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OSHA's Monitoring and Evaluation of State Programs

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SUMMARY OF GAO TESTIMONY BY WILLIAM J. GAINER ON OSHA'S MONITORING AND EVALUATION OF STATE PROGRAMS

Federal legislation encourages states to develop and operate occupational safety and health programs, which 25 states and territories currently do. Legislation also requires the Occupational Safety and Health Administration (OSHA) to evaluate these state programs to assure that they are at least as effective as OSHA-administered programs in providing safe and healthful workplaces.

MONITORING AND EVALUATION OF STATE PROGRAMS. OSHA uses an elaborate information reporting system to track state program activities in hundreds of categories, compares state to federal activities, and follows up on significant differences. It also prepares an annual evaluation report on each state. However, its approach to monitoring and evaluation still has what GAO considers to be significant shortcomings. No desired performance levels or incentives for attaining them are established for states, and information is lacking on how states assure program quality and on programs' impact on worker safety and health. GAO recommends that OSHA (1) establish desired performance levels for use by state programs and consider providing incentives for states to attain desired performance levels, (2) require that states establish quality assurance programs and then periodically review those efforts, and (3) work with the states to help them evaluate their programs' impact on worker safety and health.

CALIFORNIA STATE PROGRAM. OSHA now operates the private sector safety and health program in California, pending a final State Supreme Court decision on the legality of the state's withdrawal from private sector enforcement. As a result, worker protection coverage for about 9.5 million workers in the state may have declined for three reasons. First, occupational safety and health standards and exposure limits under California rules are more comprehensive, are broader in scope, and cover more potential worksite hazards than under OSHA. Second, state legislation is more stringent, with tougher sanctions for employers that violate the law. Third, the number of safety and health inspections in California has decreased under OSHA and is expected to remain at about a third of the previous level through at least fiscal year 1988.

Assuming enforcement responsibility in California has also disrupted OSHA's program efforts nationwide. OSHA estimates that by June 1988 about a third of its 1,100 inspectors and supervisory staff will have spent some time in California on temporary tours of duty. To maintain the level of inspections nationwide in their absence, OSHA has curtailed other activities such as state monitoring and internal audits.

Mr. Chairman and Members of the Committee:

On June 8, 1987, you requested that GAO (1) review and suggest improvements to OSHA's monitoring and evaluation of state-operated safety and health programs and (2) determine the status and consequences of OSHA's resumption of private sector enforcement in California. We are pleased to be here today to discuss the results of our review.

To assess OSHA's monitoring and evaluation of state programs we (1) determined, through discussions with agency officials, OSHA's major monitoring and evaluation activities and analyzed documents related to those activities, (2) talked with officials in 12 state-operated programs about quality assurance mechanisms, evaluation of the state programs' impact on worker safety and health, and alternative ways OSHA could use the program activity data it collects, and (3) visited two states (Maryland and Virginia) and reviewed documents such as their program operating plans and the two primary OSHA monitoring and evaluation reports for these states--the state program activity measures reports from OSHA's computerized management information system and the annual evaluation reports.

As agreed, we did not develop information on the effect or impact of any specific weaknesses in OSHA's monitoring and evaluation approach because Labor's Inspector General's Office was conducting an evaluation designed to obtain this kind of information in six states. Labor expects to report its findings later this year.

Concerning California's program, we tracked developments in California, reviewed OSHA's plan for resuming enforcement activities, obtained data on staffing and funding levels, and analyzed differences in the structure of the federal and California programs. However, we did not assess California's implementation of its worker protection activities prior to OSHA's assuming responsibility for the private sector program. We also met with program officials in OSHA's Region IX in San Francisco and in California's occupational safety and health program, with state legislative staff, and with representatives of groups opposing withdrawal of the state program.

OSHA is required by law to assure that state programs are as effective as its own in providing a safe and healthful workplace. Although it has an elaborate information reporting system that tracks program activities in hundreds of categories, the agency

-- does not set desired performance levels to which states can manage;

-- lacks information for monitoring how states assure the quality of inspections and other program activities; and

-- lacks information regarding the impact of state programs on worker safety and health.

Consequently, we recommend that OSHA

-- establish desired performance levels for use by state programs and consider providing incentives for states to attain them;

-- require that states establish quality assurance programs and then periodically review these efforts; and

-- work with the states to help them evaluate their programs' impact on worker safety and health.

Regarding OSHA's resumption of worker protection activities in California, OSHA

-- is now operating the private sector safety and health program, pending a final State Supreme Court decision on the legality of California's withdrawal from private sector enforcement, but

-- may be providing less enforcement coverage because (1) standards and substance exposure limits are less comprehensive under federal regulations than under California rules, (2) federal legislation is less stringent than that of California, and (3) the number of inspections has decreased, and

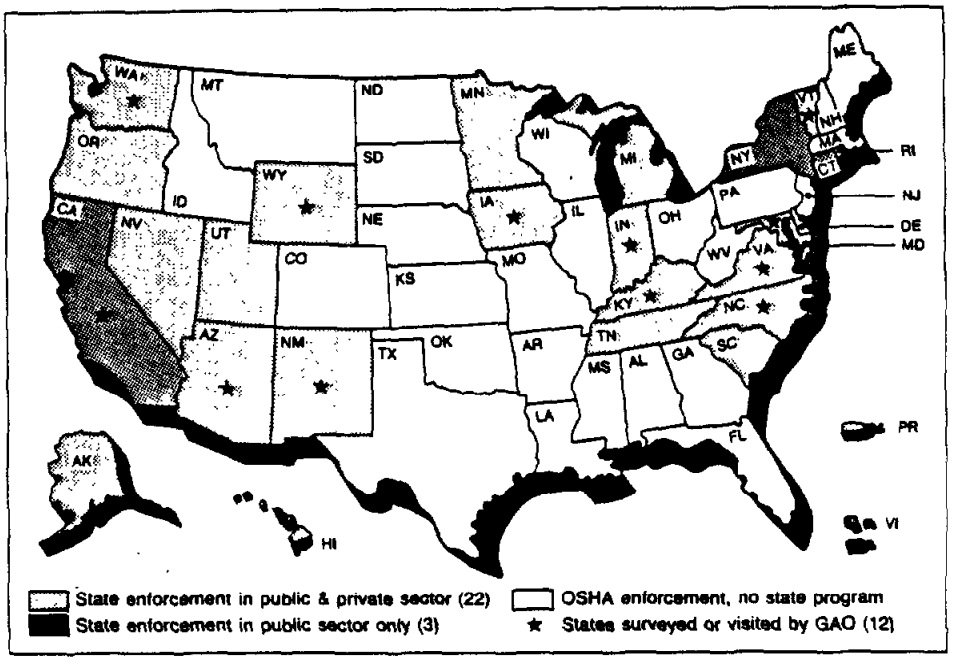
-- is experiencing a disruption of federal enforcement capability nationwide because of the diversion of staff to California from other parts of the country.

I will elaborate on each of these points after briefly describing the legislative provisions governing state occupational safety and health programs and identifying the states that operate them.

LEGISLATION PROVIDES FOR STATE PROGRAMS

To meet OSHA's mandate to assure every U.S. worker safe and healthful working conditions, the Occupational Safety and Health Act of 1970 encourages the states to develop and operate their own safety and health programs. To assume the responsibility for developing and enforcing its own program, a state must submit a detailed plan for OSHA approval. OSHA then may fund up to 50 percent of the cost of operating these programs.

GAO OSHA Monitoring & Evaluation of State Programs: Locations



As the chart above shows, 25 states and territories operate safety and health programs. Three of these states provide enforcement only in the public sector (state and local government employees) while the remaining 22 cover both the public and private sectors. With one exception, these state enforcement activities began before 1980. The chart also shows the 12 states where we visited and/or surveyed program officials by telephone (Arizona, California, Indiana, Iowa, Kentucky, Maryland, New Mexico, North Carolina, Vermont, Virginia, Washington, and Wyoming).

In fiscal year 1987, state programs had approximately 1,075 safety and health inspectors performing approximately 110,000 inspections compared to approximately 1,050 OSHA inspectors performing approximately 61,500 inspections. In fiscal year 1987, OSHA provided the 25 state programs $51.5 million. (OSHA's total FY 1987 budget was about $229 million.)

The act requires OSHA to make continuing evaluations of state safety and health programs on the basis of reports submitted by the states and its oversight inspections. OSHA may withdraw a state's authority to operate a program for failure to comply with the plan OSHA approved, but OSHA has never done so.

MONITORING AND EVALUATION OF STATE PROGRAMS

OSHA's monitoring and evaluation of state programs has two major features. The first is the collection and comparative analysis of data in computerized state program activity measures reports. Analysis involves item-by-item comparisons of state and federal program activities, supplemented by follow-up inquiries where significant differences are noted. The second is an annual evaluation report for each state that draws on that analysis and other information to conclude whether the state is "at least as effective" as the federal program, as required by legislation.

This general approach, initiated in 1983, was developed by federal and state work groups to replace one that relied primarily upon very labor-intensive, on-site monitoring by OSHA personnel. OSHA considered that monitoring approach no longer necessary given the states' experience operating safety and health programs. GAO last reported on OSHA's monitoring of state programs in 1982 (Improvements Needed in Monitoring State Plans for Occupational Safety and Health, HRD-82-29). We made no recommendations at that time because OSHA was developing a new monitoring system, which we believed would adequately respond to two GAO concerns that OSHA (1) did not efficiently use its monitoring resources and (2) had not established acceptable levels of performance for state-operated programs.

OSHA's current approach, using state-reported data, avoids the inefficiencies we described earlier, and the collection and analysis of state and federal information was expected to respond to our concern that performance standards had not been developed. As it has developed, however, OSHA's monitoring and evaluation approach for state programs still has what we consider to be significant shortcomings. It still lacks performance standards, provides no incentives for attaining those standards, requires no quality assurance mechanisms, and collects little information regarding state programs' impact on worker safety and health.

Monitoring Activities

OSHA's monitoring of state programs relies heavily on the state program activity measures reports. They include over 300 specific performance measures in 19 major categories such as standards development, public and private sector inspections, and penalty assessment and collections. Some examples are (1) the

percentage of standards adopted by the state within six months of federal promulgation, (2) the percentage of public sector safety inspections in which some noncompliance with safety and health standards was found, and (3) the average initial dollar penalty for serious violations.

OSHA uses these statistics to assess the quality of state programs through following up on potential problem areas. Although many of the measures are used for descriptive purposes only, each quarter OSHA compares state performance to that of OSHA on about 65 of these measures. Where differences exceed specified limits, OSHA may perform special inquiries if the reasons for the differences cannot be readily determined. Such inquiries include on-site monitoring such as formal interviews, reviews of other data, and visits made with state inspectors. These inquiries are made at OSHA's discretion within the limits of available resources. For example, during 1986, OSHA's Philadelphia Region performed inquiries into Maryland's program, to determine whether

-- the most hazardous worksites were inspected first,

-- the state was determining properly which complaints required inspections and which required only a letter response, and

-- why such a low percentage of the violations cited were classified as serious rather than nonserious.

Annual Evaluation Report

OSHA prepares an annual evaluation report for each state in which it determines whether the legislation's requirement that a state program be as effective as OSHA's has been met. It defines "effective" principally in terms of the state's activity level relative to OSHA's performance rather than in terms of the program's impact on worker safety and health. The evaluation also considers any follow-up inquiries, reviews of complaints about the state program, and other events reported by the state that might impact negatively on state performance (such as a state court ruling that limits state inspectors' ability to make their visits unannounced, which is a federal legislative requirement).

Overview of Problems and Needed Improvements

The following chart summarizes significant shortcomings we identified in OSHA's monitoring and evaluation of state programs and our recommendations for improvement.

GAO OSHA Monitoring & Evaluation of State Programs: Overview

Problem	Needed Improvements
No desired performance levels established	• Set desired performance levels for state programs and consider providing incentives for attaining them
Information lacking on how states assure program quality	• Require and review state quality assurance programs
Impact of state programs on safety and health unknown	• Work with states to evaluate impact on safety and health

Desired Performance Levels For State Programs Need To Be Established

A sound performance management system should identify key performance measures, establish desired performance levels, track performance, and apply sanctions to poor performance or reward good program performance. The current approach, however, does not identify key measures and goals, or desired performance levels, for them. Instead, it treats all measures reported as if they were equally important. In addition, since state performance for a period is compared to federal performance for the same period, the states, in essence, are aiming at a "moving target." Even though OSHA expects state and federal performance to be similar, there is no way for a state to know in advance what the federal performance will be and, thus, try to match it. Because federal performance fluctuates from one quarter to another, the same state performance could match that of OSHA in one quarter but be better or worse in the next. For example, 13 of 40 OSHA enforcement program measures changed by 20 percent or more from 1985 to 1986. (Nine increased; four decreased.)

Officials in all but one of the states we surveyed agreed that key measures should be identified. Some suggested that a joint federal-state work group such as those used in the past by OSHA could identify key measures and develop procedures through which OSHA could set desired performance levels.

The performance management system could be further enhanced if the desired performance levels were used as a means of encouraging program improvements by rewarding or penalizing states' performance. Instead, OSHA's current approach provides no rewards or sanctions for program performance with the exception of withdrawal of state plan approval. If OSHA were to withdraw plan approval--which has never happened--enforcement responsibilities, and the entire cost of operating the program, would return to the federal government. That could mean a significant increase in federal costs, since OSHA's share is no more than 50 percent when states operate the program. Having only this extreme alternative is a disincentive for OSHA to scrutinize state performance and makes it unlikely that states will be penalized for poor performance. Nor is there any way to reward states for attaining or exceeding desired performance levels even if those goals were established.

Officials we interviewed in six of the 12 states believed there should be financial incentives for good state programs. Concerns raised by the other six, and in some cases by those who, overall, supported the approach, were as follows:

-- State programs should not get extra funds for just doing the good job they're supposed to do.

-- OSHA would need better procedures to assure the accuracy of state data if additional funds were involved.

-- Federal funds should first be provided equitably to states. These officials believe funds now provided are more adequate for some states than for others, which would allow some states to demonstrate superior performance only because they are better funded.

   (As of fiscal year 1989, instead of continuing to distribute any funding increases equally among the states, OSHA will use a new funding method that will allocate some of the funds to states on the basis of the proportion of employees in hazardous industries. However, we did not assess whether, or how quickly, that funding method will bring states to parity with respect to the enforcement task facing them.)

We recognize that establishing desired performance levels and developing an approach for rewarding desired performance may be difficult. Nevertheless, we recommend that OSHA (1) establish desired performance levels on key measures and (2) consider providing financial (or other) incentives for states to attain them.

OSHA Needs Systematic Information On State Program Quality

As I noted earlier, OSHA relies primarily on its computerized management information system to assess state program quality; that is, if states compare favorably to federal program activity, it assumes that states are operating quality programs. If not, OSHA may perform further analysis of the state's operating procedures and management controls to determine the cause of the difference in activity measures. However, OSHA's monitoring approach, including the data in the management information system, does not provide for collection and analysis of information on management control mechanisms that relate directly to the quality of the states' program functions.

In contrast to the way it assesses quality in state programs, to assess the quality of its own inspections and other program activities, OSHA relies on an internal audit program and employee/employer surveys in addition to data from its management information system. Labor's Inspector General has recently identified weaknesses in the audit procedures now used, in that they focus too much on detail rather than on systemic weaknesses. Nonetheless, they do represent an expansion over OSHA's state program monitoring approach. In further contrast to state programs, OSHA area offices are required to have management control systems that are intended to assure the quality of inspections and other enforcement functions such as assuring prompt abatement of hazards and appropriately processing complaints and referrals. In response to the Inspector General's report, OSHA has draft audit guidelines that would revise its current procedures to require regional offices to verify that the management control systems exist, determine if they are capable of serving the intended purpose, and review the data provided by the systems.

We recommend that OSHA use a similar approach in monitoring state programs. OSHA should require states to establish quality assurance mechanisms, if they do not have them, and should periodically track and review these quality assurance efforts. For example, such mechanisms might include the following:

-- a management control system to track enforcement functions as required for OSHA's area offices;

-- supervisory reviews of compliance officer activities;

-- procedures to solicit feedback from employers and other affected groups such as unions on inspection quality; and

-- procedures for verifying state activity data reported to OSHA's management information system.

According to the state officials we interviewed, their states have in place some or all of these quality assurance mechanisms; however, information resulting from the application of these mechanisms is generally not reported to or reviewed by OSHA. For example, in Maryland and Virginia, supervisors re-inspect a sample of worksites for each inspector to evaluate the quality of the initial inspection. The results of these supervisory visits could be summarized and reported to OSHA.

OSHA Needs To Know The Impact Of State Programs On Worker Safety And Health

OSHA's legislation does not specifically define "effectiveness," but it does require that the states' standards and their enforcement should be at least as effective as those of the federal government "in providing safe and healthful employment and places of employment." OSHA, however, defines the effectiveness of state programs in terms of program activities, giving little attention to determining what characteristics of state programs have contributed to the reduction (or lack of reduction) in workplace injuries and illnesses so that program improvements could be made. For example, statewide injury and illness data compiled by the Bureau of Labor Statistics are included among the state-federal comparisons, but OSHA officials informed us that those comparisons are not used to draw any conclusion about impact.

We believe determining effectiveness should include assessing programs' impact on worker safety and health as well as reviewing the nature of the program activities themselves. As GAO pointed out in a previous report (Strong Leadership Needed to Improve Management at the Department of Labor, GAO/HRD-86-12), program evaluation is a critical management tool. Information on the impact of policies and program activities should be used as feedback to enable managers to (1) make more informed decisions, (2) facilitate better planning, and (3) identify program activities that need to be improved to increase program effectiveness.

OSHA or the states could design studies that would address the impact of state programs and at the same time provide information about which program activities are having the desired effect and which ones should be revised. For those purposes, the statewide data now reported to OSHA have limited utility. For

example, the 1986 evaluation of Maryland's program compared state changes to national changes from 1984 to 1985 in selected occupational injury and illness incidence statistics across all industries and in selected industries. Although such statewide comparisons may have some value, the differences reflect not only the effect of the worker protection program, but also factors such as the health of the economy. Consequently, to use those comparisons to draw inferences about the effect of the worker protection program, a whole range of other variables would need to be included in the analysis, and the quality and availability of data might be a problem in attempting to perform such analyses.

Analyses using aggregate data such as those for the entire state or all establishments in certain industries, even if performed adequately, still would not yield information about which program features were working well and which need to be improved. An alternative approach which has been used to provide that kind of information involves establishment-level rather than aggregate data--looking for a difference between establishments or at different times in the same establishment where information is available about what worker protection activities were actually provided.

We recommend that OSHA work with the states to help them develop and implement plans for evaluating the impact of their programs. OSHA's role would be that of encouraging states to conduct these evaluations, providing technical guidance and assistance, and reviewing the studies' findings. OSHA's guidance to the states would be especially helpful if it identified a variety of evaluation methodologies and the associated resources needed to implement each of them.

About three-fourths of the state officials we interviewed either described current efforts in their state to determine the impact of their worker protection program or said it would be feasible to develop an evaluation plan. Some had reservations because they thought they would need either assistance from OSHA on how to design and carry out the evaluations or additional resources to purchase such assistance.

STATUS AND CONSEQUENCES OF CALIFORNIA'S REDUCED ROLE IN WORKER PROTECTION

Your second question concerned the current protection provided workers in the state of California, given the state's proposed withdrawal from private sector enforcement. I will first describe the status of enforcement activities in that state and then discuss some consequences.

Private Sector Enforcement By OSHA

With the exception of a transitional period shortly after OSHA was created, the California program provided enforcement in the private sector from its beginning in 1913 until July 1, 1987. At that time, OSHA assumed the responsibility for protection of the 9.5 million workers in the private sector (approximately one-tenth of the U.S. work force), even though California retained enforcement responsibility in the public sector. In accordance with a rider to the Labor Department's fiscal year 1988 appropriation, OSHA has not terminated California's state plan agreement. Instead, OSHA is providing enforcement coverage until a decision has been reached by the California State Supreme Court on the legality of the state's termination of private sector enforcement. This does not, however, prevent OSHA from hiring staff and opening offices in California.

The actions leading to the current situation were as follows. On January 8, 1987, the Governor announced that his budget for the year beginning July 1, 1987, did not include funds for private sector enforcement in the state's occupational safety and health program, called "CAL/OSHA." According to the Governor, California taxpayers should not fund programs where alternatives exist to provide comparable levels of services. (By withdrawing, California would spend about $16 million less.)

The Governor notified the Department of Labor on February 6, 1987, of his intention to terminate the state's private sector worker protection program on June 30, 1987. In his notification, the Governor requested continued California responsibility for enforcement in the public sector and for the "consultation program" for the public and private sectors, which helps employers improve their safety and health programs without penalty.

The Governor's letter triggered lobbying in the state capital by representatives of labor unions and business groups to maintain the program and ultimately prompted litigation to prevent his actions. Committee hearings were held in the State Assembly and Senate with witnesses praising the state's performance over the years, especially its development of

comprehensive safety standards. Subsequently, the state legislature reinstated funds to continue the program, but the Governor refused to spend these funds.

Two groups (California Rural Legal Assistance and the California State Employees' Association) filed separate suits in the state's Third District Court of Appeals, challenging on different grounds the Governor's authority to end the program. In October 1987, the Appellate Court issued a decision that the Governor lacked legal authority to withdraw the private sector program by refusing to spend funds designated for the program. That decision was appealed to the California State Supreme Court, which has agreed to hear the case. Officials in California believe that the court's decision may come in September or October 1988.

The situation in California has had two major consequences:

-- enforcement coverage for workers in California may have declined and

-- OSHA's enforcement efforts nationwide have been disrupted.

Changes In Enforcement Coverage

As I noted earlier, we did not review California's implementation of its worker protection program, and thus cannot draw conclusions about the adequacy of the enforcement coverage previously provided to workers in California under the state program or currently provided under OSHA. Nevertheless, there have been changes in the enforcement structure for private sector enforcement efforts in California and a decrease in the number of inspections. The enforcement structure changes that may have resulted in a decline in coverage are (1) standards and exposure limits protecting workers that are less comprehensive under federal regulations than under California rules and (2) federal legislation that is less stringent than that of California, as shown in the following chart.

GAO California: Enforcement Structure

California Standards Are More Comprehensive	• Standards for many more activities and practices • Over 2,400 safety standards rather than about 700 under OSHA • Exposure limits for 597 airborne hazards instead of 392 • Stricter exposure limits for 100 hazardous substances
California Legislation Is More Stringent	• Civil penalties can be higher • Criminal prosecutions possible in more circumstances • Could act more promptly on imminent hazards

Under OSHA, workers in California no longer have the benefit of all the occupational safety and health standards and exposure limits developed by and adopted in the state program. States are allowed to develop different or additional standards so long as they are at least as stringent as those of OSHA. California standards generally are more comprehensive, are broader in scope, and cover more potential worksite hazards than federal standards.

California has over 2,400 occupational safety standards (excluding those related to mine safety), compared with OSHA's approximately 700 standards. Although part of the difference in the number of standards can probably be explained by the way requirements are organized into separate standards, it also reflects the fact that California's safety standards cover numerous industry activities and practices not specifically mentioned in OSHA standards. For example, petroleum drilling, a major hazardous industry in the state, is covered by comprehensive standards in California but is not covered specifically by any federal standard.

California's health standards are also more comprehensive. For example, the state has a health standard for permissible exposure limits for 597 hazardous airborne contaminants--over 200 more than the 392 addressed in OSHA's standard. For another 100 substances, the exposure level defined as hazardous in California is lower than the level considered hazardous by OSHA. Of these 100 substances with stricter exposure levels, 21 are carcinogens to which approximately 1 million California workers are exposed.

One of the most significant differences between the California program and the federal program is in the legislation. California's legislation, for example, authorizes higher maximum civil penalties, allows criminal prosecution under a much broader set of circumstances, and allows more prompt action on imminent hazards. In the construction industry, it also requires a permit for certain hazardous work. More specifically,

-- certain civil penalty assessments allowed under California law are double that allowed under federal legislation (for example, a maximum of $20,000 for each single serious and willful violation compared to $10,000);

-- California law permits criminal prosecution under a broader set of circumstances, which may be one factor explaining why over 250 cases have been prosecuted since 1973 for safety and health violations as compared to only 14 such prosecutions nationwide under federal legislation since 1970;

-- under California law, an inspector can immediately shut down work where an imminent hazard exists, while federal law requires a court injunction; and

-- California legislation requires a permit prior to initiation of certain hazardous construction work--which allows for the review of contractors' safety plans and the scheduling of inspections to monitor compliance at these hazardous locations--but OSHA has no comparable system. A 1982 California government study cited the permit system as one of the major reasons for the significant decline in injuries and fatalities from ditch, trench, and excavation cave-ins during the 1970's.

As the following chart shows, the number of private sector safety and health inspections in California has decreased substantially since OSHA began enforcement and is expected to remain at about a third of the previous level through at least fiscal year 1988. From July 1985 through June 1987, the state inspectors conducted an average of 4,672 private sector inspections a quarter. In contrast, OSHA performed 2,059

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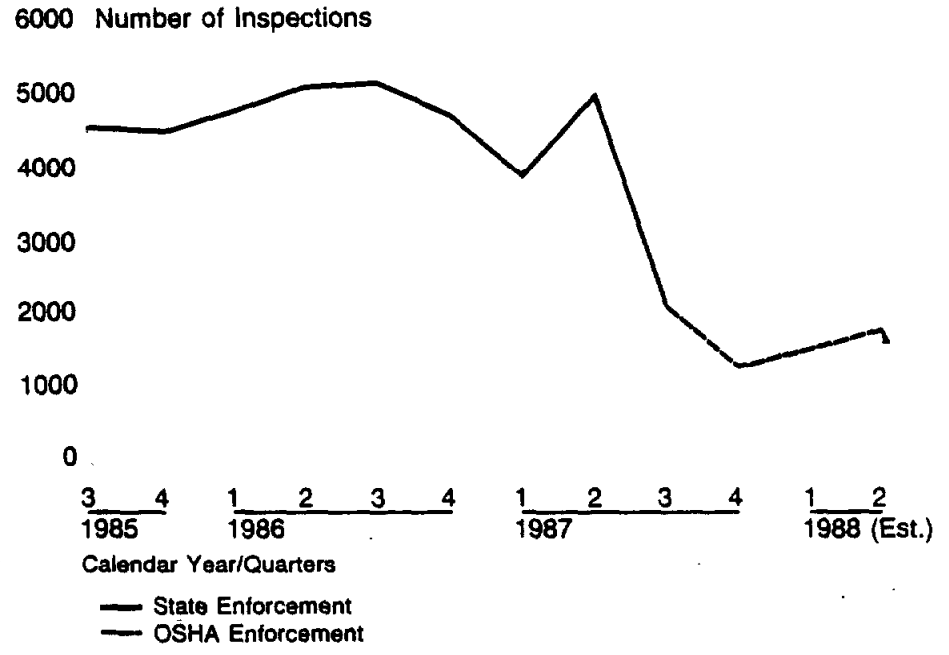
California: Fewer Safety and Health Inspections



inspections in July through September of 1987 and 1,211 in October through December. It expects to conduct between about 1,500 and 1,700 a quarter through the rest of fiscal year 1988.

The smaller number of inspections is due in part to reduced staffing levels. As of February 26, 1988, OSHA had 158 employees (128 permanent and 30 on detail from other OSHA offices) working in California. Although OSHA was in the process of filling 36 more positions, the number on the job at that time was markedly less than the 271 state program staff in compliance enforcement as of December 1986.

Disruption In OSHA's Enforcement Efforts

Assumption of enforcement responsibility in California has led to a substantial disruption in OSHA's program efforts nationwide, as shown in the following chart. The former Secretary of Labor, in a letter to Senator Hatch in October 1987 (published in the Congressional Record) stated that OSHA had provided worker protection in California on an interim basis

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OSHA Enforcement Disrupted To Send Staff to California

One third of all inspectors & supervisors detailed there	• 373 out of 1,100 detailed to California • Temporary duty 2 weeks to 4 months
Extra costs covered by funds already available for the state	• $3.5 million reallocated
Other worker protection activities curtailed to maintain national inspection level	• Completed only 43 of 62 scheduled internal audits

through the temporary shifting of staff to California from other parts of the country, but that it had been accomplished at a "great cost and at the great expense of worker protection elsewhere in the nation."

OSHA estimates that by June 1988 about a third of its 1,100 inspectors and supervisory staff will have been detailed to California for temporary tours of duty. During the first 6 months (June 15 through December 18, 1987), 292 inspectors and supervisors were detailed to California for periods ranging from 2 weeks to 4 months from its 9 other regional offices. OSHA plans for detailing another 81 inspectors and supervisory staff from January through May of 1988 will bring the total to 373 inspectors and supervisors detailed to California at some time since June 15, 1987.

As the former Secretary of Labor noted, it is costly to maintain staff and lease space and equipment on a temporary basis. OSHA used the $3.5 million remaining in grant funds that would have gone to California as the federal share of its program

for the fourth quarter of fiscal year 1987 to cover the increased costs. We were informed that these funds were sufficient to cover the additional costs, such as travel and office space rental.

While the diversion of staff resources has, according to OSHA officials, had certain negative effects on program activities nationwide, the overall number of OSHA inspections has been maintained. OSHA told us that the number of inspections has been maintained by using staff from other program areas, such as the voluntary protection program, the consultation program, state monitoring, and internal audit. The effect on the internal audit function, for example, is shown by their having performed in fiscal year 1987 only 43 of the 62 scheduled area and regional office audits.

OSHA is attempting to fill California staff positions with permanent employees, but has been hampered by potential employees' reluctance to accept positions while the federal program's status is uncertain. In addition, for former state employees--a likely applicant pool--comparable positions with OSHA would mean a salary reduction since employees in the state program had, on average, about 20 percent higher salaries. Of the permanent positions filled as of February 26, 1988, 52 were filled from within OSHA, while 4 were formerly with the California program, and 72 were hired from elsewhere.

By May 1988, OSHA expects to be operating in California with a permanent staff of 164. In fiscal year 1988, total funding for public and private sector worker protection in California is expected to decline from $33 million to $16 million. This represents a decline from $19 million to $3 million in funds from California and from $14 million to $13 million from OSHA.

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Mr. Chairman, this concludes my prepared statement. My colleagues and I will be pleased to answer any questions you and the other members of the Committee may have.