

BRIEFLY...

Highlights of Report Number **02-11-201-10-105**, to the Assistant Secretary for Occupational Safety and Health

WHY READ THE REPORT

The role of the Occupational Safety and Health Administration (OSHA) is to promote workers' safety and health. Through its programs and partners, OSHA claimed it reduced work-related fatalities, injuries, and illnesses. The Bureau of Labor Statistics reported 4,340 fatalities and 965,000 non-fatal injuries and illnesses for 2009. Liberty Mutual Annual Workplace Safety Index reported over \$53 billion in workers compensation costs for 2008.

The Occupational Safety and Health Act of 1970 (OSH Act) authorizes States to assume some responsibilities to develop and enforce safety and health standards, and authorizes grants of up to 50 percent of costs to States with programs **at least as effective as** the Federal program. Since 1972, States were granted \$2.4 billion to develop and operate effective Occupational Safety and Health (OSH) programs.

WHY OIG CONDUCTED THE AUDIT

In 2009, complaints filed with OSHA and congressional interest prompted OSHA to conduct a special review of Nevada OSH. Prior to the review, Nevada OSH received favorable monitoring reports while it was sharply criticized in media coverage on the handling of 25 fatalities. The special review revealed significant operational issues. Subsequently, OSHA expanded monitoring of other States' programs to include on-site case reviews.

The objective of this audit was to answer the question: Has OSHA ensured that State Plans operate OSH programs that are **at least as effective as** Federal OSHA? The audit covered OSHA's monitoring of all 27 State Plan programs operating in Fiscal Year 2010.

READ THE FULL REPORT

To view the report, including the scope, methodology, and full agency response, go to:

<http://www.oig.dol.gov/public/reports/oa/2011/02-11-201-10-105.pdf>

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OSHA HAS NOT DETERMINED IF STATE OSH PROGRAMS ARE AT LEAST AS EFFECTIVE IN IMPROVING WORKPLACE SAFETY AND HEALTH AS FEDERAL OSHA'S PROGRAMS

WHAT OIG FOUND

OSHA has not yet designed a method to examine the impact of State OSH programs to ensure they are **at least as effective as** Federal programs. State officials generally believed their programs were effective, but there was no quantifiable data to demonstrate effectiveness. OSHA officials acknowledged that effectiveness measures would be desirable, but difficult to develop. As a result, OSHA lacks critical information needed to make informed decisions.

- Defining Effectiveness. State officials expressed concerns regarding the lack of clear expectations for effective programs and that some program changes required by OSHA may not necessarily increase effectiveness of their states' programs.
- Measuring Effectiveness. OSHA officials admitted OSHA does not have outcome measures to gauge effectiveness. States were evaluated on activity-based data, which OSHA officials stated would provide valuable operational information and proxy measures of effectiveness.
- Establishing Minimum Criterion. OSHA has not evaluated the impact of its own enforcement program in order to establish the minimum criterion to evaluate state programs.
- Monitoring Effectiveness. In 2009, OSHA expanded monitoring to include on-site case file reviews, but had neither changed nor expanded the measures it used to evaluate performance.

WHAT OIG RECOMMENDED

We made four recommendations to the Assistant Secretary for Occupational Safety and Health to define effectiveness, design measures to quantify impact, establish a baseline for State Plan evaluations, and revise monitoring to include an assessment of effectiveness.

In responding to our report, OSHA agreed with the intent of the recommendations, but had concerns that defining effectiveness by relying exclusively on impact or outcome measures would be extremely problematic.