union printed a second letter from Dr. Selikoff explaining the hazards:

"Extensive medical research has demonstrated that excessive exposure to asbestos dust can lead to serious illness. Asbestosis (a type of scarring of the lungs), and several kinds of cancer are frequent causes of excess deaths among some groups of asbestos workers. In heavily exposed groups such as asbestos factory workers or insulation workmen, over 40% of deaths are from these causes. While continuous heavy occupational exposure to asbestos has led to this serious health experience, recent research has shown that significant risk of asbestos disease can sometimes occur with lower or intermittent exposure, or even from working near such asbestos operations. Occasionally, family contacts of asbestos workers may sometimes have exposure sufficient to produce disease, from dust brought home on workers' clothes.

The Department of Labor has promulgated a standard for asbestos currently at 5 fibers per millimeter of air (about a thimble full of air), to be lowered to 2 fibers per millimeter by July, 1976. Serious question has arisen as to the adequacy of even the 2-fiber standard. For example, it allows a worker to breathe about 2,000 fiber or more in each cubic meter of air (about the amount inhaled in an hour at work). It is not known how many of the inhaled fibers are then retained in the lung. The background is of importance when the asbestos exposure of garage workers is considered. A series of air sample were taken from several garages during brake repair operations and analyzed by the Mount Sinai School of Medicine. Asbestos dust concentrations often exceeding 5 fibers per millimeter were found during the air-blowing of dust from the brake drums. While a worker's

exposure to such levels may be brief and intermittent, they are sufficiently high that appropriate control practices should be implemented. Moreover, as the control procedures are relatively inexpensive (use of vacuum exhausts, wet wiping of dust, and occasional use of respirators), they should be applied as soon as possible."

The union's welfare plan administrator and personnel then conducted extensive shop steward training amongst the unions leadership so as to answer all questions concerning this problem. The long term solution to this auto repair problem is the switching from the currently used braking systems to disc brakes which operate on a different braking system and eliminated the need for asbestos as a fire retardant in the friction which develops in the drums. OSHA regulations require the changing of the methods of production so as to eliminate the occupational hazard. (The law and its regulations specifically prohibited the use of personal protective equipment as the final means of protection from a hazard).

The union, in cooperation with some of the auto repair owners, agreed to a number of work practices designed to reduce and eliminate asbestos from exposure to workers and to other (by-standers) in the shops:

"The Following is A Recommended Procedure for Brake Work:

1. After wheels are removed from the car, and before removing the brake drums, the mechanic should wear a mask suitable to filter dust. This will help prevent the individual from inhaling asbestos dust. The respirator or mask should be worn through the entire tearing down process and while arcing new linings.
2. After removing the drums, all dust in the drum should be vacuumed with a Shop Vac. There should be a shop vacuum available in your shop. Under no circumstances should the brake drum be banged on the floor to release dust, or should be blown in the shop air.
3. After vacuuming the drums, if there is any film or dust left over, it should be wiped away with a damp cloth. This will prevent any asbestos dust from becoming airborne.
4. Likewise, the backing plate should be vacuumed of all dust. Under no circumstance should asbestos dust be blown or brushed from the backing plate.
5. If brake linings need to be arced, masks must be worn. The dust that is released when arcing brake linings is pure asbestos and should not be inhaled. The dust bag on the arcing machine should be removed and replaced with the hose on the shop vacuum. The vacuum should be running while the grinding is taking place. When it becomes necessary to clean the arc grindings machine, all dust should again be vacuumed and any film wiped away with a damp cloth. The arc grinding of brake linings is the most dangerous operation in the brake job.
6. During the assembly of the brake job, the amount of asbestos

particles will be minimal, but to be on the safe side a mask should be worn until the drums are placed back on the car.

7. When the vacuum bag is filled with asbestos dust and needs to be changed, it should be disposed of with extreme care. This is also true when the vacuum is cleaned. These few safety rules will not add much (if any) time to a brake overhaul. It will contribute greatly to the cleaning up of your shop air that you and your fellow workers breathe every day, and contribute to your general health and safety on the job.

CAUTION: DO NOT BREATHE ASBESTOS DUST.

### NIOSH Changes Booklets

NIOSH Safety and Health Guides have been written for over 100 different kinds of jobs and industries. The Health and Safety Guide For Auto Repair Shops and Body Shops first published in February, 1975 was up-dated in August, 1977, in the following manner:

#### Old:

##### 1. Asbestos

When individuals repair brakes most of the day or where the linings are machined to fit the drums (especially in small rooms), excessive asbestos exposure could exist. To reduce the operator's exposure, a dust mask should be worn. Dust should be vacuumed (not blown) from the drums and the floor vacuumed instead of being swept.

#### New:

##### Asbestos

There is little exposure to asbestos in most body shops. But, if you repair brakes or machine-fit linings to brake drums---or work near these operations--you could be exposed to asbestos dust. This is especially true if you work in a small room.

If you breathe asbestos dust, you may develop asbestosis. Asbestosis is a disabling lung disease and continued exposure to asbestos may lead to lung cancer. It may occur when microscopic particles of asbestos become lodged in the lungs. The combination of asbestos exposure and smoking is particularly dangerous.

Dust should be vacuumed (not blown) from the drums and floor. You should use a vacuum with a special, high-efficiency filter. Dry sweeping and cleaning are prohibited. If good local exhaust ventilation at the source of the dust isn't feasible, you should wear a filter respirator for protection.

The new NIOSH Guide corrected its previous Guide, but still failed to plainly describe the three prevalent diseases of work-related asbestos exposure:

Asbestosis	A lung disease of scarring of the lung similar to silicosis and black lung disease;
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Lung Cancer	Cancer of the lung caused by the inhalation of asbestos into the lung;
Mesothelioma	Cancer of the lining of the lung caused by inhalation of asbestos into the lung.

Mt. Sinai has found that when workers exposed to asbestos do not smoke, they do not contract lung cancer more than the general population. Asbestos exposed workers who smoke have an excessively high incidence of lung cancer. However, smoking history makes no difference in regard to asbestosis and mesothelioma.

### "Cancer Alert"

On April 25, 1978, Joseph Califano, Secretary of the Department of Health, Education and Welfare responding to the massive outcry against asbestos declared a "Cancer Alert." By doing this, he called the whole country's attention to this dreaded toxic substance. Califano focused his concern on shipyard workers who used asbestos in shipyards during World War II and are now developing cancer-related diseases. Major questions remain following Califano's announcement:

1. Does the alert cover all asbestos exposed workers, their families, and communities around asbestos productions plants?
2. X-rays, pulmonary function tests, sputum tests, and rectal exams are recommended, but there was no recommendation where to have the tests taken.
3. Who pays for these exams? Will federal workers' compensation reimburse shipyard workers for past and future medical costs, weekly wage losses, and permanent loss of bodily function with a lump sum payment? Will state workers' compensation laws automatically compensate for asbestos-related diseases? Or will, for example, N.Y. State Workers' Compensation Law's 18 year statute of limitations preclude coverage?
4. The Big Questions: Is this just the tip of the iceberg? Will an "Alert" be required for benzene, arsenic, trichlorethylene and other carcinogenic agents?

The asbestos alert has taken a workplace hazard and made it and the distant possibility that many other workplace hazards major public health hazards to all Americans. OSHA is no longer an isolated issue.

### Other Local Union

#### Hazard Control Guides

Guide # 8 Noise Control Program in a Local Union

Guide # 9 Silicosis and Dust Control Program in a Local Union

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Guide # 11

## Books, Films, Newsletters For Your OSHA LIBRARY

The Labor Safety and Health Institute Guide # 1 described how a local union can start an occupational safety and health library. Guide # 3 list books, articles, and pamphlets which contain useful and pertinent information on occupational safety and health.

This Guide # 11 updates these listings. In addition, there is a special listing of locally based occupational safety and health coalitions, with their newsletters.

### Books

Building 6 - The Tragedy at Bridesburg, Williard S. Randall & Stephen D. Solomon, Little, Brown, \$9.95.

California Negotiated Clauses for Occupational Health & Safety, Compiled by Morris Davis, Labor Occupational Health Program, University of California, 2521 Channing Way, Berkeley, CA. 94720, 1976 \$2.00.

Cancer and the Worker, Phyllis Lehman, "Based on Volume 271 of the Annals, entitled Occupational Carcinogenesis," New York Academy of Sciences, 1977. (2 East 63rd St., New York, NY 10021) \$2.00.

Crisis in the Workplace, Occupational Disease and Injury, Nicholas Ashford, A report to the Ford Foundation, MIT Press Cambridge, Mass 02142. \$16.00.

Help for the Working Wounded, Thomas Mancuso, MD, International Association of Machinists, 909 Machinist Building, Washington, D.C. 20036, 1976, \$1.00.

LSHI: An Occupational Safety and Health Workbook, Labor Safety and Health Institute January, 1977, New York. \$4.00.

Occupational Disease: A Guide to Their Recognition, Revised Edition, June 1977, National Institute for Occupational Safety and Health (NIOSH 77-181), 4676 Columbia Parkway, Cincinnati, Ohio 45226. (No cost).

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The Cancer Connection and What We Can Do About It, Larry Agran, Houghton Mifflin Co., \$8.95.

Winning Before the Occupational Safety and Health Review Commission: Workers' Handbook on Enforcing Safety and Health Standards, Bertram Cottine, Health Research Group, 2000 "P" Street, N.W., Washington, D.C. 20036, \$4.00.

Women in the Workplace, Proceedings of Conference (June 17-19, 1976), Editor Eula Bingham, Society for Occupational and Environmental Health and National Institute for Occupational Safety and Health. 1714 Mass. Ave. NW, Washington D.C. 20036. \$16.00.

Women's Work, Women's Health: Myths and Realities, Jeanne Stellman, Pantheon Books, \$3.95.

Working for Your Life: A Woman's Guide to Job Health Hazards, Andrea Hricko with Melanie Brunt, Labor Occupational Health Program, University of California, and Public Citizen's Health Research Group, 2521 Channing Way, Berkeley, CA 94720. 1976. \$5.00.

Zapping of America, Paul Brodeur, Norton, 1977. \$11.95.

Occupational Health Problems of Pregnant Women: A Report for the Office of the Secretary, Department of Health, Education, and Welfare, Wilma R. Hunt, # SA-5304-75, D-HEW, Robert Taft Laboratories, 4676 Columbia Parkway, Cincinnati, OH 45226, 1975.

The Industrial Environment - Its Evaluation and Control, NIOSH, 1973, U.S.-D-HEW, Superintendent of Documents, Washington, D.C. \$13.75

National Commission on State Workmen's Compensation Laws: Supplemental Studies for the National Commission on State Workmen's Compensation, Washington, D.C., 3 vols., 1973.

#### FILMS

Asbestos: Fighting a Killer, Oil, Chemical, and Atomic Workers, 1126 16th St., N.W., Washington, D.C. 20036. \$1.75.  
(a slide/cassette presentation)

Health Hazard in the Shop, School for Workers, University of Wisconsin, 432 North Lake Street, Madison, Wisconsin 53706, 608-262-2111.

The Shop Accident, School for Workers, University of Wisconsin, 432 North Lake Street, Madison, Wisconsin 53706, 608-262-2111. To order: University of Wisconsin - Extension Division, Bureau of Audio-Visual Instruction, 1327 University Avenue, P.O.Box 2093, Madison, Wisconsin 53701.

Working Steel, Labor Occupational Health Program, University of California, 2521 Channing Way, Berkeley, CA 94720, 415-642-5507. (\$175 sale, \$30 rental).

SAFETY AND HEALTH COALITIONS

Trade unionists, medical, scientific, legal and other safety and health activists have come together to form coalitions and committees to initiate and carry on safety and health projects. The following is a partial listing of these groups with their newsletters, where they exist.

Black Lung Association, c/o Bill Worthington,  
Box 68, Coxton, Kentucky 40831.

Carolina Brown Lung Association, P. O. Box 334, Greenville, South Carolina 29602,  
803-235-2886. "Brown Lung News" Newsletter.

Carolina Brown Lung Association, P. O. Box 1101, Roanoke, Rapids, N.C. 27870  
"Brown Lung Blues" Newsletter.

Chicago Area Coalition for Occupational Safety and Health (CACOSH), Room 508,  
342 South Dearborn Street, Chicago, Illinois 60605. 312-939-2104.  
"CACOSH" Newsletter.

Labor Health Committee, P. O. Box 92565, Milwaukee, Wisconsin 53202  
414-962-2096.

Mass. Coalition for Occupational Safety and Health (MASCOSH),  
120 Boylston Street, Room 206, Boston, Mass. 02116.  
"Survival Kit" Newsletter. 617-482-4283.

Minnesota Committee for Occupational Safety and Health,  
C/O METRO Community Health Consortium, 1729 Nicollet Avenue,  
Minneapolis, Minn. 55403.

New Jersey Committee for Occupational Safety and Health,  
80 Central Avenue, Clark, New Jersey 07066.  
201-381-2459.

New York Committee for Occupational Safety and Health,  
P. O. Box 3285, New York, NY 10017  
212-577-0564.

North Carolina Committee for Occupational Safety and Health,  
Box 2514, Durham, N.C. 27705. 919-286-2276.

Philadelphia Project for Occupational Safety and Health (PhilaPOSH)  
Room 607, 1321 Arch Street, Philadelphia, Pa. 19107  
215-568-5188  
"Safer Times" Newsletter

Rhode Island Committee for Occupational Safety and Health  
Box 95, Annex Station, Providence, Rhode Island 02901  
401-751-2015.

Western New York Committee for Occupational Safety and Health  
120 Delaware St., # 225, Buffalo, NY 14202.  
716-842-4270.

# LABOR SAFETY AND HEALTH INSTITUTE

377 Park Avenue South (27th Street)  
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212-689-8959

*"To assure safe and  
healthful working conditions  
for working men and women..."*

## Guide #12

FRANK GOLDSMITH, Director

### LOCAL UNION COST SAVINGS PROGRAM: SCREENING OFF-THE-JOB DISABILITY INSURANCE CLAIMS FOR WORKERS' COMPENSATION INJURIES AND DISEASES

Union health benefit programs face a tremendous financial crisis. The uncontrolled cost of health care has increased pressure on unions to negotiate greater employer contributions to maintain or expand current benefits. This is often done in lieu of a greater wage increase. The failure of the federal government to respond to workers, unions and community demands and enact a national health program has further aggravated this problem.

A unique feature of most New York City union benefit programs is a negotiated (off-the-job) disability insurance program which substitutes for the mandatory New York State Disability Insurance Program (DBL).

These health fund administered DBL programs often provide a larger weekly benefit (sometimes \$10-\$15 more) than required under the N.Y. State (\$95/week) benefit. The fund facilitates quicker payments than the state agency. Under DBL, the union-negotiated health fund pays all the medical and hospital bills at the same physician and hospital rate normally paid for other claims.

#### Union Hazard Control Program

Local 447 of the Printing Specialties and Paper Products Union (of the Int'l Printing and Graphic Communication Union) has a vigorous leadership and health benefit program. It provides an extensive health benefit package, including a negotiated off-the-job disability program for its 3,000 members in New York and New Jersey. The union has an aggressive occupational safety and health hazard detection, control and prevention program. The special hazards of printing include machine guard injuries, illnesses from exposure to toxic substances and cancer-causing chemicals.

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The union leadership became aware of its occupational disease problems through membership complaints and from federal agencies (the Occupational Safety and Health Administration and the National Institute for Occupational Safety and Health) and independent scientific institutes. In fact, the landmark study on the hazards of printing inks was done with Local 447 by the Mt. Sinai Environmental Sciences Laboratory.

Using the results of this study, the union embarked on a prevention program which includes the following activities:

- Hazard identification in which new chemicals used by employers are researched through the use of NIOSH personnel and other information agencies. (The companies are supposed to inform employees of hazards and new chemicals in use, but rarely do.)
- Education programs for the local and initiating regional educational conferences based on its job safety and health programs;
- Placing demands on employers to switch to safe chemicals, and correct unsafe machine guards;
- Participating in conferences and meetings inclined toward greater knowledge for all workers and unions.

### Injuries and Illnesses

#### On or Off the Job?

The union became aware that increasing membership interest in safety and health education programs and in particular, occupational disease, did not appear to increase claims for workers' compensation. However, in the same period, the union leadership found a tremendous increase in its health care costs and in the health fund's deficit. This was reflected in the skyrocketing cost to the health fund, since it pays medical and hospital bills under DBL. The union began an intensive educational program through its shop stewards to inform members of the importance of directing their claims for job-related illness and injury to Workers' Compensation, not DBL. In addition, the union decided to screen all DBL claims to determine if any were actually job-related, and, therefore, to be filed with the N.Y. State Workers' Compensation Fund. If effective, this screening procedure would greatly relieve the health fund since the employer's Workers' Compensation insurance carrier would pay physician and hospital care costs as well as the weekly benefit. Prior to the current period, the \$2,520 weekly benefit maximum for 26 weeks (\$95 x 26 wks.) was the major cost. However, rising costs have propelled these costs ahead of the weekly financial benefit. By screening its disability claims, the union did not intend to eliminate or place workers at risk of losing their weekly benefits.

On the contrary, the union understood the difficulty of attaining Workers' Compensation for occupational disease. Therefore, the union quickly conforms to N.Y. State law which requires immediate granting of DBL benefits to its members once their Workers' Compensation claim is controverted (challenged) by the employer's insurance carrier, something which almost always takes place for job-related diseases. This is also the proper method under ERISA\* rules. If and when the claim is approved by Workers' Compensation, the union health fund is financially reimbursed by Workers' Compensation for all physician and hospital payments and the weekly benefit.

### Results of Cost Saving Screening

The union reports that this DBL screening program has resulted in a dramatic cost savings. From 1976 to 1977, the Blue Cross insurance premium paid by the Health Fund increased from \$661,000 to \$759,000. In the same period insurance costs for physicians also increased. Overall costs to the Fund increased from \$1.4 million to \$1.5 million. These increases were dramatically above the costs in the previous years. The Union instituted its screening program in the beginning of 1976.

In that 1976 - 1977 period, at the same time that hospital and physician rates were on the increase, the union reduced its Health Fund deficit from \$350,000 to \$175,000. In the 1977 - 1978 fiscal period the fund broke even. The reductions, according to the union leadership, were directly attributable to the DBL screening program.

The Union does not keep a record of the number of claims shifted from DBL to Workers' Compensation. Nor does it know the amount of increased use of Workers' Compensation which has taken place among its membership.

### Conference Findings

In 1978, the New York State School of Industrial and Labor Relations, Cornell University, held a conference on "Who Pays for Job-Related Injuries and Illnesses of Workers: Workers' Compensation or Union Negotiated Disability Insurance?" to discuss the prevalence of occupational disease and who pays for it. The twenty-five unions who attended reported programs similar to Local 447's or were about to embark on such a program.

Unions who self-insure their physicians and/or hospital claims reported that they have had disability screening programs for a longer time with the same successful results.

\*The Employee Retirement Insurance Security Act.

### Remove Impediments

Thus, these union-connected disability programs, while attractive and certainly increasing workers' rights under the state DBL law, actually may be serving as an impediment to workers' seeking Workers' Compensation for occupational diseases. This problem is one more of many impediments which workers face when they seek their rights under Workers' Compensation.

Other obstacles may include general discouragement from shopmates, no confidence in government programs, union representatives not knowing how to direct workers, employment fears (e.g., being fired, or manipulation of overtime), wage loss (re-assignment to "light duty" at lower pay), inaccessibility of physicians and lawyers, etc.

### Federal Reform

Under the 1970 Occupational Safety and Health Act, Congress mandated the Labor Department to reform the Workers' Compensation system. A provision in the 1977 Black Lung Amendments to the Social Security Act require special attention to the problem encountered by workers seeking compensation for respiratory diseases. Union-initiated programs such as Local 447's coupled with the Black Lung Amendments and the OSHA Acts's mandate have expanded the discussion concerning the necessity of fundamental reform of the Workers' Compensation system. However, there appears to be little understanding of the everyday problems workers face in receiving Workers' Compensation for job-related diseases. A pre-condition to future legislation reform (whether the 19 recommendations of the W.C. Commission or a full reform toward a federal system) should be the elimination of all the loopholes and impediments facing workers who deserve Workers' Compensation. These barriers are often very subtle and societal in nature or they can be obvious, as in fear of job and/or wage loss. They are often not immediately perceivable to the casual or even academic/government researcher. Without their elimination, a new system may be created to compensate victims of occupational disease which appears equitable and effective to Congressional, government, academic and administrative personnel, but will not be used by those for whom it is intended.

- 1 There are two basic health benefit arrangements in collective bargaining: 1) Union health benefit programs administered through a joint labor management board of trustees (with the union playing a leading role of negotiating the greatest amount of benefits per employer contribution.) 2) Employer-provided health care benefit at a union-negotiated, collectively bargained contribution rate.
- 2 N.Y. is one of the five states which has a mandatory DBL program for all private sector employees. However, many large companies in non-DBL states, and also government units, provide their own DBL programs for their employees.





# QUARTERLY

FALL

OCCUPATIONAL ILLNESS - WORKERS' COMPENSATION DOESN'T WORK

1977

An extensive survey conducted by the federal government recently found that one out of every four American workers is exposed on-the-job to some substance believed capable of causing death or disease. Approximately 1,000 people die from cancer every day in the United States and each year 900,000 new cases are diagnosed; many of these cases have job-related causes. (See CCAHS QUARTERLY "Cancer and Jobs," Summer 1975 for a more detailed examination of this relationship.) The National Institute for Occupational Safety and Health of the United States Public Health Service reports the discovery of 390,000 new cases of occupational disease every year. Yet, New York and other state workers' compensation listings of awards granted due to occupational disease do not reflect these statistics or new cases. To understand this apparent discrepancy the system of workers' compensation must be understood.

When the original state-run workers' compensation laws were passed, starting in 1910, they were heralded as being a fool-proof method of assessing employers for the injuries and disease which come upon employees "out of or in the course of employment." The keystone of workers' compensation was the principle that workers would forego their right to sue an employer for negligence and accept in its place another mechanism to determine just compensation for job-related injury and illnesses. Basic to this was the understanding that employees would not have to prove that the hazard was due to the employers' negligence, and the employer therefore would not be liable for negligence in the courts. Awards would be decided by a simple administrative procedure.

## INCENTIVE: CLAIMS REJECTION

In theory, workers' compensation was created to aid employees afflicted with the effects of job-related illness and accidents. However, at the time the laws were passed knowledge concerning the linkage between illnesses and workplace conditions was still rudimentary; in fact workers' compensation was essentially limited to compensating workers for industrial-related injuries.

The program was set up to pay the cost of workers' medical and hospital care and to compensate for the loss of physical function. Additionally, injured workers would be paid weekly benefits similar to those of unemployment insurance, although for an indefinite period of time.

However, unlike unemployment insurance, workers' compensation is underwritten by private insurance companies who depend on the employers for their business. The fewer claims they have to pay, the lower the employers' insurance premiums will be. The more claims they challenge -- controvert -- the better they will be able to serve their clients -- the companies -- by assuring low premiums. These incentives combine to encourage insurance companies to challenge employees' claims -- thus causing a hearing to be called and preventing an award from being granted. The outcome of this hearing can be appealed. However, many workers are not aware that a right to appeal exists and those who are aware of this right are often intimidated or confused by the

NOTE - The title workmen's compensation has recently been changed to workers' compensation in recognition of the millions of women in the American work force.

system; others simply do not have the resources to retain the staff, including attorneys, or accumulate the data necessary to pursue their case through the administrative maze. If compensation is denied by the appeals board, the worker may be able to recover hospital and medical costs from union or labor-management health and welfare funds or from insurance programs. However, none of these programs will provide weekly living benefits or compensate for impaired physical functioning. The only other financial remedy remaining open to the worker is to sue the manufacturers of the problem-causing substance or equipment on a third-party product liability basis.

### ACCIDENTS / DISEASE

In the case of industrial accidents the direct causal relationship to the work setting is usually obvious, and, in that employers' insurance companies do not routinely controvert and fight each claim, the system seems to work to some extent. Still, this does not mean that workers' compensation awards are an accurate indication of the amount of workplace injuries. Companies use all means available to keep workers' compensation injury claims at a minimum.

In the area of occupational disease the situation is extreme. Workers' compensation insurance companies almost always successfully controvert workers' attempts to receive awards for job-related illnesses. Until recently, the relationship between workplace conditions and illness was not widely recognized. Still today, discovering these relationships requires sophisticated -- expensive and technical -- research efforts. Further complicating this task is the fact that many job-related diseases do not manifest symptoms until many years after exposure to the offending substance. In this gray area of not-obviously-job-related illnesses, the insurance companies aggressively fight every worker's claim for compensation.

In fact, according to recent Bureau of Labor Statistics data compiled for the Occupational Safety and Health Administration of the Labor Department, only occupational dermatitis receives statistically significant awards from compensation boards! In some states dust diseases, silicosis, for example, are beginning to be recognized as work-related health problems. However, even in these states a worker usually has to be totally and permanently disabled before a compensation settlement is awarded.

All other job-related diseases, even those recognized by leading research and medical laboratories such as the National Institute for Occupational Safety and Health (NIOSH) of the Center for Disease Control (CDC), are treated by the state-run workers' compensation hearing boards as if they do not exist.

### STATISTICS: NUMBER GAMES

Even the meager data afforded by successful workers' compensation claims for job-related illnesses are of little statistical use. The numbers are not accurate since insurance companies and employers seek to keep down work-related illness awards by settling out-of-court (especially when the claim seems sure to be upheld). Why would any company agree to give its own money to a worker when they pay insurance companies to cover just such an eventuality? Because most companies don't want documentation to accumulate which suggests that, individually or collectively, industry is a cause of job-related illness and disease. That type of finding might force government to take more drastic steps to protect workers.

A recent University of Washington study documented that out of a group of 600 workers in six different production plants, over one-third of the workers' illnesses were job-related. For that same group of workers Washington State workers' compensation statistics reflected only 3% of the occupational diseases reported by the study.

Similarly, workers in textile mills never receive workers' compensation for byssinosis, a disease resulting from exposure to cotton dust. In fact, when seven North Carolina textile workers who had contracted byssinosis were about to be awarded compensation, the company, which until then had been fighting the workers' claims, offered them out-of-court settlements far exceeding those they probably would have received through workers' compensation. Thus, the company can still point to the award records to prove that byssinosis does not exist. Indeed, industrial representatives often do just this in congressional testimony.

### STATISTICS: NO CONCLUSIVE BASIS

Rather than being "no-fault" insurance, workers' compensation is a highly adversarial arena in which workers face employers and their insurance carriers to fight for compensation awards. The statistical outcomes of this fight are no more objective than the process itself. Unfortunately, legislative bodies and others interested in OSHA problems depend on these data to document the breadth of work-related illness and injury. The level of appropriations and expenditures of money approved for enforcement or expansion of coverage (e.g. to previously exempted categories of employees such as public employees and farms with ten or fewer employees), of OSHA type programs is often based on conclusions drawn from this limited and misleading data.

The future of controlling occupational hazards is thus being broadly impacted by conclusions drawn from severely understated data!

### CONFLUENCE OF PROBLEMS

The unfortunate adversarial nature of workers' compensation boards must be added to related compensation problems: lack of national standards among the 50 states; long backlogs of payments to claimants and doctors; and small financial awards which fail to reflect inflation rates and Bureau of Labor Statistics figures on acceptable living standards. Related to these problems is the serious trouble being experienced by union and labor-management health and welfare funds which are absorbing the claims made by workers who either do not seek or are denied workers' compensation awards.

### SHORT RUN REFORM POSSIBILITIES

There are several reforms which if immediately implemented could ameliorate some of the problems in the current workers' compensation programs.

First, a workers' compensation, state-wide, "hot-line" could serve to help workers and physicians in identifying compensable job-related illnesses. With such a system up-to-date information concerning disease symptoms, diagnostic categories, compensation standards, rules, regulations, etc. could be made widely available.

Additionally, to insure that all legitimate occupational health claims are honored by each state's workers' compensation office, newly constituted expert occupational health panels should be assembled in each of the 50 states. To guarantee their impartiality, these panels should be composed of physicians, trained in occupational medicine, and representatives of labor and industry groups.

These expert panels would serve a dual purpose. First they would be responsible to keep abreast of all new safety and health standards promulgated by the Occupational Safety and Health Administration and research conducted by the National Institute for Occupational Safety and Health, the Environmental Protection Agency

(particularly since this agency is in charge of the implementation and research under the Toxic Substances Control Act), and the National Cancer Institute. They would inform compensation bureaus on all new developments in the area of job-related hazards which cause illness and would provide consultant services to workers' compensation physicians who frequently are not versed in the symptoms and treatment of occupational health problems. The second purpose of these expert panels would be to serve as an appeals board for those who believe they have been unfairly denied compensation at the lower administrative level.

Finally, with the establishment -- currently being proposed -- of federal workers' compensation standards, a national expert health board could be established which would hear cases on appeal from all the state programs. This panel of occupational health experts would also coordinate and provide technical assistance to the 50 separate state panels.

These short-run reforms in the workers' compensation system are urgently required and should immediately be instituted.

#### FULL REFORM NEEDED

To correct all the deficiencies and inequities in the workers' compensation program one national system of workers' compensation on a true "no-fault" basis -- using the existing federal workers' compensation payment schedules (often three times the states' rates) and totally covering all occupational health problems -- is needed.

A "no-fault" workers' compensation system, combined with strict enforcement of OSHA standards and open recognition of and intensive research into the relationship between the work environment and health problems can begin to control workplace hazards while assuring the equitable compensation of injured workers.

## Controlling Occupational Hazards

FRANK GOLDSMITH

While the economic status of workers has fluctuated between apparent affluence and depression, job safety and health hazards have consistently taken their toll in the United States. Each year over 100,000 workers die as a result of workplace hazards. Over 14,000 of these deaths result from accidents and the remainder from exposure to toxic substances and chemicals that induce disease.

The Industrial Revolution brought with it many safety and health hazards. The twentieth century has had a "chemical revolution," which has added new products and increased industrial production. David Baltimore, who received a Nobel Prize in cancer research, and other United States and international experts claim that over 85 percent of all cancers are related to environmental and occupational causes. Thus the 350,000 Americans who die each year of cancer would have faced a different fate if workplaces and industrial plants had controlled their pollution.

About 2.3 million workers are either permanently or temporarily disabled each year by work accidents. This figure is only an estimate and could be much higher. A federally supported study conducted at the Department of Environmental Health, University of Washington, indicated that both employers' and workers' compensation logs, on which national estimates are based, are unreliable for determining workers' safety and health status. This study, which covered 600 workers from six plants in Seattle, Washington, found that over 30 percent of workers' illnesses were job-related and an additional 30 percent were influenced by workplace hazards. The employers' logs in the same plants listed only 3 percent of the workers' illnesses and the workers' compensation log only 2 percent.

The cost of job hazards has not been documented by government agencies. The National Safety Council has estimated that work accidents (not illnesses)

cost \$15.3 million in 1974 alone, with an additional \$3 billion in wages lost, \$1.7 billion in medical expenses, \$2.1 billion in insurance administration costs, \$1.7 billion in fire losses, and \$6.8 billion in indirect costs.

If it were not for the legal powers of the Occupational Safety and Health Act (OSHA) of 1970, the study would not have been possible. The study director was unable to receive voluntary permission from the plant managers to have a medical doctor from the university examine employees from the plants. After informing the plant managers of the legal mandate of the OSHA, however, permission was given. The doctor hired by the university then administered the physical examinations and health care questionnaires.

As section 2 of the OSHA indicates, Congress found that work-related illnesses and injuries "impose a substantial burden upon, and are a hindrance to, interstate commerce in terms of lost production, wage loss, medical expenses and disability compensation payments." The estimates of the total cost of the nation's job hazards, however, have not been put to a thorough cost accounting by the OSH Administration or by the National Institute for Occupational Safety and Health (NIOSH). Once again, the sources are private and partisan, such as industry economists. Since the premium rates paid to compensation insurance companies are based on industry's cost determinations, they are tapered to lower figures. The goal of the OSHA was to correct these inadequacies and inaccuracies in statistical documentation of the impact of job hazards. Additional cost factors involve unsafe and unhealthy working conditions. These are not based on hard data, but on the estimates derived through an extrapolation of various work-related factors. Cost figures are usually expressed in terms of the money that industry says it will cost to correct the workplace—not in terms of the cost of leaving the working conditions uncorrected, nor of the benefits gained by hazard correction.

Despite the "Chartbook on Occupational Injury and Illnesses" (Report 460), conducted by the OSH Administration in 1974 and released in 1976, the Bureau of Labor Statistics is still unable to produce a substantial data base on job-related illnesses. Job injuries are stressed throughout the report. The Labor Department still does not document hazards of chronic, long-term exposures. This is clearly stated in the chartbook: "For the third straight year, skin disease and disorders were the most prevalent of all the categories of job-related illnesses recorded. This may be due in part, to the ease of recognition of these cases and the speed with which symptoms appear after contact with an irritant." Thus the debate on which figures are correct continues, precluding the objective use of documentation by congressional committees at appropriations time.

The failure to accumulate an adequate data base presents an obstacle to medical and public health officials, professionals, practitioners, health planners, and health care consumer advocates, who are trained to use a data base as the main source for determining program direction. The 1975 law (PL 93-641) establishing local Health Systems Agencies called on these agencies to assess the

occupational and environmental dangers in factories in the planning areas. Prior to the OSHA, each state collected its own data base according to its own criteria. No national figures were possible, since there were no national programs or reporting requirements. Thus, reliance on industry filled the vacuum.

Absenteeism, unnecessary sick days, and other expressions of worker resistance to unpleasant work conditions are often referred to as "social costs." Pinning a figure on these worker "job actions" is one aim of those who try to point out the costs of working in an unsafe and unhealthy workplace. Another figure that must be calculated is "annoyance costs," the added wages that workers demand when they work under hazardous conditions. This figure was seen as significantly high by Nicholas Ashford, a professor at the Massachusetts Institute of Technology, in his study for the Environmental Protection Agency, "Some Considerations in Choosing an Occupational Exposure Regulation."

The necessity of calculating these social and annoyance costs, in addition to the other "harder" figures, stems from the insistence of executive branch officials through the Office of Management and Budget (OMB) on assessing the economic and inflationary impact of proposed federal job safety and health standards. Until the twentieth century, the prevailing theory concerning workplace accidents and, to some extent, job-related illnesses held that "acts of workers" were responsible for workplace hazards. The reason for blaming them was financial, for the employer was then free of liability. The impact of this type of reasoning was blunted to some extent with the passage of state-sponsored workers' compensation laws. These established a "no fault" system for injury and illness at the workplace. Under these state laws—no federal law was established except for federal jurisdictions—the injured employee had to accept certain disability and compensation payments in return for not suing the employer. Workers and their unions did not support this legislation.

With the recent revelations concerning the recognition of long-term, latent, job-related illnesses, however, workers' compensation laws alone are not satisfactory. In order to gain some compensation for injury and illnesses beyond the low compensation and disability payments, workers are beginning to bring third-party suits against the manufacturers of machinery. For example, frustrated by the Labor Department's and the steel industry's lack of action to protect them from coke-oven emissions, coke-oven workers and their families have sued the makers of coke ovens who supply the steel companies.

The steel industry is among the most outspoken in its claims that the "acts of workers" are responsible for most job-related disabilities. The general attorney in charge of occupational safety and health for U.S. Steel, William L. White, has stated that "our figures for our steel operations over many years show that about 85% of all disabling injuries and illnesses are caused primarily by these unsafe actions, not by unsafe conditions." While most other industries have conceded that job-related illnesses (as opposed to accidents) may stem from working conditions, here too they usually hasten to add that workers'

life-styles, particularly their smoking and drinking, are the probable primary causes, with working conditions only a contributing factor.

George Hagglund, director of OSHA programs for the University of Wisconsin's School for Workers, initiated a study of the university's Division of Safety and Buildings to test the theory that physical safety standards will not effectively reduce injury rates because most accidents result from improper human behavior. The results of the study, the first of its kind in recent history, determined that unsafe conditions were responsible for twice as many accidents as unsafe acts of workers. It found that between 54 and 58 percent of accidents were the result of unsafe conditions, while unsafe acts of workers were found in just 26 to 34 percent of the cases.

So-called black lung disease is a good example of a health problem for which responsibility has been shifted from the worker to his work environment. Before the 1960s, coal miners were continually turned down for workers' compensation for their breathing problems. State and local courts ruled in favor of the coal companies' claims that it was not the rock and coal dust but the miners' life-styles that caused their respiratory illnesses. In the 1960s this view changed as a result of efforts by the Black Lung Association and the Miners for Democracy with the cooperation of the growing, independent medical-scientific community.

Now, black lung benefits, under the Coal Mine Health and Safety Act of 1969 administrated by the Social Security Administration, are being awarded to coal miners who can prove that their disability is due to mining. Indeed, the reform leadership of the United Mineworkers of America is pressing for the automatic awarding of benefits if a coal miner works at least fifteen years in the mines, in light of the fact that X-rays and other methods of measuring lung damage are not fully accurate and a number of coal miners may not be able to prove that their disability exists.

Occupational safety and health have received a low priority in the United States from health professionals and administrators alike. Citing a study by Henry Howe, head of the American Medical Association's Occupational Medicine Division, Edward Dolinsky documented the low priority that occupational medicine has both in medical professions and in health care policy in general. He reported that "while between 10,000 and 20,000 physicians provide occupational health services [in industry] in the United States, only about 2,000 of these . . . were engaged in the full-time practice of occupational medicine."<sup>1</sup>

Dolinsky's report continued: "Since the establishment of occupational medicine as a field of specialization by the American Board of Preventive Medicine in 1955, only 60 persons have completed the formal residency programs, while

<sup>1</sup> Edward Dolinsky, "Health Maintenance Organizations and Occupational Medicine," report (New York: Health Care Research for Metropolitan Life Insurance Company of New York, 1974).



350-400 people have taken the examinations of the board. The number of persons who have certificates in occupational medicine . . . is decreasing. All but 90 are employed by corporations and are unavailable for clinical consultation. Questionnaires sent to senior medical students during the past five years reveal little evidence of interest in this field of practice." (These figures were provided by the American Board of Preventive Medicine.) There are no medical schools in this country that give required courses in occupational medicine. Only a few offer electives in job-related illnesses. Medical doctors and public health professionals, given their lack of training in detecting job-related illnesses, cannot diagnose them and thus cannot suggest preventive measures to stop the hazards.

In contrast, according to Dr. Christoph Bruckner, chairperson of the Health Commission of the People's Assembly of the German Democratic Republic and also a professor of occupational medicine in Jena University, each medical student in the GDR is required to take sixty hours of occupational safety and health education. This training includes both job-related medical courses and administrative training in the duties and responsibilities of the Health Ministry in occupational safety and health matters. In addition, the four years of specialization include occupational medicine. These four years are spent gaining additional medical training, serving under a county health inspector, and working under the direction of a medical doctor in a factory polyclinic. (All factories with 4,000 or more workers have a fully equipped polyclinic.) Dr. Bruckner reported that occupational medicine is highly regarded in GDR medicine and there is no problem in filling the demand for more professionals in this field. Nicholas Ashford found a similar interest in occupational health and safety among professionals in the Western European countries.<sup>2</sup>

Prior to 1970 government protective programs in this country were assigned to state and local labor and health agencies. These agencies performed more as industrial hygienists and labor relations professionals than as medical and public health practitioners interested in preventive medical practice to eliminate hazards. As a result, employers were given a free hand in the determination of working conditions. The only exceptions took place when workers organized unions to protect themselves.

One reason for the medical and public health professionals' lack of interest in workers' job-related health problems is that workers are medically documented as being the healthiest group of people in the country, and at work they generally are. Standard public health and medical school curriculums indicate this fact, with the result that students are steered away from these potential subjects and toward those more in need of health care, such as community residents, children, the disabled, and patients who present more "interesting" health problems.

<sup>2</sup> Nicholas Ashford, *Crisis in the Workplace: Occupational Disease and Injury* (Cambridge, Mass.: The MIT Press, 1976).

Neither is there a great deal of personal remuneration in the practice of occupational medicine, even if a medical doctor works for a company. A salaried position could rise, with other compensation, to \$75,000 or more a year. But in private practice, under fee-for-service incentives, doctors receive higher incomes than that. Also, the overwhelming majority of medical and public health professionals come from middle-to-upper-income family brackets with little knowledge of industrial or even white collar work.

Another reason for the health professionals' lack of interest in workers is the ideological framework in which these people have been viewed during the last twenty-five to thirty years. The thrust of this view is that the working class has somehow melded into the middle class. Workers are seen as owners of two cars who live in split-level homes with two garages in middle-class neighborhoods. This apparent prosperity has led health professionals and others to ignore workers' job-related health problems in their studies, grouping them along with other "at risk" groups.

However, this perspective is changing. Andrew Levison has exploded the myth of the affluent worker.<sup>3</sup> His *Working Class Majority* showed that while workers have attained considerable gains since the Great Depression—including the right to organize into unions of their choosing, the passage of social security, and unemployment compensation—in the 1970s less than 20 percent are organized into unions. Unemployment in the 1970s has reached double-digit figures and, for black, Puerto Rican, and other minority youth, the rate is as high as 50 percent. Unemployment is now reaching workers with over twenty years' seniority in steel mills and automobile plants. The construction trades are particularly affected. Moreover, the national unemployment problem is now coupled with inflation. Thus, workers are definitely not well off.

Industrial hygienists and medical scientists in the employ of industry, labor, and government have been increasingly concerned about the health effects of workplace hazards. By contrast, the average busy medical practitioner, including specialists in obstetrics-gynecology, urology, and pediatrics, have little if any knowledge of job-related health problems. This lack is most alarming in obstetrics and pediatrics as a large number of young women are entering the labor force in potentially hazardous jobs where transplacental toxic and cancer-causing substances may have a direct effect on reproductive organs. Yet obstetricians and pediatricians are not aware of job-related hazards to male and female reproductive organs.

United States public health schools are not training occupational health professionals, either. In fact, environmental health departments in most public health schools pay scant attention to occupational safety and health. In the current budgetary crisis facing public health schools, environmental health departments themselves are facing severe cutbacks. Some schools of public health,

<sup>3</sup> Andrew Levison, *The Working Class Majority* (New York: Coward-McCann & Geoghegan, Inc., 1974).

such as those at Harvard University, the University of Illinois, and the Johns Hopkins University, are attempting to parlay "soft" government monies with negotiated labor and management agreements that provide for research dollars into financial support for their programs.

The development of medical and public health professional expertise has lagged even though the purpose and findings of the OSHA directly addressed the need to focus on occupational health issues. The act clearly emphasized medical research, documenting latent diseases, establishing medical criteria, and personnel training programs. The Labor Department, however, has failed to act on these mandates since the creation of the OSH Administration in 1970.

The National Institute for Occupational Safety and Health (NIOSH), under the OSHA, was entrusted with medical and scientific research into job-related diseases. NIOSH has a low placement in the federal bureaucracy, being located within the Center for Disease Control, which is under the Public Health Service in the Department of Health, Education, and Welfare. Unlike almost every other country, the United States does not give this agency cabinet status. The combination of these administrative and policy problems with the severe underfunding of the agency means that NIOSH gets less than \$40 million annually. A career with NIOSH has not become a professional career goal for many medical doctors, scientists, or public health professionals. In addition, the Labor Department does not treat NIOSH with high professional respect. In fact, under the OSHA, the OSH Administration need not adopt the recommendations of NIOSH and often has disregarded them in favor of a particular company's argument.

Scientific research is blurred with the medical care program of an occupational health services program. The former is necessary to determine the relationship between a job-related hazard and an illness. This is a necessary first step as mandated by the OSHA, but it has taken practically all of the time and money of NIOSH programming, which could include the development of protocols for occupational health services for hospital clinics and emergency rooms.

Federal guidelines under the new health planning legislation (PL 93-641) provide for the incorporation of environmental health planning as a basic priority of regional planning. To be included in each regional planning system are "the promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services." This provision was minimally incorporated under previous health planning attempts, such as the Comprehensive Health Planning Act (CHPA). In some environmental planning programs, as in Detroit, Los Angeles, and New York City, the issue of occupational health and safety has been incorporated to some extent. Environmental planners in these programs understood that incorporating for occupational safety and health was a first line of defense against factory pollution. Stopping the hazard at the workplace meant that it would not reach the outside environment.

Proper planning activity must include local and grass roots participation

and analysis. The first function of planning guidelines is to inventory all health facilities, including hospitals, neighborhood health and mental health centers, and free standing clinics. The main purpose of the inventory is to determine the extent to which occupational health services are offered, data on job-related illnesses are collected, and what other occupational health capabilities exist in the area. The second function is an inventory of all factories in the planning area. In accordance with the guidelines in PL 93-641, the regional Health Systems Agency (HSA) must list each factory by type of production, materials produced, safety and health hazards present, and number of workers with demographic descriptions that are essential for epidemiologic studies, such as race, age, and sex. The third function is the creation of an inventory of all medical and health related schools and educational programs to identify whether occupational safety and health courses are included in their curriculums.

These inventories would be summarized and analyzed on local and regional HSA levels to establish patterns of job-related illnesses and diseases, existing health resources, available occupational health service programs, and job safety and health educational opportunities. Involvement by health planning units would be valuable in the implementation of the mandate of the OSHA. It would also aid in the implementation of the HSA legislation. However, HSAs are dropping the environmental-occupational health committees they have inherited from their CHPA predecessors.

The above examples indicate that there has been considerable government intervention on a state and local basis to protect workers from hazardous working conditions. The United States does not have a constitutional provision, however, that protects workers at the workplace.

Workers' compensation has been the key legal protection against the consequences of job-related accidents and illnesses. In 1908, the first workers' compensation law was passed, but it covered only federal employees. These laws were not extended to all workers under the Interstate Commerce Act; rather, "states' rights" prevailed and each state set its own workers' compensation system. By 1921, after the Supreme Court upheld the establishment of state compensation laws, forty-six states had established these "no fault" liability laws. In 1976, about 85 percent of the nation's workers were reported covered in some manner.

The lack of uniformity in state compensation laws contributed to a company argument: "If we have to spend money to correct the workplace, this will make us uncompetitive with other companies which operate in states with weaker laws. In those states, the companies do not make changes and, even if workers seek and get workers' compensation for their injuries, the rates are one-third to one-half of those in the stronger states, thus making their compensation premiums less. They can then undersell us or sell at the same price and make more money. They can then invest in newer equipment and newer methods of production."

This argument, while rather ruthless, does have a kind of truth to it. Its logic was partially responsible for the mass exit of industry from the highly industrialized and labor-organized areas of the Northeast to the South and the Midwest. The turning back of federal occupational safety and health responsibilities to state agencies can lead only to that same breakdown. In fact, it did occur frequently prior to the passage of the OSHA in 1970.

There is an ongoing effort to establish a federal workers' compensation system with one national rate schedule and one set of medical criteria for all state programs. This was mandated by the OSHA (section 27), but according to the administration's staff director, while there was a willingness to create such a national rate program for workplace accidents, little consideration was given to job-related illnesses. Rather than establishing a federal compensation system, however, the commission is merely recommending standards by which state compensation programs would be judged. State workers' compensation programs would remain intact.

Federal involvement has not been very effective in guarding the lives and health of federal employees. A report to the Congress by the General Accounting Office (GAO), "Inequalities in the Preventive Health Services Offered to Federal Employees," indicated that the kind of health rights federal employees have is impressive, especially in comparison to other workers with or without union contracts. But these federal health rights are often taken away by local administrators who are not required to deliver services if they determine that there is not enough money available. In fact, the pattern of inequities among work sites seems to pervade the enforcement of PL 79-658, which was designed to give preventive medical services to federal employees. The GAO reported: "Depending on location, an employee can receive either a complete physical examination, a limited number of screening tests, or no preventive health services at all. Federal agencies believe that preventive health services are beneficial but that it is not always economically feasible to eliminate all inequalities in the provision of services." The GAO report did not assess whether this economic decision to deny health services was based on a comparison of the cost of preventive services with the cost of medical expenses that were not detected early. Thus, a right given at the federal level can be taken away by local administrators on the basis of "economic feasibility." According to the GAO report, "some local officials doubted the benefit of preventive health services in occupational settings. . . . Some believed preventive services were valuable but had not established them because of other priorities." The report continued, "For instance, the Long Beach Naval Shipyard, with 8,100 employees—6,500 industrial workers and 1,600 office workers—required yearly physical examinations for about 60% of the industrial workers. The naval industrial hygiene inspector determined that their jobs exposed them to some hazards or imposed certain physical requirements. Officials said that, although preventive services for the shipyard's 1,600 office workers were desirable, such services had not been provided because the medical unit was experiencing difficulties in meeting its existing workload."

The long and continuing debate over the establishment of medical criteria had to be addressed directly with the passage of the OSHA in 1970. Prior to that, medical and safety criteria were usually prepared by industry sources, since organized workers and their unions did not have the capability to do so. Federal attempts usually withered, owing to the lack of a legislative mandate and a financial commitment. Medical and public health schools that did job-related research were held suspect because their research was usually sponsored by industry.

The National Safety Council, the American Conference of Governmental Industrial Hygienists (ACGIH), and the American National Standards Institute (ANSI) all have attempted to establish a rational and objective approach to setting standards for job-related hazards. They review the existing literature on a particular substance and hazard, often taken from industry sources, and then establish a consensus or middle ground based on the findings. There has been little if any involvement by those most affected—the workers and their unions—in these proceedings.

The passage of the OSHA in 1970 completely changed this. A top priority of the act was to establish federal safety and health standards, not on a consensus basis but on a scientific basis, using NIOSH and other reliable scientific sources. The first step in 1970 was taken by the assistant secretary of the OSH Administration, which adopted all of the consensus standards previously used by ACGIH and ANSI, pending review by industry, labor, and medical-scientific resources. Most, if not all, of these standards have been challenged and are under review. The vinyl chloride exposure level is an example of how out of line these old consensus standards could be. The ACGIH first established a vinyl chloride standard in 1967 at 500 parts per million (PPM), but later reduced it to 300 PPM. The Labor Department chose to adopt the 500 PPM level in 1970 as its standard. However, after the discovery of cancer among vinyl chloride production workers in B. F. Goodrich's plant in Louisville, Kentucky, the OSH Administration held an emergency standard setting procedure and within eighteen months lowered the exposure level to 1 PPM.

The vinyl chloride hearings, and those on asbestos, showed that modern research advances have made possible the identification of workplace hazards, enabled scientists to determine hazardous levels, and enabled engineers to develop machinery that can correct the conditions to make workplaces safer.

### *The Occupational Safety and Health Act*

The OSHA was passed to protect all workers whose employers are engaged in interstate commerce. The main responsibilities for its administration lie within the Labor Department's OSH Administration.

The OSHA carries a full range of duties and responsibilities covering the establishment of federal safety and health standards, inspections (there are about 700 federal inspectors for the nation's 4.1 million covered workplaces), cita-

tions and penalties under a "right of entry" provision that is new to job safety and health legislation, and an emphasis on occupational health factors in occupational safety and health programs. The act focused on a key complaint directed at previous state legislation, namely, the area of voluntary compliance under which state inspectors exhorted employers to correct their workplaces without the use of financial penalties or threat of imprisonment.

Another major element of the act was the provision in section 2(10) of an enforcement program that would "include a prohibition against giving advance notice of any inspection and sanctions for any individual violating this prohibition." The requirement of an advance notice to employers had been one of the major drawbacks of pre-1970 state occupational safety and health programs. Under the federal law, any worker or organized group of workers can now file a complaint with the OSH Administration regional office (or area office), and an inspector must appear at the plant gate, without informing the employer. The inspection is then carried out with the worker who filed the complaint or the representative of the worker, the plant management, and the labor department inspector. Because of the low number of inspectors, however, responses to complaints are not as fast as the framers of the act intended.

Twenty-two states have taken advantage of a major loophole in the OSHA, in section 18, which permits individual states to pass legislation that is "as effective as" the federal act, which can, after a three-year trial period, supersede their occupational safety and health responsibilities on the federal level. This provision, worked into the legislation through the conference bill between the House and the Senate, never had the backing of organized labor or those who had experienced the effects of previous state programs.

To workers and organized labor, this provision has presented the problem of monitoring as many as twenty-three pieces of legislation. Large unions, such as the United Steelworkers of America, autoworkers, chemical unions, and construction unions, now have to keep track of twenty-two state plans and the federal program. The federal monitoring of state plans must take place in the Labor Department's OSH Administration. But, because of the leanings of the executive branch since the passage of the OSHA (the president appoints its top administrators), monitoring of these state plans has not matched the pressure for their enactment. Thus the same patchwork quilt of nonuniform statistics is being perpetuated.

The OSH Administration has not conducted an exhaustive study of its own to determine the effectiveness of these state plans. Questions remain: Are the state safety and health standards as effective as federal standards? Do states have the same rigorous criteria as the federal government, or are they awarding variances as they did prior to the 1970 law?

On the key issue of voluntary compliance, the North Carolina Public Interest Research Group, a Nader organization, found that the governor of North Carolina and his commission of safety and health affairs have been lenient with J. P. Stevens and Company, Cannon Mills, and other large companies in enforcing

safety and health laws. Using voluntary compliance as its primary enforcement method, North Carolina, according to this report, is not protecting its workers and is using the section 18 loophole to evade its responsibilities.

Another consideration is that corporations operate across state lines and can therefore manipulate, on an internal corporate basis, the production of goods to encourage the establishment of state plans. At present, however, the establishment of major conglomerates that operate with virtual regulatory impunity has made federal enforcement a necessity.

The New York State AFL-CIO's position on whether New York should enact a state plan indicates a logical middle-ground position. It has stated its "firm and unequivocal opposition to any state plan or any state enabling legislation which does not contain specific worker protections afforded by the federal OSHA, does not have enforcement provisions equal to that contained in the federal statute, does not provide for immediate coverage and adequate enforcement of programs for all public employees on the same basis as for employees in the private sector . . . and does not provide for adequate appropriations together with adequate skilled staff under civil service." It has recommended the termination of "any further New York State participation in standards and enforcement of the OSHA by withdrawing the state developmental plan." But it has supported a potential role for the states, by asking Congress to "provide for federal assistance to those parts of approved state plans dealing with areas that could remain under state jurisdiction, such as manpower training, education . . . and research."

The nailing down of enforcement and other key parts of the bill as a federal function stems from the poor experience with state inspectors who were often charged with corruption in regard to company payoffs. The charge, and the possibility of its being true, is indicated in other documented corrections of state government and state courts. It is far more difficult to offer payoffs on the federal level, where federal courts have jurisdiction and federal inspectors carry federal policing powers. As pointed out earlier, local and regional Health Systems Agencies could also complement a federal OSH Administration program to keep those with federal responsibilities informed of local issues and problems.

The OSHA has brought a new set of positive, democratic conditions into the determination of new federal medical and safety standards and the subsequent elimination of old, inadequate ones. Some of these conditions are as follows: First, the federal government must have access to private property without the use of a search warrant. Such inspections can be initiated by an individual worker, a trade union, or the Labor Department itself. Second, workers and their unions must play an active part in the establishment of "criteria documents" prepared by the National Institute for Occupational Safety and Health. Every research study conducted by NIOSH, whether on its own premises or under a subcontract to private research groups, including company laboratories, must make available advisory space to workers and their unions most affected by



the hazard under analysis. These advisory committees, which have no veto power, do have complete access to all information on the hazards. Militating against this right is the lack of mandatory use of NIOSH documentation and recommendations by the OSH Administration in its standard setting process.

Third, workers and their unions must also serve on the Labor Department advisory committees, starting with the National Advisory Committee on Occupational Safety and Health (NACOSH) to special ad hoc committees established by the assistant secretary. This provides workers and their unions with the disclosure of the OSH Administration's administrative procedures and rulings that have had to be sought through other sources, as well as an opportunity to advise in their making. This, coupled with new "sunshine laws" and "freedom of information laws," enhances a further potential for an open government. Militating against these advisory committees are the infrequent meeting of the NACOSH and the willingness of the assistant secretary to bypass recommendations of the special ad hoc committees, such as the Coke Oven Advisory Committee. This committee had tripartite representation and recommended rather stringent standards for cancer-causing coke oven emissions, but the assistant secretary at that time, John Stender, chose to promulgate a proposed standard based on the "minority report" filed by the steel representatives on the committee.

A major problem facing the OSH Administration in the implementation of the OSHA is that, since its passage, there have been three secretaries of labor and an equal number of assistant secretaries in charge of the administration. There have been two directors of NIOSH.

In reaction to the advances—especially those in the standard-setting process—achieved under the federal OSHA, partly as a result of the democratic participation of those most affected by the hazard, the president issued Executive Order 11821, which requires the Labor Department to develop economic (and later inflationary) impact statements on its proposed standards. These statements are not developed with the participation of workers and their unions, and although hearings are held on each of them, testimony at that juncture has not been effective in representing the best interests of those affected by the hazard.

The Oil, Chemical and Atomic Workers International Union and the AFL-CIO have gone to court to have these executive orders declared illegal on the basis that economic feasibility is not a criterion of standard-setting under the OSHA. While economic feasibility was an issue raised by companies during the hearings on asbestos and vinyl chloride, those arguments were not considered relevant. The OSHA did not say that all working men and women would be protected "except when the company could not afford it."

The Labor Department did promulgate three federal standards for worker exposures relating to asbestos, vinyl chloride, and a group of fourteen cancer-causing chemicals prior to the issuance of Executive Order 11821. The standard-setting procedures were put to the test with success in each case. The net effect was to invalidate industry's assertion that chemicals as causes of workers' illnesses are secondary to workers' life-styles, which include smoking and drinking. It

was also established that the technical ability to correct workplace hazards does exist. Workers and their unions actively participated in these proceedings and began to develop their own capability in occupational safety and health work. In addition, a new independent scientific medical community surfaced that, working with NIOSH, established medical and scientific proofs that are considered authoritative, reliable, and valid by labor and management alike. International sources of research were used extensively, particularly in the vinyl chloride hearings.

The Society of the Plastics Industry, using an A. D. Little, Inc., study that it financed, pointed out that 1.6 million workers would lose their jobs if a rigorous vinyl chloride standard were adopted. Such prognoses of doom were later condemned by the *Wall Street Journal*, which said that kind of "wolf crying" was invalid since most vinyl chloride and polyvinyl chloride producers are now complying with the 1 PPM standard. Makers of asbestos also claimed that a stringent standard would wreck their insulation business.

Two key standards, those regulating noise and coke oven emissions, are being contested with support from the economic and inflationary impacts drawn up by the Labor Department under subcontracts on the basis of financial arguments. In both cases the economic estimates projected were astronomical. The hearing processes for both of these standards have been disrupted and left in a state of anarchy. Workers are in danger of having their present working conditions perpetuated by law if the Labor Department strongly considers the economic arguments of industry.

The legalizing of the present standard of noise exposure would undoubtedly result in loss of hearing by many workers. A complicating factor in this particular hazard is that the federal Environmental Protection Agency, which, incidentally, has its own federal, state, and local apparatus, also claims jurisdiction over the noise standard under the Noise Control Act. It has recommended an 85 decibel level, while the Labor Department is still proposing a 90 decibel standard.

Coke oven emissions, under the proposed standard, will continue to cause cancer in coke plant workers. This situation has a racist edge, since a disproportionate number of black and other minority workers are being hired in coke oven plants and remain there throughout their working lives because of archaic department seniority rules. It has been known for over 200 years that these emissions cause cancer.

A new White House group, the Council on Wage and Price Stability (COWPS), has further disrupted the OSHA standard-setting process. COWPS economists do studies on the economic feasibility of a standard in the economic and inflationary impact statements, each one costing in excess of \$100,000. These economists know little or nothing about occupational safety and health and merely apply economic, marketplace equations to support their assertions. Nicholas Ashford, in *Crisis in the Workplace*, points out that the attempt to use marketplace formulations in the workplace is invalid and unreliable.

### *Conclusion*

There is no question that, on balance, the intervention of the federal government and, to some extent, the state and local governments on behalf of workers has had a positive effect on protective legislation against workplace hazards. Although a federal program can ensure continuation of that progress, the evidence indicates that the habit of rendering these responsibilities to states would be a major step backwards.

No authoritative study has been conducted to determine whether the workplace has become safer and healthier. Certainly workers and their unions are more aware of job-related hazards. Their participation in the setting of standards and the inspection process is an important democratic advancement at the workplace.

The National Safety Council claims that deaths due to accidents at the workplace were reduced from 14,000 in 1975 to 13,000 in 1976; however, these figures were submitted by industry and have not been audited. On the negative side, basic industry is not putting more money into its safety and health programs. According to the first three surveys of nineteen industries, published each year by McGraw-Hill, companies were investing less money with each succeeding year through 1975, but in the 1976 survey the figures increased slightly over the preceding year. The investment is still very small, with approximately 3 percent of corporate investment monies going into safety and health programs. In this last survey, however, basic industry indicated a lower investment.

This does not auger well for employees and is one indication of the ineffectiveness of the OSHA in forcing employers to correct working conditions. It is still cheaper for companies to pay OSH Administration fines (the average fine for the first three years was about \$50 per citation) and pay more for increased workers' compensation premiums, although this has not been adequately proven, than to invest in new machinery or even in personal protective equipment.

An encouraging note is that medical and public health professionals, administrators, technicians, and organized health consumers are beginning to understand the field of job-related illnesses and disease, though primarily on an individual basis. Their awareness has not influenced the medical and public health establishment. State and local health departments have little or no interest in OSHA programs.

One important step would be to incorporate occupational safety and health programs into national health legislative proposals now being considered in Congress. Only the Committee for National Health Service Bill has done so, and its proposal could serve as a model to others. Such legislation would not rid future administrators of the OSH Administration of the menace of executive orders and of economic impact statements, but it would bring into the arena the employers who end up with broken and mutilated bodies of workers from hazardous workplaces.



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