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## Occupational Risks Insurance in the United States

Organization and 2008-2009 Statistical Data

## Foreword

This document presents a descriptive overview of the occupational risks insurance in the United States. It deals with its history and its operating modes. A statistical chapter details the incidents at work and occupational illnesses data.

The statistical chapter comes from the use by EUROGIP of the Bureau of Labor Statistics official publications and it is presented according to the EUROGIP's knowledge of the American insurance system. These data have not been reprocessed by EUROGIP. For any confirmation, one has to refer to the source which is systematically given.

Financial data given in euros are calculated with an exchange rate of (2011/07/26) 1 € for 1.44 USD.

## Note to the reader

The recording and the compensation of occupational injuries follow two completely separate paths and are taken care of by different institutions.

Information sources used for drafting this overview are diversified and complete but they are not harmonized and not synthesized.

Considering the heterogeneousness of the occupational risks insurance mechanisms in place in each State, only the main common characteristics will be discussed.

About the occupational injuries statistics, the numerous exemptions and a complex recording system are to be kept in mind when one wants to analyze the figures. Finally, frequent rounding make that the totals may not be equal to the arithmetic sum of the lines and/or columns.

With this overview, EUROGIP did its best to gather data and points of view issued from various credible protagonists. These points of view may be divergent.

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## Summary

Insurance against occupational risks was **the first form of social insurance** to develop in the United States, at state level. Indeed, for private sector workers, there is no federal legislation fixing the obligations owed to employees when it comes to insurance for occupational injuries and illnesses. Each state has its own Workers' Compensation Act (**WCA**). For the most part, these texts were put in place before 1920.

Occupational risk insurance is **compulsory** in all states, except Texas where it is optional for private sector employers. The system is based on the principle of employer's **civil liability** insurance, which ensures its immunity from civil suit by the victim. Such suits are prohibited except in a limited number of circumstances.

The obligation to insure covers practically all forms and sizes of business with a certain number of exceptions related to the business's activity and / or size. Incidents at work and related to work, and occupational illnesses are insured, but not incidents that take place when the employee is traveling to and from the place of work.

The insurance provides payments in kind and in cash to workers who have fallen victim to an illness or accident in the scope of their employment, and to their next of kin and helps avoid costly court proceedings.

The employer can get insurance from **different types of insurer**. Depending on the state, it can opt for a private or state-run insurer. The employer can be its own insurer in all states but two, if it has the financial capability and the necessary authorization. In a few states, the state-run fund (a not for profit public mutual) is the only authorized insurer. Certain states expand the possibilities, others limit them.

If the employer is not insured, the victim can bring legal proceedings or make a claim to the state authorities responsible for indemnifying occupational risks or a guarantee fund.

Each state has an authority charged with ensuring the proper application of the legislation.

Specific insurance systems exist for federal employees (Federal Employment Compensation Act - FECA), railway employees, merchant navy employees, employees of the nuclear weapons industry, dock workers and miners affected by pneumoconiosis (Black Lung Benefit Act).

To **fund the insurance**, calculation methods are similar across the states, even if rates can vary slightly. For employers with private insurance, the key figure in calculating the size of the premium is a rate expressed in dollars for every \$100 in a week's salary. The rate is fixed according to profession. The seriousness of the incident is measured according to the cost of harm, that is to say medical costs and indemnities paid directly to the victim.

The rate, multiplied by the number of \$100 portions in a month's salary, gives the weekly premium. This process gives an average (manual rating) for businesses in the same risk class. For example, in California, the risk class for office workers is around \$1.25. With a weekly salary of \$500, the premium would be  $1.25 \times 500/100$  or \$6.25.

Insurers can increase or decrease the amount of the premiums taking into account the past history of the business (experience rating).

The recent development of deductibles in insurance regulation should be noted. It increases emphasis on employers insuring themselves. Employers can insure themselves if they receive authorization to that effect. Payments are, as such, deductible as business expenses.

Employers pay the entirety of insurance premiums. In some states, a symbolic contribution from employees is required.

Insurance means that victims do not have to go to court to receive **compensation**. Payments that are included: benefits in kind (medical treatment without cap on cost or duration) and cash payments (for complete or partial, temporary or permanent disability).

The victim receives payments for temporary disability up to the date of MMI (maximum medical improvement). MMI signifies the point at which there is no further chance of improvement at which point the worker can either go back to work or enter a state of permanent disability.

Insurance against occupational risks is regulated at state level, calculation methods and payment amounts varying considerably from state to state. The same is true for the number of weeks that payments may be made for.

Indemnity for loss of earnings is not taxable at federal or state level. Such payments tend to be versed weekly.

In the United States, the **recording of accident and illness statistics and compensation statistics** follow completely different administrative channels. Numerous studies have tried to put them together, and their conclusions feed a lively debate on the quality of available statistics. However, they concern only a small number of states and certain biases have been identified in the methodologies used by these studies.

The first collecting of statistics took place toward the end of the 19<sup>th</sup> century. Then, during the First World War, the Bureau of Labor Statistics (BLS) published the first report on occupational illnesses in the metals industry. The first studies on

occupational illnesses date from the start of the 20<sup>th</sup> century. Though the BLS continued to publish annual statistics, considerable gaps appeared over the years. It was only in 1970, when the Occupational Safety and Health Act (**OSH Act** of 1970<sup>1</sup>) came into force, that the BLS was entrusted with the creation of an integrated reporting system for the private sector. The OSH Act provides that private sector employers (excluding businesses with fewer than 11 employees and those considered devoid of risk) are required to keep an internal register of all incidents at work and occupational illnesses, with or without days away from work.

From these records, kept by employers, the BLS creates its national records for non-fatal incidents at work and occupational illnesses. It collects data from employers' records by **surveying** randomly selected businesses. The sample can contain businesses with fewer than 11 employees, though certain employers are exempt, such as the self-employed household workers, or agricultural establishments with less than 11 employees. The BLS compiles the results, makes estimations for the national level, and publishes. For fatal incidents, the BLS compiles data from a number of administrative sources. Occupational illnesses are not reflected in the fatal data. Certain illnesses with long-latency periods are rarely captured by the non-fatal survey.

In 2009, out of a working population of nearly 130 million workers, the BLS estimated **1,238,490** incidents with at least one day away from work for private sector workers, and municipal and state employees. In the same year and for the same population, this time including self-employed workers and federal employees, **4,551** fatal incidents were recorded.

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<sup>1</sup> Hereinafter, "OSH Act" will refer to the legislation, whereas the term "OHSA" will be used for the institution, at state and federal level, charged with the application of the legislation.

The **quality of statistics on incidents and illnesses**<sup>2</sup> has been the subject of intense debate for a number of years. Criticism is focused largely on the statistics for non-fatal incidents which are estimated based on an annual survey. As already mentioned, these statistics are collected on the basis of a random sample of around 250,000 establishments. Selected businesses have to send the required data immediately following the year of reference. This system is considered to be conducive to underreporting. A number of studies suggest that the BLS records between 30% and 69% of all real life cases. For some researchers, the decrease in injuries at work seen over the last decade can be attributed, in 83% of cases, not to the effectiveness of prevention measures, but rather to the ineffectiveness of the administration and to the modifications made to the reporting system. The BLS underlines that studies that point to considerable underreporting of incidents and illnesses can contain biased statistics.

Congress, and the United States Government Accountability Office (**GAO**), Congress's audit, evaluation and investigative organization, have gotten involved in the situation. The agency, the BLS and the National Institute for Occupational Safety and Health (NIOSH) are currently looking at ways to confirm and combat underreporting of occupational incidents and illnesses. The first step has been, for the BLS, to widen the cover of its statistics and include, from 2008, state and municipal employees

The impact of **financial incentives**, essentially the employer's insurance premium and the amount of the victim's compensation, have been the focus of a number of empirical studies. These studies have shown that more generous compensation pay-outs led, in the 1970s and 1980s, to an increase in compensation claims and to an increase in the average duration of sick leave. Since the 1990s, legislation on compensation has become more restrictive. Certain analysts consider

<sup>2</sup> Given the current debate on under-declaration of incidents at work and occupational illnesses and the warnings signalled by the various agencies on the disparities between the reality on the ground and the numbers recorded, prudence seems necessary in any form of analysis of occupational injuries' statistics.

that the decrease in loss of earnings compensation payments can be attributed to this tightening of the legislation and not to a decrease in the incidence of incidents and illnesses.

Indeed, in light of the debate on the quality of the BLS's statistics and despite the effective decrease in reporting of incidents and illnesses, it does not seem feasible to establish a direct link between a perceived long term decrease in the number of incidents and illnesses at work and the level of insurance, in particular if account is taken of the restrictions on compensation pay-outs. Though such a link has been established by certain studies, it must be measured against the positive impact of certain other factors, such as regulation and inspections.

The **OSH Act** creates the Occupational Safety and Health Agency, the primary federal agency with national competence in matters relating to health and safety at work. Its mission is to encourage employers and employees to reduce occupational risks and to put into place effective prevention programs.

The **OSH Act** provides that employers must create and organize a working environment which is free of all danger, potential or obvious, that is capable of causing death or serious injury. They must:

- Create for employees a working environment which is free from serious known risks;
- Conform to the OSH Act safety standards, under the surveillance of the agency created by the legislation;
- Identify and correct health and safety problems;
- Attempt, in the first place, to eliminate or reduce risk before providing individual protection equipment;
- Make employees aware of chemical risks through training, information, proper labelling and other procedures;
- Keep an accurate record of incidents at work and occupational illnesses;
- Undertake testing in workplaces (e.g. air quality) as required by the OSH Act standards that set exposure limits;
- Organize medical tests as required by said standards;
- Put up notifications and advice from the OSHA in the workplace, as well as

- information on incidents and illnesses, so that they can be seen by employees;
- Notify the agency within 8 hours of all fatal incidents and those that require at least three workers to be hospitalized<sup>3</sup>;
  - Avoid action that is discriminatory or constitutes a reprisal against an employee that uses his or her rights accorded by the OSH Act.

The OSH Act **provisions** must be obeyed by employers. They outline standards that must be met. These are minimum standards that must be respected, but can be surpassed. Secondary norms, set in pursuance of the legislation, can be challenged during their elaboration, so as to be amended, or contested before a judge once finalized. These secondary norms cover the construction industry, agriculture, and industrial and maritime activity in the broadest sense. For other sectors, the general legal obligation of safety applies. This general obligation requires that employers maintain a working environment which is free of all serious known risks that will or might cause death or serious physical injury.

To ensure that the **OSH Act is applied**, the agency conducts inspections. One of the legislative scheme's fundamental attributes is that it accords a right to inspectors to enter workplaces. If the employer refuses, the inspector can obtain a warrant. When a violation has been committed, the inspector issues a cease-and-desist, suggests a penalty and sets a timetable to correct the violation. Financial sanctions, or even prison sentences, can be handed down. The employer can contest any findings against him, or he can accept them. In the latter case, he can seek assistance from the agency to develop prevention methods and to train employees. The OSH Act's provisions allow employees to inform the agency of dangerous or unhealthy working conditions and to request an inspection. The employee is protected when exercising this right.

The effectiveness of the agency is the subject of some debate. Its detractors argue that the number of inspections is

<sup>3</sup> Deaths caused by heart attacks have to be reported. However, those caused by traffic incidents, on aeroplanes, trains, metros, or buses do not have to be notified.

low, as well as the average amount of fine compared with the considerable quota of workplaces open to inspection. The probability of an inspection ending in a fine is very low. Moreover, it can be seen that the agency's standards deal essentially with technical issues, whereas the majority of incidents result from a complex mix of factors: the job being done, the equipment and the working environment. So, when the agency discovers a violation of a technical standard, it does not necessarily get to grips with this interaction of factors and so can have but a limited influence on the likelihood of incidents and illnesses. On the other hand, studies have identified a decrease in incidents and illnesses and the number of days away from work in the three years that follow an inspection, all while noting that the effectiveness of an inspection followed by a fine diminishes with time. The explanation offered relates to an increase in the cost of insurance which drives employers to improve health and safety at work.

The debate relates also to the resources of the agency. On the issue of the number of inspections, the American Federation of Labor and Congress of Industrial Organizations (**AFL-CIO**) has calculated, from BLS data, the number of years that would be needed for the agency to inspect every workplace in a state. It would need 241 years for Florida, or 23 years for Oregon to complete this task.

The agency is involved in a number of actions to promote health and safety in workplaces. In certain programs, the involvement of the employer is compensated by an exemption from regular inspections during the program. Outside of respect for the law and altruism, economic performance is underlined. An example is the Voluntary Protection Programs (**VPPs**) which bring together management, workers and the agency in cooperative and proactive programs which focus on prevention and risk control, analyzing the workplace, training, the involvement of management and employees. As for the Safety and Health Achievement Recognition Program, (**SHARP**), it recognizes small and medium sized business that put in place exemplary systems of health and safety management. SHARP presupposes that workers in an establishment are protected from all risks

and that there has been collaboration with the OSHA to determine which good prevention practices to put in place. Creating a culture of safety is an important element. SHARP participants have a role to play in their community and employees can spread the values of health and safety at work.

**Research** in health and safety at work is the job of NIOSH which has the aim of developing knowledge and transforming it into good practice for the well-being of workers. It prepares draft norms on behalf of the agency. The NIOSH undertakes scientific research, creates recommendations, gives out information and responds to evaluation requests for potentially dangerous workplaces.

Research is focused around the National Occupational Research Agenda (**NORA**). Launched by the NIOSH in 1996, NORA is a public/private partnership which sets research priorities for the NIOSH and other institutions in the field of health and safety at work. NORA coordinates the action of its participants and ensures that research goals remain in line with the realities of the working world. Research has to have a measurable impact in improving working conditions for employees.

In each state, NORA coordinates this agenda, in particular:

- By evaluating risks in business, and producing recommendations when consulted by employers, employees, or federal or state agents;
- By promoting a culture of work safety through grants and cooperation programs;
- By financing research on a large range of subjects in universities and other organizations;
- By supporting training programs.

On the subject of medical surveillance, the nature and structure of services are very varied. In some cases, only a preliminary at-work medical examination is undertaken, while in other situations, complete medical supervision, including health promotion at home and at work, is on offer. If there is no internal service, employers can call upon independent practitioners, clinics and hospitals. The size of the business is not the key criterion

when choosing to bring occupational medicine in-house.

The range and nature of services offered by an in-house or external team is variable.

Such services generally include:

- Evaluating employees' ability to carry out working tasks safely (a preliminary examination is the norm);
- Drug and alcohol testing, commonplace or even compulsory in certain professions;
- Compulsory medical surveillance where employees are exposed to dangerous substances as defined by the OSH Act;
- Identifying common symptoms, suggesting illnesses that result from dangerous work, as provided for by the OSH Act, and conducting medical tests to this end; when symptoms are identified, the employee is monitored;
- Treatment and follow-up after an occupational illnesses or accident at work;
- Promoting well-being, personal health evaluations with courses of action proposed to cut out bad habits. Such programs can include cholesterol reduction, help quitting smoking, stress management and education in nutrition;
- Supervising health and safety policy and programs in the workplace.

Some of the regulations provide for mandatory medical surveillance that can be refused by the employee. The employer's obligation, therefore, stops at offering free access to medical care, because the law does not require him to impose it. The employer has to document uptake and offer other forms of care or examination acceptable to the employee, or offer him advice on the subject.

Often, **unions provide services**, which are usually preventative in nature, for their members. Unions often have at their disposal experts in industrial hygiene, ergonomics, occupational medicine and other health professionals who come in when a complaint is received from an employee. They undertake evaluations of workplaces. They assist in interpreting medical statistics and where an employee contests the conclusions of a survey undertaken by the employer. They are active in informing and training employees, and take part in the political process that is



responsible for producing regulations, especially when it comes to collective bargaining.

Since the start of the 1980s, **university occupational health clinics** have sprung up as part of university hospitals. Some of them offer basic occupational health services, but their primary activity is diagnosing illness related to work or to the

working environment. They are centres of expertise for occupational illnesses and for training in occupational health. These clinics are usually not for profit organizations and are not formally linked to any employer. They are independent, and are usually consulted in complex or contentious cases.

## 1. The History of occupational risks insurance

Regulating health and safety at work was the first form of social insurance to develop in the US, in the northern states.

The first governmental efforts to regulate working conditions took place at state level. Indeed, to respond to concerns about poor working conditions in the burgeoning industrial landscape, the majority of northern states created occupational statistics bureaux, the first of which being instituted in Massachusetts in 1869. This bureau's first inspection report was issued in 1870. Other states (Ohio, Wisconsin and Minnesota) followed. The reports show that working conditions were often very poor, and the causes and circumstances of incidents and work were often shocking. In order to create these reports, bureau agents would visit businesses and take notes on the state of working conditions.

A legislative framework was gradually put in place. Pennsylvania adopted the first law on coal-mine inspection in 1869. Massachusetts was the first to enact a law on health and safety at work in 1877, and to create a body of work inspectors in 1879. This legislation, inspired by examples in the UK, started a domino effect. From 1897, fourteen other industrialized northern states got similar legislation dealing with, for example, the obligation to install protective equipment on machines, a prohibition on cleaning moving machinery or the requirement that incidents should be reported.

As such, the first statistical records date from the end of the 19th century, notably in New Jersey and Pennsylvania where it became clear that falls from a height was one of the most commonly occurring incidents at work. However, the requirement that employers declare incidents at work to the statistical bureau in their state was not widespread, as can be seen in the examples of Wisconsin and Minnesota where no such obligation existed.

Indeed, the states did not establish a common level of protection. Legislation was often incomplete and simply added to for new risks. For example, only eight out of fourteen states made declaring incidents obligatory. Also, the number of inspectors varied greatly: one in Connecticut, seven in New Jersey, twenty-six in New York. These inspectors did not always have the right to enter premises. Moreover, a form of social dumping meant that the more advanced a state's system of legislation in this area became, the more it would lose businesses to other, less stringent states.

Federal government did not play a significant role in this early period. However, at the start of the 20<sup>th</sup> century, the situation had to develop in reaction to a number of disasters and the press reaction there too. A mining accident in 1907 necessitated the creation, from 1910, of the Federal Bureau of Mines. Its mission consisted of investigating incidents, consulting with the mining industry, undertaking research on safety and output, and conducting training and accident prevention programs, as well as programs on first aid and rescue in mines. In 1910, the journalist William B. Hard published an exposé on working conditions in the metals industry. According to his article, for every 10 000 employees, 1 200 were seriously injured or killed each year. The industry undertook to revolutionize its methods and was followed by others. This movement led to the creation of the National Safety Council in 1915, which is still in existence.

At the same time, the predecessor to the National Institute for Occupational Safety and Health (the **NIOSH**) was created in 1914 under the title of the Office of Industrial Hygiene and Sanitation. Its role was to conduct research and to assist states in solving problems related to health and safety at work.

The Department of Labor (DOL) was set up in 1913 by Congress. One of its principal roles was the improvement of working conditions. At the same time, the Bureau

of Labor Statistics, the BLS, a daughter agency of the DOL, was compiling regular statistics on incidents and illnesses in the metals industry. This practice was eventually extended to other industries.

In 1934, the Bureau of Labor Standards was set up. It became the key federal agency for pursuing a permanent health and safety at work agenda. The agency assisted states to raise the standard of their legislation. Also, inside the framework of President Roosevelt's New Deal, Congress enacted three laws expanding the role of federal authorities. First of all, the Social Security Act 1935 authorized public funding for studies. Next, the Fair Labor Standards Act 1938 created a minimum salary and regulated child labor. The DOL was therefore able to outlaw certain dangerous activities being undertaken by under 18s. Finally, in 1936, the DOL began to play a regulatory role with the enactment of the Walsh-Healey Act on tenders which required certain federal bodies, when issuing a call for tender, to respect basic health and safety standards.

This legislative framework mixed state and federal law to create a degree of complexity which, according to some, did not effectively combat incidents at work and occupational illness.

The main federal health and safety laws were introduced in 1969 and 1970. In November 1968, an explosion occurred at Farmington, West Virginia, killing 78 workers in a coal mine and leading to calls from miners for stricter federal regulation. In 1969, a federal law on health and safety in coal mines, fixing obligatory health and safety standards, was enacted. Combined

with other mining legislation already in force and amended and enlarged, the 1969 Act became a 1977 Act on mine safety which created the Mine Safety and Health Administration (MSHA), charged with issuing health and safety regulations for the entirety of the mining sector and ensuring their proper application.

During the 1960s, an increase in incidents made change a priority. After a three year legislative battle under the Nixon administration, the Occupational Safety and Health Act, the **OSH Act**, was adopted in 1970. The Act created the Occupational Safety and Health Administration under the auspices of the DOL. That agency sets and applies federal occupational health and safety norms. However, the law continues to allow states to directly administer their own health and safety at work programs, on condition that they respect a minimum level of health and safety as set by the agency. Finally, the law outlines the role of the NIOSH under the authority of the Department of Health. It is charged with research, training occupational health and safety professionals, and setting standards in this area

On the subject of **compensating** employees' occupational risks, most states adopted, between 1910 and 1920, laws on compensation without fault through private insurance. The operation of the various systems varies from state to state. Currently, they are becoming more restrictive. There is no federal legislation on compensating employees in the private sector. Only employees of the railways, ports, docks, nuclear industry, certain types of mine and federal agencies are entitled to federal compensation.

## 2. Relevant organizations

The two governmental bodies primarily involved in applying the provisions of the 1970 Occupational Safety and Health Act are the Occupational Safety and Health Administration (**OSHA**) on prevention issues, and the Bureau of Labor Statistics (**BLS**) for collecting statistics.

### 2.1 Institutional organizations

Social and employment issues are dealt with by the United States Department of Labor, the **DOL**.

For more information on the DOL:

<http://www.dol.gov/>

Follow the [safety and health in the workplace](#) tab to access the DOL's information concerning the employer's rights and obligations.

The Occupational Safety and Health Administration (**OSHA**), the most important of the agencies listed, is in charge of prevention of occupational risks.

Employers, beyond simply having to follow the letter of occupational health and safety legislation, have a general obligation to ensure that the working environment in which their employees work is free of all serious and identifiable risks. Employees' health and safety conditions, in most of the private sector, are monitored, in most states, directly by the agency. In other states, these issues are administered by the state itself through agency approved programs which respect the rules set at federal level. California and Michigan use this system. The results of these state-run programs are assessed each year by the agency

Information on prevention programs is available by following this link:

<http://www.osha.gov/dsg/topics/safetyhealth/index.html>

Almost all private sector workers come under the competency of the agency, apart from miners, certain transport industry workers, numerous public sector workers and the self-employed. This equates to around 112 million employees out of around 8.6 million businesses.

For more information on the agency:

<http://www.osha.gov/>

The Mine Safety and Health administration (**MSHA**) is responsible for ensuring the proper application of the Mine Safety and Health Act 1977. This piece of legislation sets out the measures that have to be put in place in the nation's mines. The Act applies to all forms of mining activity and ore extraction, whatever the size of the establishment, the number of workers or the extraction method the mine uses.

For more information on the MSHA:

<http://www.msha.gov/>

The Wage and Hour Division (**WHD**) ensures the application of legislation on disloyal labor practices (the Fair Labor Standards Act) which sets out rules applicable to hiring under 18s, their health and their wellbeing at work. The text defines the minimum working age, authorized hours and the jobs that are available.

For more information on the WHD:

<http://www.dol.gov/whd/>

In addition to the work done by these three bodies, the DOL runs the [Working Partners for an Alcohol- and Drug-Free Workplace](#) scheme which is aimed at helping employers keep workplaces free of alcohol and drugs. Even though not required by law, such schemes are considered to be the natural extension of other programs directed at promoting healthy and safe working environments.

The work of these three bodies is also complemented by the following programs:

The [Office of Workers' Compensation Programs](#), (**OWCP**) manages four major invalidity payment schemes which provide for a replacement salary, medical costs,

help in getting back to work as well as other payments to certain workers or their families who have fallen victim to an accident at work or an occupational illness, for employees outside of the private sector.

A specific system has been put in place to compensate workers in the nuclear sector who suffer from occupational illnesses. This is the Energy Employees Occupational Illness Compensation Program (the **EEOICP**), managed by the [Office of the Ombudsman for the Energy Employees Occupational Illness Compensation Program](#), **EEOMBD**.

Insurance for federal employees is the responsibility of the Division of Federal Employees' Compensation (**DFEC**), which runs the Safety, Health and Return to Employment (SHARE) initiative. For more information, go to <http://www.dol.gov/owcp/dfec/share/perform.htm>

Founded in 1913, the National Safety Council (**NSC**) is an association of businesses and institutions who work for the promotion of health and safety at work and at home, and transport security. The NSC works alongside the agency to provide information and necessary training to employers and employees to ensure better safety standards at work. For more information: <http://www.nsc.org/Pages/Home.aspx>

Founded in 1916, the American College of Occupational and Environmental Medicine (**ACOEM**) brings together 4,500 occupational and environmental health professionals. As such, it is the largest medical institution that works for the promotion of health and safety at work through preventative medicine, institutional care, research and education. For more information: <http://www.acoem.org/>

Founded in 1987, the Association of Occupational and Environmental Clinics (**AOEC**) brings together not for profit clinics and occupational health professionals. Its mission is to improve occupational and environmental health practices. For more information: <http://www.aoec.org/index.htm>

## 2.2 Recording and publication of occupational injuries statistics

Social statistics are compiled and published by the **BLS**, a branch of the DOL. For more information, see <http://stats.bls.gov/home.htm>

For statistics on the harm caused by occupational risks, data are compiled by the *Injuries, Illnesses and Fatalities (IFF)* program at the following address: <http://stats.bls.gov/iif/home.htm>

## 2.3 Administrative structure at state level

Most States have a non-court (administrative) adjudicative system<sup>4</sup> in charge of mediating in disputes relating in disputes relating to victims' compensation and ensuring the proper application of state legislation on compensation by insurers. In some States, it is a public body. These bodies also supervise businesses that self-insure. They collect data on compensation demands, which insurers must send them. On the other hand, in some states, disputes go directly to the civil court system.

For a list of useful links by state, see: [http://www.workerscompresources.com/W/CPR\\_Public/WC\\_Agency\\_Websites/site\\_address\\_update.htm](http://www.workerscompresources.com/W/CPR_Public/WC_Agency_Websites/site_address_update.htm)

For the most part, the states have an insurance regulatory authority (a State Insurance Board). These authorities grant the licenses necessary to operate as an insurer. They also regulate the setting of insurance premiums to a greater or lesser degree depending on the state. For example, certain states require a preliminary agreement on the size of premiums before application. Where the state only has a state-run fund (North Dakota, Ohio, Washington and Wyoming), this fund adopts both functions.

## 2.4 Scientific organizations

The Center for Disease Control and Prevention, (**CDC**) is a branch of the

<sup>4</sup> This body is also known as the Workers' Compensation Commission or Compensation Administration or even Industrial Commission of Arizona in that state.

Department of Health and Human Services (**HHS**).

For more information:

<http://www.cdc.gov/>

The National Institute for Occupational Safety and Health, **NIOSH** is the federal agency responsible for research into health and safety at work and for issuing recommendations in this area. It is a branch of the CDC. It aims to develop knowledge in this area, and to translate knowledge into good practice. To this end the NIOSH conducts scientific research, produces obligatory guides and recommendations, publishes information, and deals with requests to inspect occupational hazards in workspaces. NIOSH's research priorities are determined as part of the National Occupational Research Agenda (**NORA**). For more information on the NORA agenda: [www.cdc.gov/niosh/nora](http://www.cdc.gov/niosh/nora)

For other information:

<http://www.cdc.gov/niosh/>

Since 1986, the National Institute of Environmental Health Sciences, (**NIHES**) has been involved in supporting education and training programs that help protect workers from exposure to toxic substances during the treatment of dangerous waste and chemical by-products. This includes training workers who have to work in extremely polluted zones.

For more information:

<http://www.niehs.nih.gov/index.cfm>

The Chemical Safety Board (**CSB**) is an independent federal agency responsible for investigating industrial chemical incidents (explosions, fires, etc.) so as to protect workers, the general public, and the environment. Each accident is investigated and the results are made available on the agency's website.

For more information:

<http://www.csb.gov/>

### 3. The functioning of the occupational risks insurance system

#### 3.1 The occupational risks insurance

Insurance against occupational risks was the first form of social insurance to develop in the United States, at state level. Indeed, for private sector workers, there is no federal legislation fixing the obligations owed to employees when it comes to insurance for occupational injuries. Each state has its own Workers' Compensation Act (**WCA**). For the most part, these pieces of legislation were put in place before 1920. Occupational risk insurance is compulsory in all states<sup>5</sup>, except Texas where it is optional for private sector employers.

The system is based on the same principle as employer's civil liability insurance, ensuring immunity from civil suit by the victim. Such suits are prohibited except in a limited number of circumstances (see below, point 3.4). In most cases, the parties reach an agreement on the compensation and settle out of court. These agreements are subject to the approval of the state agency that supervises the implementation of the WCA. However, in Texas, as insurance is not obligatory, victims can pursue claims against their employer in cases where there is no insurance.

The obligation to insure covers practically all forms and sizes of business. There are some exemptions. For instance, in 36 states agricultural operations are exempted. Another example is the small businesses exemptions in 15 states<sup>6</sup>. Finally, around 2.6 million workers in Texas<sup>7</sup> are not insured. Incidents at work

and occupational illnesses are insured, but not commuting incidents<sup>8</sup>.

The aim of the insurance is to provide payments in kind and in cash to workers who have fallen victim to an illness or accident in the scope of their employment, and to their next of kin. The different types of payment are not the same across the states.

The employer can get insurance from different types of insurers. Depending on the state, it can opt for a private or state-run insurer. The employer can be its own insurer (see below, point 4.6)

If the employer is not insured, the victim can bring legal proceedings or make a claim to the state authorities responsible for indemnifying occupational risks.

Specific insurance systems exist for federal employees (Federal Employment Compensation Act - FECA), railway employees, merchant navy employees, employees of the nuclear weapons industry, dock workers and miners affected by pneumoconiosis (Black Lung Benefit Act).

#### 3.2 Funding of the system

Calculation methods are similar across the states, even if rates can vary slightly. Here we will discuss private insurance and insurance from state funds.

The key figure in calculating the size of the premium is a rate expressed in dollars for every \$100 in a month's salary. The rate is fixed according to profession, since different professions are divided into risk classes according to the frequency and severity of the risks encountered in the profession. This is measured according to

<sup>5</sup> Including Puerto Rico, the District of Columbia, Guam, the US Virgin Islands and American Samoa.

<sup>6</sup> In 8 states, insurance is not obligatory for private businesses with less than 3 employees, in 2 states for less than 4, and in 4 for less than 5.

<sup>7</sup> Voluntarily bought insurance covers around 75% of employees in the state.

<sup>8</sup> There are some exceptions if, for example, the journey includes a stop-off or detour linked to the job. In such a case, it will be an "accident at work".

the cost of harm, that is to say medical costs and indemnities paid directly to the victim.

The rate, multiplied by the number of \$100 portions in a month's salary, gives the weekly premium. This process gives an average (manual rating) for businesses in the same risk class. For example, in California, the risk class for office workers is around \$1.25. With a weekly salary of \$500, the premium would be  $1.25 \times 500/100$  or \$6.25.

Insurers can increase or decrease the amount of the premiums taking into account the past history of the business (the experience rating). This is obligatory in a large number of states. Several other mechanisms (deviations, schedule ratings, premium discount plans, retrospective rating plans, dividend plans) provide flexibility in the weekly premium.

The *manual rating* is applied mainly to small businesses, while the *experience rating* is most relevant to large businesses, the majority in the country.

In most states, employers pay the entirety of insurance premiums. In some states, a symbolic contribution from employees is required.

#### *Note on deductibles*

Private insurers and state funds are authorized in the vast majority of states to offer deductible insurance policies with a certain limit. The insurer can pay the entirety of the compensation due, then claim reimbursement from the employer for the deducted sums. Another possibility consists in the employer taking responsibility for paying directly a part of the compensation, the insurer coming in when the amounts go beyond the agreed sum.

This practice has seen considerable growth since 1992 and, according to certain analysts, this growth stems from the increased cost of insurance. In 2008, deductibles payments represented 14.1% of the total amount of compensation payments (USD 57.633 billion, around EUR 40 billion), a sum close to USD 8.11 billion (around EUR 5.63 billion), of which USD 7.6 billion (EUR 5.28 billion) came from private insurers, and USD 500 million (EUR

350 million) from state funds. The sum is paid by businesses.

In fact, these deductibles mechanisms allow employers to self-insure up to a point, all the while remaining linked to an insurer. In parallel, the number of self-insuring employers has also been growing since 1992, but at a less dramatic pace.

### **3.3 Victims' compensation**

Insurance should allow, in theory, a victim to receive compensation without having to go to court. The mechanisms described below apply to incidents at work and occupational illness.

#### **3.3.1 General remarks**

The most commonly made payments include:

- Payments in kind: uncapped medical costs with no time-limit; depending on the state, the choice of healthcare provider belongs to the victim or to the employer. The insurer can have the victim's current state of health examined by a doctor of his/her choice during any sick-leave,
- Monetary payments for four types of disability:
  - Temporary partial or total disability,
  - Permanent partial or temporary disability. Where there is permanent disability, it may be that the costs of modifying the victim's home are covered,
- Rehabilitation payments, including professional retraining.

Compensation for loss of earnings is not taxable at state or federal level. It is paid weekly by the insurer in the majority of states. The amount is controlled by state agencies.

Since this branch of the insurance industry is managed at state level, calculation methods vary from state to state. This is also true of the number of weeks for which payments will continue to be made. Compensation methods for permanent disability vary greatly from state to state.

#### **3.3.2 Treatment of temporary total and partial disability**

Daily payments for *temporary total disability* are paid after a period of between



3 and 7 days. Payments for this initial period can be made retroactively if disability lasts longer than a set period<sup>9</sup>. In general, the day on which the accident occurred is not compensated. If the victim goes back to work before complete consolidation, with a reduced workload and a reduced salary, he or she enters into the category of temporary partial disability.

For these two types of disability, compensation is calculated on the basis of the victim's salary when the accident occurred. The replacement rate is normally around 66.66% of the latest salary up to a ceiling. This cap varies depending on the state, going from a weekly rate of USD 398.93 (EUR 277.03) in Mississippi, to a ceiling of USD 1,366 (EUR 906.94) in Iowa (2008 figures). In numerous states, these payments are made without time limits. Some states attach a maximum duration, 104 weeks in Minnesota or 500 in Indiana.

Where the after-effects last a long time, the victim can claim payments for temporary disability up to the point of MMI, maximum medical improvement (the equivalent of consolidation). MMI signifies that no further improvement can be expected in the patient's condition. Either the victim returns to work or enters into the permanent total disability category if work is no longer possible.

### 3.3.3 Permanent total or partial disability and death

Disabilities that give rise to a permanent disability are, in general, listed in a schedule annexed to legislation defining the scheme of compensation. This payment is made as soon as the temporary disability period comes to an end, and the mechanisms behind it vary greatly from state to state.

Compensation for *permanent partial disability* is for those who can continue to work despite a permanent handicap. The amount is generally calculated in percentage of the employee's previous salary (usually 66.66% thereof), reference to a level of disability determined by a

doctor<sup>10</sup>, and to the number of weeks. Depending on the state, compensation may or may not be capped. It is capped, for example, at USD 220 (EUR 152.78) per week in Alabama, and at USD 1,257 (EUR 872.92) in Iowa. In practice, the replacement rate of the salary does not automatically reach 66.66%

On the other hand, if by the time consolidation or MMI is reached the victim is no longer able to work, he or she enters into the permanent total disability category. Periodic payments are made either for life, until a certain age is reached, or for a set number of weeks, 500 in Indiana, for example. The amount is, in principle, 66.66% of the victim's previous salary, with a weekly cap. For example, in Alabama the cap is USD 706 (EUR 490.28) per month, payable for the duration of the disability or for life. However, in Indiana, the weekly cap is set at USD 636 (EUR 441.67) with a total cap of USD 318,000: 500 weeks at USD 636.

Checks are made to see if those who are claiming payments are capable of working, or indeed do work again. Developments in medical science and new technologies mean that total permanent disability is no longer seen as necessarily definitive. For example, in Arizona, the claimant must fill in a yearly questionnaire sent to him or her by the insurer.

In case of death, funeral costs are covered and payments are made to next of kin. These payments are subject to a cap and in certain states limited in time and in size. For example, in Kansas, the weekly cap is USD 529 (EUR 367.36) with a total cap of USD 250 000 (EUR 175,611.11)

<sup>9</sup> For example, in Arizona the delay period is 7 days. For sick-leave of 10 days, the victim will receive daily payments for only 3 days, but over 14 days, the payments are dated back to the first day except the day of the accident.

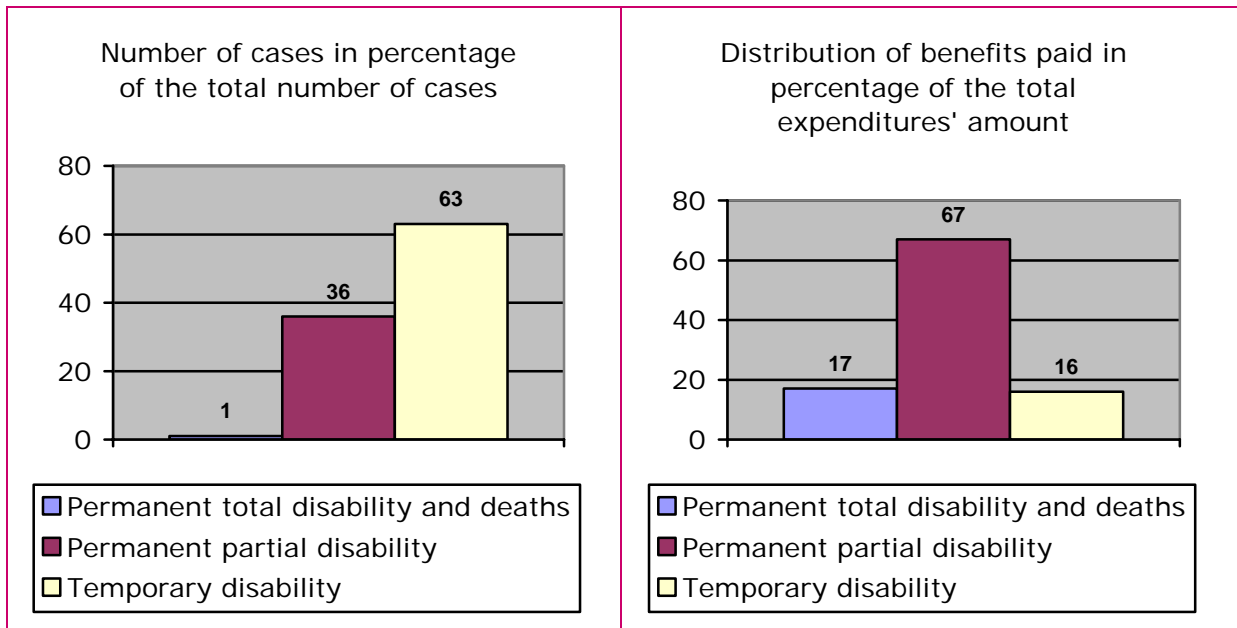
<sup>10</sup> The disability rate for an identical injury is not necessarily the same from one state to another, even in the states that use the American Medical Association Guides (a method of evaluating disability).

### 3.3.4 Breakdown of payments

A study looking at 41 states for the period 1998-2005 has shown that, as most sick-leave does not last as long as the initial uncompensated period, these periods of sick-leave, though they counted for 77% of all cases, accounted for only 8% of payments. These payments are constituted entirely of medical costs. On the other hand, the other 23% are 92% medical

costs and compensation for loss of earnings.

More precisely and as shown by the spread of costs in 2005 in the table below, temporary disability represented 63% of cases, and 16% of payments made; permanent partial disability represented 36% of cases for 67% of payments made; permanent total disability and death represented 1% of cases and 17% of payments.



### An example of a procedure

In Arizona<sup>11</sup>, the doctor or hospital that treats the victim gives him a form to complete and sign. This signature is constitutive of a demand for compensation. Then the health professional sends a copy to the victim's employer, a second to the insurer, and a third to the ICA (Industrial Commission of Arizona, see point 2.3). As soon as the document is received, the ICA formalizes the demand by addressing confirmation of receipt to the victim and the insurer. The latter must, accordingly, compile a dossier within 21 days. For payments in kind, it's the ICA that checks and modifies, if need be, the amount paid by the insurer.

In case of refusal by the insurer, or contestation by the employer, the victim may, within 90 days, appeal to the ICA. An administrative judge (in the employ of the ICA) makes the final decision. If there is such an appeal, the victim is advised to seek legal advice. If the appeal is successful, the lawyer in general receives a sum equal to 25% of the compensation he secures<sup>12</sup>. Moreover, the arrangement is no-win-no-fee.

In any case, the victim must make his or her demand for compensation at the latest one year after the accident.

<sup>11</sup> See the Workers' Compensation information for the Injured Worker for Arizona : [http://www.ica.state.az.us/Claims/Forms/Claims\\_InjuredWorkerHandbook\\_2011.pdf](http://www.ica.state.az.us/Claims/Forms/Claims_InjuredWorkerHandbook_2011.pdf)

<sup>12</sup> For some examples of compensation secured by the Susan J. Sadow law firm in Atlanta, Georgia, see: <http://www.sadowworkerscomplaw.com/sadow/workers-compensation-settlements>

### 3.4 The “Exclusive Remedy” Principle: the employer’s immunity from suit

From the very inception of laws on workers’ compensation<sup>13</sup>, the legislation included an essential principle. They provided for the neutralization of the victim and next of kin’s right to sue in exchange for not having to prove the fault of the employer in order to receive compensation. The law introduced the principle of liability without fault to the benefit of victims of occupational illnesses and incidents at work.

As such, the law provides that compensation, the modalities and levels of which are defined by law, and which has as a corollary the immunity of the employer, is the sole method of seeking compensation. This principle that of an “exclusive remedy” is said to be under attack. Indeed, certain states have amended their legislation to include certain exceptions to the principle of employer immunity from suit or to respond to certain judicial decisions that have set binding precedents. For their part, employees and their lawyers have a strong propensity to go to court to secure a second or elevated compensation compared to that offered by the WCA. That being so, employers find themselves in court for matters pertaining to occupational risks that would before have been dealt with within the confines of the liability without fault regime set out in the WCA

Some of these exceptions pertain to instances of intentional fault, third party actions, class actions, compensation demands in bad faith and gross negligence.

Here again, impressions cannot be generalized as the situation evolves

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<sup>13</sup> 2011 is the 100<sup>th</sup> anniversary of the first legislation in the state of Wisconsin.

following decisions of state Supreme Courts. For example, the Kentucky Supreme Court has insisted on the “exclusive remedy” principle by refusing to allow a victim to bring an action against their employer’s insurer who had refused to compensate in circumstances that suggested bad faith.

#### *The role of the lawyer*

EUROGIP’s research has shown three different manners in which law firms get involved in the process:

- As counsel to the victim, navigating the complexity of the compensation process, even without contest from the insurer or employer. The victim can also seek the help of a mediator, usually available from one of the state agencies that ensure the implementation of the WCA;
- When employers or their insurers reject a compensation demand (for example, if the demand has no connection with the employment), if litigation ensues on the amount of compensation due to the victim, or if the procedure instigated by the insurer is unduly long and torturous. If the employer is not insured, the victim will seek the intervention of a judge or the state insurance guarantee fund. The agency that oversees the fund will then act against the employer;
- When the victim brings a court action to obtain compensation over and above that accorded by the law as monetary payments and payments in kind. These complementary sums take the form of a *pretium doloris* to compensate pain and suffering, loss of faculty and cosmetic prejudice. Such will also be the case where the victim brings an action against a third party, for example the manufacturer of the machinery that caused an injury.

### 3.5 Fixing compensation for partial permanent disability

The method of fixing this form of compensation is one of the aspects on which the states most vary.

Around 44 states use a list of “scheduled losses”<sup>14</sup>. That is to say that there is a list of body parts that are compensated, which gives a maximum number of weeks for which compensation will continue. The effective duration of the indemnity is the meeting point between the level of disability (determined by a doctor) and the maximum number of weeks for the injury. The amount is calculated on the basis of a proportion of the weekly salary (usually 66.66%) within a cap. WCA legislation in each state provides for a minimum compensation level.

#### Example

Delaware	100 % disability base
Hand	220 weeks
Leg	250 weeks
Thumb	75 weeks
Eye	200 weeks

Injury	Real disability rate	Value	Length	Salary base
hand	30 %	220 w	66 w	66.66 %

Extract from the list in the state of Delaware and its application to an accident involving a hand with a disability level of 30%. Compensation is accorded for 66 weeks on the basis of 66.66% of the victim’s previous salary, capped at USD 609,82 (EUR 423,49) per week (June 2010). The minimum rate is USD 203.27 (EUR 141.16).

Source: [http://delcode.delaware.gov/title19/c023/index.shtml#P-1\\_0](http://delcode.delaware.gov/title19/c023/index.shtml#P-1_0)

It is worth noting that the states that adopt the “scheduled losses” system do not take into account loss of earning capacity. A hairdresser and a teacher are compensated in the same way for a hand injury.

However, for the majority of states, the list is not comprehensive<sup>15</sup>. If the body part injured does not appear, it is an “unscheduled loss”. In general, the maximum total value in weeks that applies to the entire body is given to these unlisted body parts. This value is 300 weeks in Delaware (2008 figure). It should be noted that occupational illnesses are treated as unscheduled losses. In these States where the “unscheduled loss” principle applies, the loss of earning capacity is considered.

Injury	Real disability rate	Value	Length	Salary base
Back (all body)	20 %	400 w	80 w	66.66 %

Extract from the list for the state of Delaware and application to an accident involving the back, assimilated to the totality of the body as the back does not figure on the list of scheduled losses. The disability level is 20%. Compensation is accorded for 80 weeks on the basis of 66.66% of the victim’s previous salary, capped at USD 609.82 (EUR 423.49) per week (June 2010). The minimum rate is USD 203.27 (EUR 141.16).

Other complementary approaches go some way to fill in the gaps. They are also used by states which do not adopt a list-based system. Some states blend the different methods on a casuistic basis.

<sup>14</sup> The scale generally appears as a schedule to the Workers’ Compensation Act.

<sup>15</sup> Often, it does not include the trunk or internal organs.

For a more complete description of the compensation system for permanent partial disability, the reader is invited to look at the article "The Shape of Permanent Partial Disability Benefits" published in the May-June 2008 edition of the "Workers' Compensation Policy Review", available from the following address:

[http://www.workerscompresources.com/WCPR\\_Public/WCPR%20PDFs/MJ08.pdf](http://www.workerscompresources.com/WCPR_Public/WCPR%20PDFs/MJ08.pdf)

#### *Note on permanent total disability*

The rate of permanent total disability presupposes that the victim has experienced a complete loss of earning capacity for all types of employment, all possibilities of using past experience, training and rehabilitation having been exhausted.

The same is true for the after effects of an accident at work or occupational illness. Concretely, the texts link permanent total disability to the loss of both hands, both feet, both legs, both eyes and all combinations thereof.

The victim can opt for a lump sum payment or weekly payments.

If the injury in question is in combination with others sustained prior to the employee's current employment, the current employer and his insurer will only be held liable for a permanent partial disability. The victim will have to go to a guarantee fund, the "Second Injury Fund", to obtain compensation for the permanent total disability.

Recent changes in the law, particularly in California, have made it so that if the permanent partial disability stems from a multitude of factors, the last employer will only be held for the prejudice engendered while the employee worked under his supervision. Before that, the last employer was held liable for the entirety of the prejudice if the harm caused by him served to aggravate a pre-existing situation.

#### *Note on guarantee funds*

There are three types of guarantee fund involved in compensation:

1. "Second Injury Funds", funded by a tax on insurance policies, compensate for incidents at work and occupational illnesses that occur as the result of an aggravated pre-existing condition. They also compensate victims and next of kin where the employer is uninsured. In 2008, around 40 states had such Second Injury Funds. The sum of their pay-outs in that year was slightly over USD 1 billion (EUR 690 million);
2. "Guaranty Funds" become involved where the insurer is insolvent. In 2008, around 15 states had Guaranty Funds. The total of their pay-outs was around USD 248 million (EUR 172.22 million);
3. "Self-Insurance Guaranty Funds" operate where an employer's self-insurance arrangement does not operate as it should. In 2008, 7 states had such funds, and they paid out around USD 16 million (EUR 11.11 million).

### 3.6 Compensation parameters' examples – 2008 data

	Waiting period In days	Retro-active period	Temporary total disability		Permanent partial disability	
			Maximum weekly benefit allowed	Benefit limitations	Maximum weekly benefit allowed	Benefit limitations
				Maximum length of benefits in weeks		Maximum length of benefits in weeks for "unscheduled injury"
<b>Arizona</b>	7	14 cd	\$466.06 with dependents	Continued until employee is medically stable or released to work	Depends on the percent of disability	None
<b>California</b>	3	14 cd	\$916.33	104 (a)	\$230 if the impairment is below 70% and \$270 above 70%	Not applicable
<b>South Carolina</b>	7	21 days	\$746.00	104	\$746.00	2 weeks for each % of impairment from 1 to 10 %, 3 from 11 to 15 %, 4 from 16 to 20 % and 6 weeks for each rating over 21 %.
<b>Florida</b>	7	14 cd	\$661.29	Duration of the disability with a maximum of 500 weeks	\$661.29	340
<b>Texas</b>	7	2 weeks	\$712.00	105 (b)	\$498.00	300

cd: calendar days

(a) In California there are some limited exceptions where benefits may be paid for 240 weeks.

(b) An exception to this amount could be made when an extension of the Maximum Medical Improvement based on spinal surgery is approved.

	Permanent total disability				Death benefits		
	Intended benefit as a % of the weekly reference wage	Weekly payments		Benefit limitations		Maximum weekly benefit allowed	Benefit limitations
		Maximum	Maximum as a % of the average weekly wage of the State	Maximum length of benefits	Total maximum monetary benefit		Statutory limit for dependency benefits
<b>Arizona</b>	66.66% of the pre-injury monthly reference wage	\$461.60	66.66 % of the monthly reference wage limited to \$3,000	Benefits are for the length of disability and may be paid for life	None	\$461.60	None
<b>California</b>	66.66% of the average weekly rate	\$230 a week if the disability is below 70% and 270\$ over 70%	Established legislatively	For the number of weeks allowed for a specific disability or for life if 100% disability	Depends on the number of weeks for the disability and the compensation rate – there is no limit for a 100% lifetime disability	\$958.01	None
<b>South Carolina</b>	66.66% of the pre-injury weekly reference wage	\$746.00	100%	Benefits are payable to age 75	None	\$746.00	Maximum payable is \$150,000
<b>Florida</b>	66.66% of the pre-injury weekly reference wage	\$661.29	100%	500 weeks unless eligible for lifetime benefits	\$330,645 unless awarded lifetime benefits	\$661.29	500 weeks
<b>Texas</b>	66.66% of the average weekly rate	\$710	100%	For length of disability and can be for life.	None	\$712	A minimum of 364 weeks would be paid in a fatal claim

Over the last decade, the amount of compensation for permanent partial disability has reduced alongside reforms to state WCA legislation.

For example, from 2000 to 2009, the size of payments has reduced by 60% in California, by 20% in Florida and 20% in New York.

### 3.7 Debate on economic incentives

According to John W Ruser, economic incentives play a role<sup>16</sup> when it comes to occupational risks. The author, basing his arguments on a series of studies from the 70s and 80s, believes that businesses and

employees make a rational economic calculation as to the level of an insurance premium for the business and on the level of compensation for the victim. For many businesses, the calculation method for the premium takes into account its accident history. This individualizes the premium, and introduces a degree of fairness, in so far as those businesses which are responsible for the highest number of incidents and illnesses are made to contribute more. In theory, obligatory

<sup>16</sup> See Economic Incentives Influencing Occupational Risk Prevention by John Ruser in n° 1 of volume 8 (Jan/Feb 2008) of the Workers' Compensation Policy Review.

insurance compels the businesses to deal with risks in advance so as to cut the size of the premium. This principle is as true of businesses taking out insurance from a private insurer as of those who take it out from a state fund.

According to Ruser, an economic calculation would lead to different behaviors. For the employee, more generous compensation would lead him or her to report injuries that he or she might otherwise not have, temper his or her self-preservation instinct in the face of occupational risk, and have the effect of extending the length of sick-leave. This would lead to an increase in the frequency and seriousness of incidents and illnesses which would, in turn, lead to an increase in an employer's insurance premium. The business would therefore be driven to take accident and illnesses prevention measures. Several studies cited by the author confirm the truth of this analysis. They show a correlation between more generous compensation followed by an increase in the number and duration of claims and, accordingly, an increase in the insurance premium. At least one study shows that decreasing compensation leads to a decrease in the number of claims. On the other hand, from the employer's point of view, it can be observed that businesses who would otherwise be driven to take prevention measures, become more restrictive in matters of prevention, limiting, for example, compulsory injury recording and by adopting a more combative stance in contesting claims.

However, the fact that these studies use BLS statistics on non-fatal injuries, the reliability of which is in doubt (see below), has been underlined. One study using the more reliable fatal accident statistics, thereby eliminating the bias introduced by over-claiming in non-fatal cases, has shown that the increase in the amount of compensation has a positive effect, since it lowers the numbers of incidents and illnesses in the long run.

Moreover, other studies put into perspective the positive impact of individualizing the insurance premium. It is noteworthy that any reductions can be slight and introduced after considerable delay. Also, some doubt that employers are up to speed with these subtleties, given the complexity of the pricing system.

The upshot is that the level of the insurance premium promotes prevention if it is in line with the frequency of claims, all the while driving employers to carefully manage compensation claims. Equally, more generous compensation leads to more sick-leave which is, on average, longer in duration. On that point, the phenomenon relates more closely to claims that would not have otherwise been made than to extra risks taken by workers.

More recent studies<sup>17</sup> show that generous compensation still tends to lead to an increase in the length of sick-leave but does not influence the number of claims. This relates to restrictive measures taken by states, insurers and employers in response to the rising cost of incidents at work and occupational illnesses since the start of the 1990s.

It is worth keeping in mind that conclusions on the impact of the individualized premium are contradictory and that further study is recommended by the papers EUROGIP has consulted.

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<sup>17</sup> See Workers' Compensation: Recent Developments in Moral Hazard and Benefits Payments by Xuguang Guo and John F. Burton, Jr. in volume 63 n° 2 (Jan 2010), pp. 340-55, Industrial and Labor Relations Review.



## 4 Financial data

### 4.1 General

This data is sourced from the National Academy of Social Insurance, (**NASI**). NASI studies a number of insured employers that is less than that studied by the BLS. Indeed, uninsured subjects who benefit from certain exemptions have been ignored. On the other hand, employees in the private sector who come under the Federal Employees' Compensation Act (**FECA**) system or other related systems are included. Self-employed persons are not. The following financial data concerns nearly 131 million workers covered by various types of insurer.

Cost of insurance and amounts of benefits paid – 2008 data

	2008
<b>Number of insured workers (in thousands)</b>	<b>130,643</b>
Benefits paid per \$100 of salary	0.97
<i>For medical costs<sup>(1)</sup></i>	<i>0.50</i>
<i>To compensate lost wages<sup>(1)</sup></i>	<i>0.48</i>
Estimation of the average cost for employers <sup>(1)</sup>	1.33
<b>Total benefits paid<sup>(2)</sup></b>	<b>57.6</b>
<i>For medical costs<sup>(2)</sup></i>	<i>29.1</i>
<i>To compensate lost wages<sup>(2)</sup></i>	<i>28.6</i>
<b>Total cost for employers<sup>(2)</sup></b>	<b>78.9</b>

Cost given in unit dollar (1) and in billions of dollars (2)

At an exchange rate of 1 euro = 1.44 USD (applicable on 27/07/2009), the total sum of payments made amounted to a little over EUR 40 billion for a total cost of EUR 54.79 billion.

### 4.2 Benefits paid

According to the NASI, the combined total of payments attributable to medical costs and loss of earnings compensation comes to USD **57.633** billion (EUR 40.03 billion) in 2008, 4.4% more than in 2007. These payments are made by various types of insurers.

2008 benefits paid per type of insurers:

Type of insurers	Amount in dollars	Amount in euros	As percentage of total payment
Private insurers	30.150	20.94	52.3
State funds	10.482	7.28	18.2
Federal State	3.424	2.38	5.9
Self-insurance	13.578	9.43	23.6
<b>Total</b>	<b>57.633</b>	<b>40.03</b>	<b>100.0</b>

Amount in billions

This **57.633** billion is divided between:

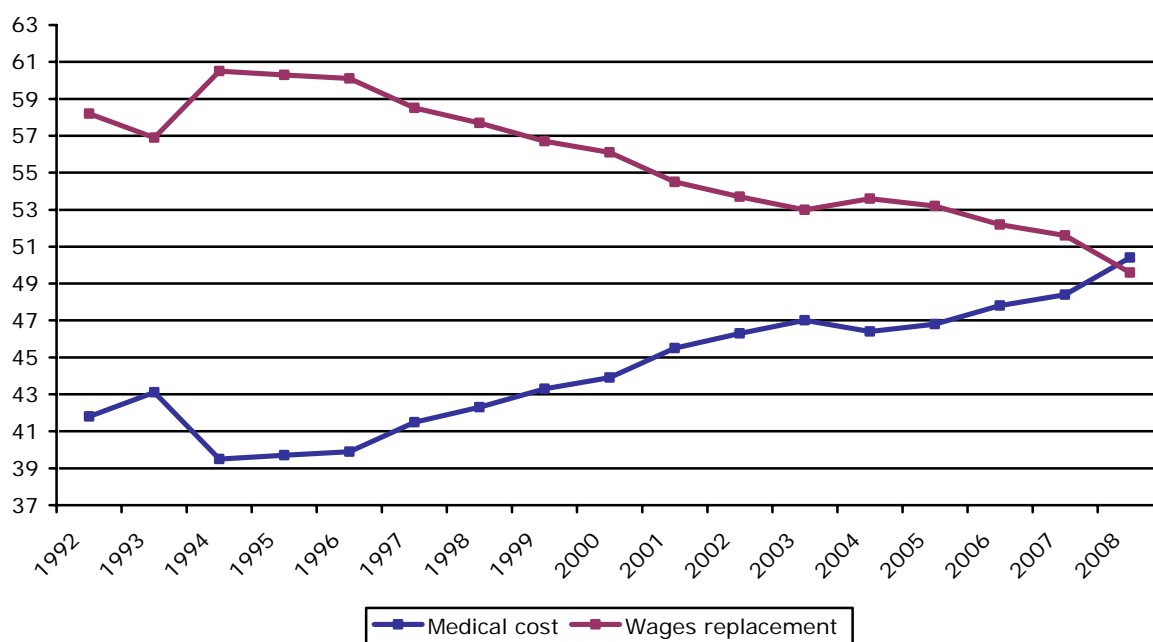
- Medical expenses which account for USD **29.1** billion (EUR 20.21 billion), an increase of 8.8% on 2007;
- The amount given in compensation for loss of earnings increased by 0.3% to USD **28.6** billion (EUR 19.86 billion).

Moreover, as a percentage of the 57.633 billion total, deductibles accounted for 13.2%, or 7.6 billion. This can be assimilated to self-insurance. Deductibles of state funds rose to 0.9% of the total, or 510 million. Combining these two elements (8.11 billion) with standard self-insurance (23.6%) gives 37.7% of total compensation, or USD 21.72 billion (EUR 15 billion).

In 2008, for the first time, medical expenses (50.4% of the total) exceeded the cost of compensating loss of earnings, which has been steadily decreasing since 1994, as shown by the following graph. The two trends are developing in opposite directions.

“Compensation” refers to sums transferred in a calendar year to a victim or health professional. “Employers’ costs” refers to sums paid to victims, administrative costs and / or insurance premiums.

Compared trends of the medical cost and the wages replacement's cost in percentage of the total amount of paid benefits



### 4.3 Costs for the most serious incidents

Daily payments are only made after a period of delay of between 3 and 7 days, depending on the state. In most cases, sick-leave does not last longer than this period of delay.

A study looking at the period between 1998 and 2005 in 41 states has shown that cases where medical expenses were incurred but not these daily payments accounted for 77% of cases where compensation was available, but only 8% of total costs. The other 23% of cases account, therefore, for 92% of total medical expenses and daily payments<sup>18</sup>.

Distribution of the work stoppages according to their length

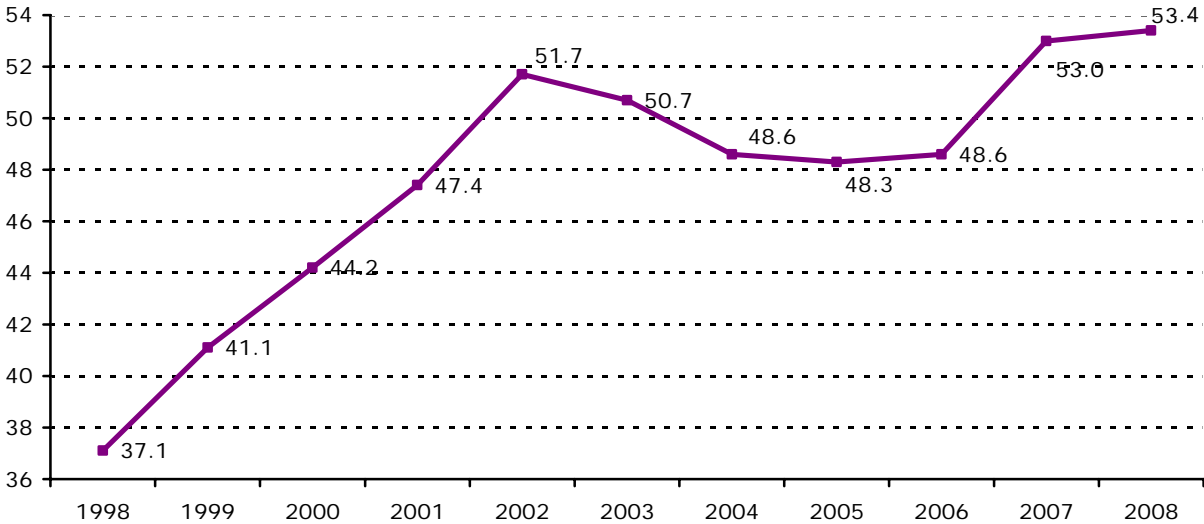
Length	2008		2009	
	Number	%	Number	%
1 day	160,190	14.9	140,400	14.5
2 days	118,600	11.0	105,900	11.0
3 to 5 days	192,180	17.8	168,500	17.5
6 to 10 days	127,920	11.9	120,370	12.5
11 to 20 days	126,060	11.7	110,590	11.5
21 to 30 days	73,370	6.8	61,600	6.4
31 days and over	279,830	26.0	257,630	26.3
<b>Total</b>	<b>1,078,140</b>	<b>100.0</b>	<b>964,990</b>	<b>100.0</b>

<sup>18</sup> NCCI study of 41 States for the period 1998-2005

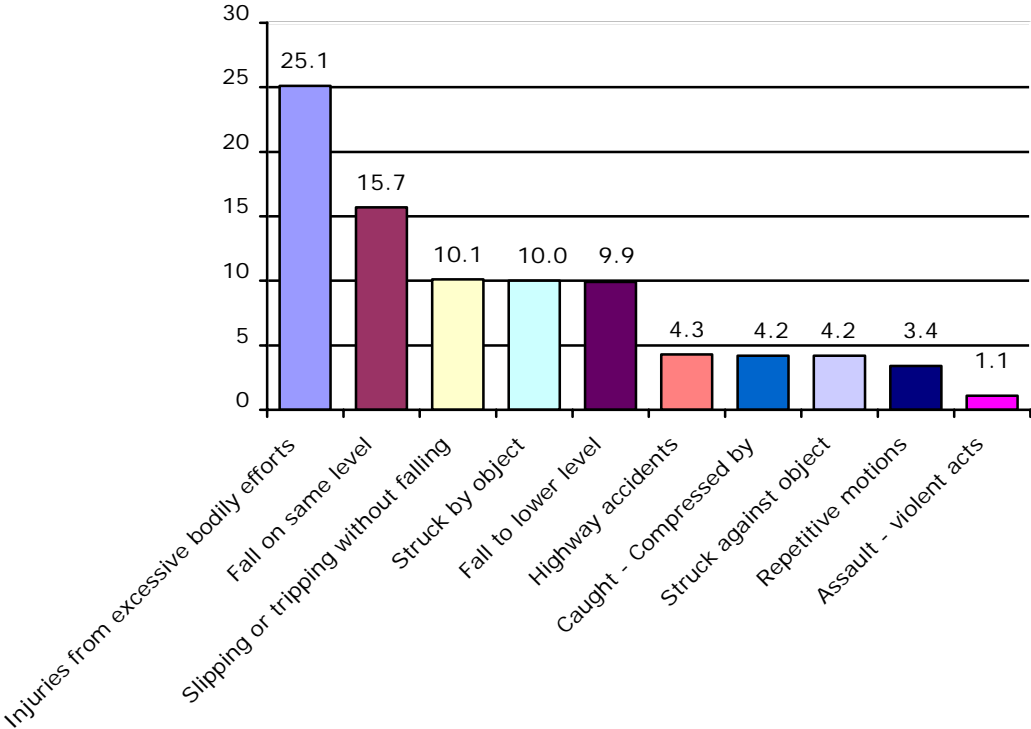
According to the Liberty Mutual Workplace Safety Index, compiled by Liberty Mutual, the BLS and the NASI, the total cost (those covered by the workers compensation insurances) of the main types of injuries causing at least six days away from work rose to USD 53.42 billion (EUR 37.10 billion) in 2008, more than 1 billion dollars (690 million euros) per week for 607,170 cases recorded.

This total has increased by an average 2% per year (inflation taken into account) from 1998 to 2008.

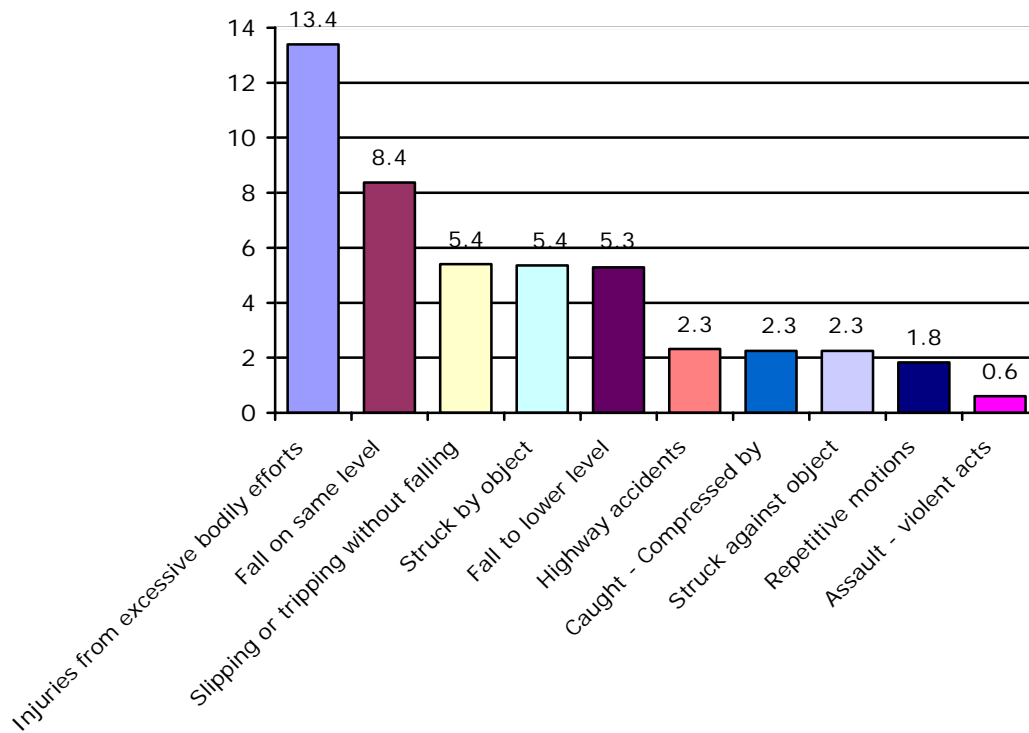
1998-2008 trend of the serious incidents at work costs in billions of dollars



Main causes of incidents expressed in percentage of the total costs



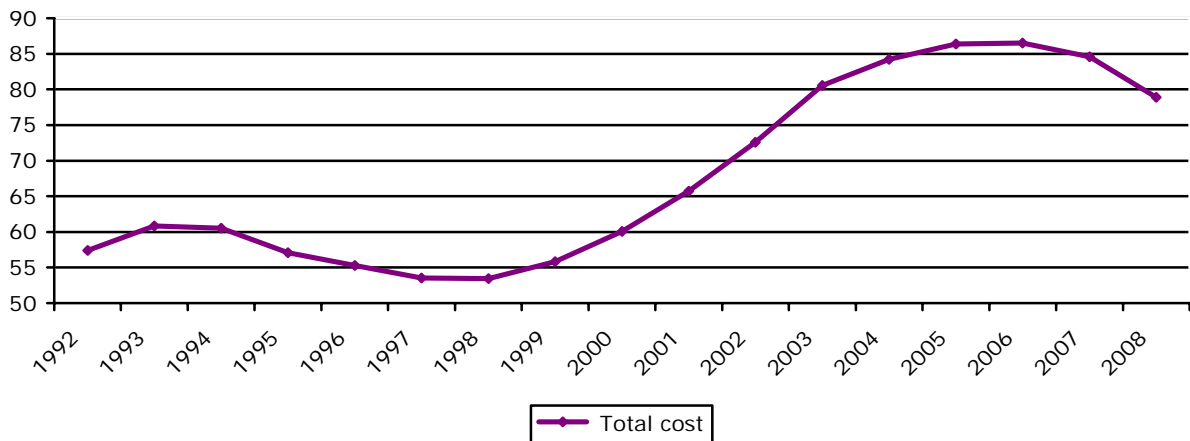
Cost of the main causes of incidents in billions of dollars



#### 4.4 Cost of insurance

In 2008, the total cost of insurance in its many forms was, for employers, USD **78.9** billion (EUR 54.79 billion), a decrease of 6.7% on 2007. "Cost" includes the total of payments made, administrative costs and / or the insurance premium. This downward trend since 2005 can be explained by a reduction in pay-outs for loss of salary in all areas, California in particular.

Insurance total cost's trend in billions of dollars



Source: Workers' Compensation: Benefits, Coverage, and Cost, 2008. National Academy of Social Insurance

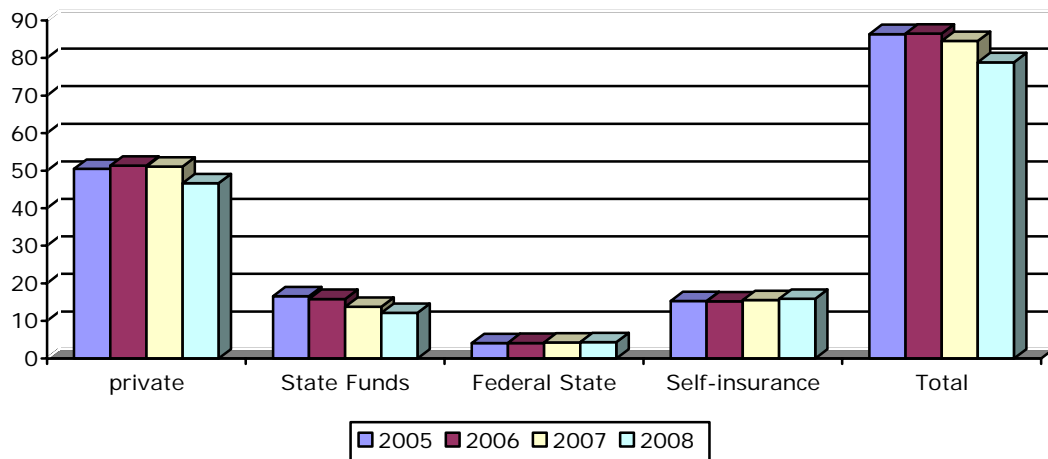
## 2008 insurance costs distributed per type of insurers

Type of insurers	Amount in dollars	Amount in euros	In percentage of total cost
Private insurers	46.6	32.36	59.1
State Funds	12.1	8.40	15.3
Federal State	4.3	2.99	5.5
Self-insurance	15.9	11.04	20.1
<b>Total</b>	<b>78.9</b>	<b>54.79</b>	<b>100.0</b>

Amounts in billions

The sum of USD 4.3 billion (EUR 2.99 billion) paid by the federal government accounts for the cost of payments made to employees under contract with the federal government under the FECA scheme, and other associated schemes (workers exposed to radiation, dock workers, etc.) as well as the cost of managing each of these federal schemes.

Distribution of the insurance costs from 2005 to 2008 in billions of dollars per type of insurer



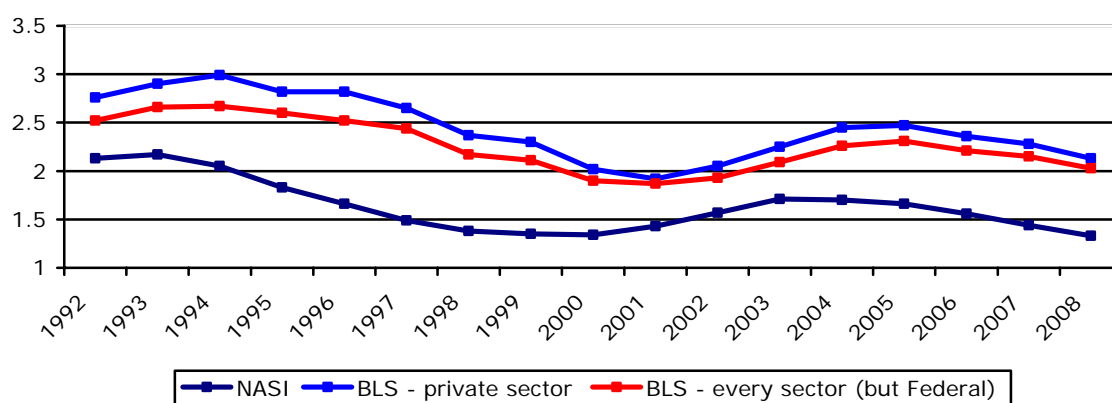
In 2007, 60% of the 131 million workers were insured by private insurers, 17% by state funds, 5% by the federal government and 18% worked in businesses that were self-insuring. The total cost of insurance was USD 85 billion, a little more than EUR 59 million.

### 4.5 Different perspectives on the cost of insurance

No exposé of the costs of insurance would be complete without a word on the three estimates made for the cost of insurance by portions of \$100 (€69.44) in the salary.

For 2008, the NASI's estimate was \$1.33 (€0.92). This relates to almost 131 million employees (black trend line on graph). As for the BLS, it gives a level of \$2.13 (€1.48) for the private sector, 115 million employees (blue trend line), and a rate of \$2.03 (€1.47) for all employees, except those covered by a federal scheme, around 134 million employees (red trend line). See point 6.1 below on the makeup of the working population.

## Insurance cost's trends per \$100



Source: Burton calculation from BLS Costs for Employee Compensation data

It is worth noting that the trend lines have been showing a downward trend over the past few years.

The NASI estimates include private sector workers, state employees, local government employees and those covered by a federal scheme. Rates are calculated solely on the basis of the earnings of insured employees. Data is collected at state level in every state, and then transposed to federal level.

However, the BLS data is calculated on the total earnings of employees, whether they be insured or not. This data excludes employees covered by federal schemes. Data on costs are available by industry, by profession, by size of business but are not available by state.

Sources consulted by EUROGIP point out methodological differences, but do not comment on the wide spread of rates according to calculation method. This spread has been recognized and work is in progress on this subject. Coming NASI publications are set to give greater detail on methods used to set these rates.

### 4.6 Note on different types of insurers

Private sector employers can choose between private insurance, state fund insurance, and self-insurance. In most states, all are available. However, in 2009, private insurance was not available in four states: North Dakota, Ohio, Washington state, and Wyoming. These four states had a state fund only. Moreover, in North Dakota and Wyoming, self-insurance is not permitted, although it is in Ohio and Washington.

In 47 out of 51 states, employers can legally take out private insurance. In 2008, the total amount of premiums came to USD 46.637 billion (EUR 32.36 billion).

Employers can opt for a state fund in 26 states. This option is responsible for USD 12.074 billion worth of premiums (EUR 8.4 billion). Despite appearances, this is not a system of insurance managed by the civil service. They complement and compete with private insurers. Though they operate according to the rules of the market, they are not for profit organizations and refund surpluses to their clients once pay-outs and administrative costs have been met.

State funds are often the insurer of last resort for employers who have a history of occupational risks. They only operate within their state and deal exclusively with occupational risks. The Californian state fund, for example, has insured an average of one in five businesses since its creation in 1914.

However, the fact that that state funds can be exclusive, does not mean that they are completely secure. For example, the West Virginian fund, willfully underfinanced, almost went bankrupt. That state has since opted for private insurance.

The self-insurance system allows large businesses or groups which have sufficient financial clout and who obtain the necessary authorization to be their own insurer. They assume the costs of medical intervention and paying replacement salaries to the victims of incidents at work and occupational illnesses. USD 15.831 billion (EUR 11.04 billion) corresponds to the sum paid directly by employers and spent on administrative costs in 2008.

The first collection of statistics took place toward the end of the 19<sup>th</sup> century. Then, during the First World War, the Bureau of Labor Statistics (BLS) published the first report on occupational illnesses in the metals industry. The first studies on occupational illnesses date from the start of the 20<sup>th</sup> century. Though the BLS continued to publish annual statistics, considerable gaps appeared over the years.

The OSH Act legislation in 1970 impacted upon two important points as far as producing statistics was concerned. The OSH Act defines the obligation for certain categories of employers to keep a **record**<sup>19</sup> of all incidents at work and occupational illnesses, whether or not time off work had to be taken as a result. The OSH Act also provides for the putting in place of an **integrated** statistical system for the recording of incidents and illnesses in the private sector.

- In the business's internal record, all incidents at work and occupational illnesses, except minor ones<sup>20</sup>, are recorded using form n° 300, the Log of Work-Related Injuries and Illnesses. In addition, each incident is described using form n° 301, the Injuries and Illnesses Incident Report. These rules apply to all private enterprise with at least 11 employees who undertake high risk activities (see point 5.1). These obligations in fact only cover a small percentage of businesses and the working population. In its October 2009 report<sup>21</sup>, the US Government Accountability Office, (**GAO**) notes that 83% of employers are not concerned,

<sup>19</sup> See <http://www.osha.gov/recordkeeping/index.html> for more information on recording methods.

<sup>20</sup> It should be underlined that the emphasis here is on the seriousness or otherwise of the injury. This issue is highlighted as a difficulty that employers face when deciding whether or not to record an incident.

<sup>21</sup> "Enhancing OSHA's Records Audit Process could improve the Accuracy of Worker Injury and Illness Data"

either because of having less than 11 employees, or because their activities are considered historically less risky. They are therefore exempt from recording incidents under the OSH Act.

- To produce these statistics (see point 5.2), the BLS developed in 1972 the annual Survey of Occupational Injuries and Illnesses (**SOII**). Problems having been identified, the statistical system was expanded and re-established in 1992. In its new form, the recording of fatal incidents has been separated from the rest into its own Census of Fatal Occupational Injuries (**CFOI**).

Since 1992, the BLS has published its statistics in three principal publications:

- The *National Census of Fatal Occupational Injuries* dealing with fatal incidents;
- The *Survey of Occupational Injuries and Illnesses* dealing with all non-fatal work related incidents and illnesses;
- The *Nonfatal Occupational Injuries and Illnesses Requiring Days away From Work* which details incidents and illnesses that require at least one day away from work.

The last two categories present incidents and illnesses on the same terms. Separating occupational illnesses from the total figure is only possible for a small fraction of the data.

The entirety of these statistics is available online.

### 5.1 Recording cases under the OSH Act

Recording methods for businesses are set out by Regulation n° 1904<sup>22</sup> which is likely to be amended soon. For the moment, the obligation to record incidents and illnesses concerns businesses with at least 11

<sup>22</sup> [http://www.osha.gov/pls/oshaweb/owastand.display\\_standard\\_group?p\\_toc\\_level=1&p\\_part\\_number=1904](http://www.osha.gov/pls/oshaweb/owastand.display_standard_group?p_toc_level=1&p_part_number=1904)



employees in an industry that is considered at risk.

The obligation concerns any business that meets the threshold of 11 employees at any point in the year. If there are several organizations in one enterprise, it is the combined total that counts. For the purposes of the calculation, full time, part time, temporary and seasonal workers are all taken into account. Along with this criterion, the obligation concerns businesses operating in at risk industries (agriculture, construction, transport, etc.). Industries that are not concerned can be found in an exhaustive list<sup>23</sup>. For example, restaurants and banks are dispensed of the obligation to record whatever the size of their workforce. When the business is concerned of several organizations, it is at this level that the recording takes place.

As soon as an establishment is subject to the obligation to record, incidents and illnesses must fulfill certain criteria. It is up to the employer to decide whether or not an accident or illness merits recording. To fall into the definition of accident at work or occupational illness, an incident must be the result of an event or an exposure in the course of employment and be the cause of the worker's condition or be shown to have substantially contributed thereto.

In deciding whether a case merits being recorded, the following should be taken into account:

- Death, loss of consciousness, length of sick-leave;
- Whether a worker has to be assigned less strenuous duties, or a new task altogether;
- Necessary treatment going beyond first aid;
- Serious injuries or illnesses as diagnosed by a doctor or other health professional, such as occupational cancers, irreversible chronic illnesses, bone fractures or fissures, or perforated eardrums.

Elements that can lead to a case being recorded:

<sup>23</sup> <http://www.osha.gov/recordkeeping/ppt1/RK1exempttable.html>

- Pricks and cuts by needles and other objects that have been in contact with the blood of infected people or all other potentially infectious materials;
- Where an employee has to leave his or her job for medical reasons, in line with the OSH Act;
- Cases of infection by tuberculosis after a positive result in a cutaneous test or a diagnosis by a doctor or another health professional, after coming into contact with someone known to have tested positive for the illnesses;
- Hearing tests that show a loss of hearing after exposure to loud noise.

Injuries considered minor because they require only first aid at the site of injury and not formal medical treatment, usually because they have not caused a loss of consciousness, have not prevented the employee from working or restricted his or her mobility and because they have not required the employee to be assigned different work tasks, do not have to be recorded.

It is worth noting that fatal incidents and those that require the hospitalization of more than three people have to be declared by the employer to the OSHA within 8 hours of the incident. This obligation concerns all businesses, without taking into account size or the industry in which the business operates.

However, industries exempt from recording because of their size or activity can be made subject to the declaration obligation at the request of the OSHA or the BLS, especially if they are selected as part of the SOII sample (see below).

## **5.2 Statistical methodology of the BLS**

To investigate incidents and illnesses in businesses, the BLS uses the SOII survey for non-fatal cases and the CFOI census for fatal incidents at work.

### **5.2.1 Identification of non-fatal incidents and illnesses by the SOII**

Injuries and illnesses that are non-fatal, with or without sick-leave, are identified during the annual SOII survey. The survey uses a random sample of around 240,000

establishments<sup>24</sup> with at least 11 employees, working in at-risk industries and permanently subject to the OSH Act obligation to record incidents and illnesses, as well as some of those who do not meet these criteria. The sample does have some exemptions, in so far as self-employed workers, agricultural operations with less than 11 workers, domestic workers and federal workers are not included.

The statistical unit employed is the establishment, defined as a single physical space used for a commercial, industrial or service activity. Selection methods mean that establishments with a large workforce are routinely selected, while smaller ones will be selected less frequently. The same business can often have several of its establishments selected.

Concretely, at the end of year (N-1), the establishments are selected and warned that they will have to send to the BLS their incidents and illness data for the reference year (N). To do so, at the beginning of the following year (N+1), they receive a questionnaire<sup>25</sup> on which the statistics from the previous year are written<sup>26</sup> with the aid of forms 300 and 301. Record keeping is obligatory for those enterprises subject to the OSH Act recording obligation. For those not subject to that obligation but who have been selected, incidents and illnesses are recorded on identical forms, but only for the reference year.

The response level for establishments is actually relatively high. Where there is delay, the local agency chases the business up. Some fail to respond either out of a pure and simple refusal, or because they go out of business. In order to take into account these issues, the data is modified accordingly.

The SOII study is a co-operation between the state and the federal government which finances it. Around 44 states take part. They collect and analyze the data according to a procedure and using IT systems provided by the BLS. So as to

<sup>24</sup> Out of 8 million businesses that fall under the scope of the OSH Act

<sup>25</sup> The questionnaire is addressed to businesses directly by the local BLS office in the states that do not participate.

<sup>26</sup> <http://www.bls.gov/respondents/iif/forms/soii2010.pdf>.

collect data for the entire country, the BLS operates directly in states that do not take part in the survey, this via their regional offices. As such, state specific estimations are only available for those states that participate. Whether the data collection is conducted by the state or by the BLS, the process is identical.

For more information on the SOII, see: [http://www.bls.gov/opub/hom/homch9\\_a1.htm](http://www.bls.gov/opub/hom/homch9_a1.htm)

### *5.2.2 Fatal incidents identified by the CFOI*

The CFOI compiles all data about fatal incidents at work in a calendar year. The CFOI does not deal with occupational illness.

In order to collect this data, the CFOI uses various sources (from the states, federal sources and independent sources) to identify, check and describe fatal incidents. The data is collected on an on-going basis throughout the year, from various documents, such as death certificates, reports on workers' compensation, federal reports (OSHA) and newspaper articles. In 2009, more than 17,000 sources were used. To avoid doubling of the data, given the numerous sources, a check is made against the surname of the deceased. The process is conducted on a contractual basis with the states; the running costs are shared equally between the states and the federal government. The information is coded by the state and entered into the national IT system which checks the data and its coherence.

The CFOI covers private sector employees from all sectors, including agricultural workers in operations of fewer than 11 workers. It also covers self-employed workers, at-home workers and all employees of the federal government, states and local government. There is no sampling as all states take part in the CFOI.

For more information on the CFOI, see: [http://www.bls.gov/opub/hom/homch9\\_a1.htm](http://www.bls.gov/opub/hom/homch9_a1.htm)

### *5.2.3 Coding*

Once the SOII data has been collected from the sample establishments, they are coded by the states according to the system set out as part of the Occupational

Injury and Illness Classification System (OIICS)<sup>27</sup>. The same is true for the CFOI.

The coded data from the states is then collected, checked and sorted by the BLS at the national level, who has the duty to analyze and publish it at the national level.

The SOII uses four variables to describe incidents and illnesses that lead to sick-leave, and the CFOI adds a fifth for fatal incidents.

The variables employed are the following:

1. The **nature of the incident** or the physical attributes of the injury or illness, such as a cut, fracture or electrocution;
2. The **place of injury**: arm, finger, back, etc. This is directly linked to the nature of the incident just described;
3. The **event** or **exposure** at the root of how the accident or illness has affected the victim, for example a fall, a vehicular accident, overwork or exposure to electricity;
4. The **source**, object, substance, exposure or action by the victim that led directly to the incident, such as a machine, the ground or an electrical cable;
5. The **secondary source** which identifies the object, the substance or the person at the root of the injury or illness or who contributed to the event or the exposure, such as for instance ice or water.

### 5.3 Debate

Though the data collected by the BLS shows a fall, it is considered imperfect by some and should be two or three times more comprehensive. These considerations led to a Congressional hearing being held<sup>28</sup>. Criticisms focus on non-fatal incidents. Data on fatal incidents is seen as being more reliable. On the other hand, data on fatal occupational illnesses is non-existent.

<sup>27</sup> <http://www.bls.gov/iif/oshoiics.htm>

<sup>28</sup> See transcripts of the 19/06/2008 House of Representatives hearing entitled *Hidden Tragedy: Underreporting of Workplace Injuries and Illnesses*  
[http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110\\_house\\_hearings&ocid=f:42881.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&ocid=f:42881.pdf)

#### 5.3.1 The under-reporting of non-fatal incidents and illnesses

Various academic studies agree that under-reporting is a problem. The following paragraphs summarize, if incompletely, a debate relating to several issues.

The first issue relates, beginning with the total of incidents reported across all of the different systems, to a comparison between those reported by the SOII and those reported by insurers after compensation. In Michigan, a study<sup>29</sup> conducted between 1999 and 2001 shows that the SOII identifies two times fewer incidents, or 38.8% of incidents, than insurers, which identify 78.8%. Moreover, the SOII identifies cases for which the connection with employment is easy to identify, whereas insurance identifies more complex cases, including musculo-skeletal disorders. This study forms the basis of the estimates and comparisons published every year by the American Labor Federation, AFL-CIO (see below). Another study<sup>30</sup>, making similar comparisons, suggests that on average the SOII identified 69% of cases that end in compensation in the six states studied, with an identification rate that varies between states, from 56% to 80%. It appears that the data produced by insurers is more comprehensive.

The second issue concerns the under-reporting of incidents which, because not reported, escape the SOII and insurers since they are not compensated. An extension to the study conducted in Michigan, cited above, estimates this under-reporting to be at around 16.5%. The second study cited puts it at somewhere between 3% and 13%, depending on the state.

However, the methods used by these studies have been criticized by the BLS. The interdependence of the two variables, reporting to the BLS and to insurers, has

<sup>29</sup> Rosenman, Kenneth D., Alice Kalush, Mary Jo Reilly, Joseph C. Gardiner, Matthew Reeves and Zhewui Luo, —How Much Work-Related Injury and Illness is Missed by the Current National Surveillance System, *Journal of Occupational and Environmental Medicine*, 42, April, 2006, p. 357-65

<sup>30</sup> Boden, L. and A. Ozonoff(2007), "Capture-Recapture Estimates of Nonfatal Workplace Injuries and Illnesses", *Annals of Epidemiology*, p. 261-267

been identified as introducing a bias that decreases the apparent seriousness of the under-reporting.

A third issue looks at the effectiveness of the controls put in place by the OSHA, and administrative changes. As such, the attribution of a decrease in incidents and illnesses at work to improved safety is contested. In fact, at least 83% of it should be attributed to modifications in recording methodology and the weakness of the agency in controlling recording by employers<sup>31</sup>. In truth, the quality of the BLS statistics depends on the quality of the recording done by employers in the initial stages. The BLS has no power to control that; that job falls to the agency which uses a survey to audit the recording done by at-risk employers. Numerically, the number of checks is feeble, compared with the potential number. The GAO says that around 250 audits take place each year, for 130,000 at risk workplaces. Also, at least 8 at-risk activities are not subject to control by the agency because, for that to be so, it would require new regulations. On the other hand, these audits show that deliberate omissions are infrequent and that over-reporting can exist.

<sup>31</sup> Friedman, University of Illinois

It must be kept in mind that in its current state, the system leaves the job of evaluating whether or not an occupational injury, for instance MSDs, has a link with employment to the employer. Reporting occupational illnesses, such as cancers, can be a problem given the delay in illnesses manifesting themselves and the difficulties that can be experienced in making a link with present or former employment. More frequent intervention by doctors is put forward as a means of improving the system.

The following table underlines the disparities between collected data. It is published annually by the AFL-CIO. Estimates are made according to theories espoused by Kenneth D. Roseman et al in their article "How much Work-Related Injury and Illness is missed by the Current National Surveillance System?" In this study, the performance of the various recording systems is compared.

The BLS figures relate to the private sector, state employees and local government employees. It seems that the AFL-CIO has not yet taken into account the recent expansion in the BLS's coverage of the workforce and it has been suggested that this distorts the reality of the situation.

Type of data	2008 estimation	2009 estimation	2008 BLS data	2009 BLS data
Total number of non-fatal occupational injuries	11.1 millions	11.1 millions	3.7 millions	3.3 millions
Frequency rate (per 100 workers) for non-fatal occupational risks of the private industry	11.7	11.7	3.9	3.6
Total number of occupational injuries with work stoppage of the private industry	3.3 millions	2.9 millions	1.1 million	0.965 million
Frequency rate (per 100 workers) for occupational injuries with work stoppage	3.39	3.18	1.13	1.06
Total number of MSD with work stoppage	952,320	851,400	317,440	283,800
Estimation of the total MSD number	3,259,959	2,890,932	1,086,653	963,644

Source: Death on the Job. The Toll of Neglect. AFL-CIO.

### 5.3.2 Proposed measures

These criticisms have not been left without response. Since 2008, municipal and state employees have been included in the SOII.

The BLS also conducts its own investigations and has identified certain technical limitations in the system. Firstly, the identification rate used in studies that alleged that undercount in the SOII, is lower for businesses which have several

establishments than for those with just one. This relates to the fact that information on compensation is centralized at the company's seat, whereas the statistical unit for the SOII is the establishment.

Surveys<sup>32</sup> show that more complex and / or easily contested conditions are less frequently recorded. This is notably the case for carpal tunnel syndrome, hearing loss or where there might be a multiplicity of conditions.

There is also the problem of cases where the decision to compensate or not is delayed or contested, taking it outside the reference year. Moreover, the SOII identifies few incidents that cause some expense but no sick-leave.

The BLS has come together with partners to conduct other studies which should report their findings at the end of 2012. The intention is, in particular, to better understand the discrepancies in identification of incidents and illnesses across the different systems, identifying biases in previous studies and eventually to produce strategies to increase the coverage of the SOII. The difficulties experienced by employers in managing records will also be analyzed.

Finally, the use of multiple information sources will be tested with three states and two types of variables. One will be an easily identifiable serious accident like

amputation, and the other carpal tunnel syndrome which is less easy to diagnose. However, on that point, the BLS has remarked on the cost of using multiple sources at federal level.

In response to the attention given to under-reporting by Congress and to the GAO report, the agency, the BLS and the NIOSH are exploring conjointly measures to combat it. The GAO report had underlined the deficiencies in the agency's quality control procedures for data recorded by businesses. It also highlights the pressure placed on employees not to declare. This report had identified a number of incentives for employers and employees not to declare incidents and illnesses on the business's records.

The agency has launched a national program for the study of data recorded by businesses in high-risk sectors and those having abnormally low declaration rates. In parallel with the study on quality, the agency plans to examine business practices that discourage workers from reporting an accident or an illness, such as disciplinary actions or dissuasion.

In conclusion, if the BLS does not contest the existence of under-reporting and it does welcome studies on the subject. It remains prudent when it comes to the under recording's importance and does not answer for the seriousness which is given to it. It points out, moreover, studies it is conducting that look at modifications to its working practices that might help with the problem.

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<sup>32</sup> For instance refer to Nicole Nestoriak, Brooks Pierce – Comparing Workers' Compensations claims with establishments' responses to the SOII, Monthly Labor Review, May 2009, p. 57-64  
<http://www.bls.gov/opub/mlr/2009/05/art4full.pdf>

## 6 Occupational injuries data

### 6.1 Main data

Employed population

Per sector	2008	2009
Workers of the private industry	115,035.1	111,469.1
State government workers <sup>33</sup>	4,841.6	4,883.2
Local government workers <sup>34</sup>	13,840.9	13,963.6
<b>Total</b>	<b>134,035.1</b>	<b>130,315.8</b>

Data are given in thousands. Because of rounding data may not sum up to the totals.

In 2010, there were a little bit less of 310 million inhabitants within the country.

Total BLS recorded non-fatal incidents at work and occupational illnesses of the private industry, State and local governments' workers

Per sector	2008	2009
Workers of the private industry	3,696.1	3,277.7
State government workers	196.8	193.0
Local government workers	741.2	670.0
<b>Total</b>	<b>4,634.1</b>	<b>4,140.7</b>

Data are given in thousands. Because of rounding data may not sum up to the totals. Occupational injuries for farms with less than 11 workers are excluded.

Distribution of the BLS recorded non-fatal incidents at work and occupational illnesses of the private industry, State and local governments' workers

Per sector and per kind of injury	2008	2009
Workers of the private industry	3,508.7	3,111.5
State government workers	182.5	180.2
Local government workers	685.2	624.5
<b>Incidents at work total</b>	<b>4,376.3</b>	<b>3,916.1</b>
Workers of the private industry	187.4	166.2
State government workers	14.4	12.8
Local government workers	56.1	45.5
<b>Occupational injury total</b>	<b>257.8</b>	<b>224.5</b>
<b>Total</b>	<b>4,634.1</b>	<b>4,140.7</b>

Data are given in thousands. Because of rounding data may not sum up to the totals. Occupational injuries for farms with less than 11 workers are excluded.

<sup>33</sup> Prison staff and certain police and health workers are state employees.

<sup>34</sup> Primary school teachers, firemen, and most police and health workers are employed by local government.

Number of BLS recorded non-fatal incidents at work and occupational illnesses with at least one day away from work of the private industry, State and local governments' workers

Per sector	2008	2009
Workers of the private industry	1,078,140	964,990
State government workers	71,100	75,840
Local government workers	206,580	197,660
<b>Total</b>	<b>1,355,820</b>	<b>1,238,490</b>

Data are given in units  
Occupational injuries for farms with less than 11 workers are excluded.

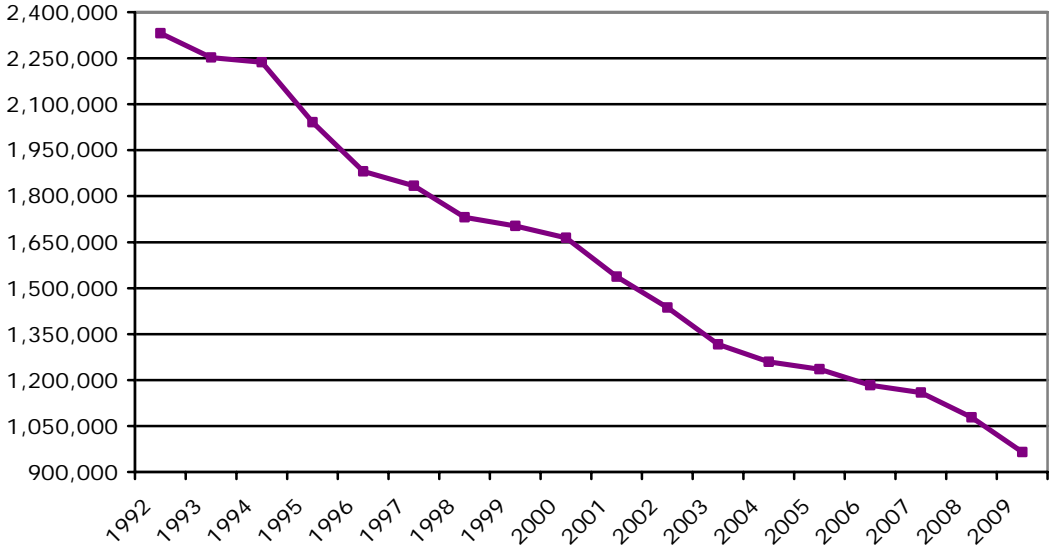
Frequency rate of the BLS recorded non-fatal incidents at work and occupational illnesses with at least one day away from work of the private industry, State and local governments' workers

Rate per sector	2008	2009
Workers of the private industry	113.3	106.4
State government workers	170.0	180.0
Local government workers	194.6	184.8
Global rate	123.3	117.2

Data given as a frequency rate  
Occupational injuries for farms with less than 11 workers are excluded.

The frequency rate is the ratio of the number of occupational injuries divided per 10,000 full-time equivalent workers (FTEs) and multiplied by 20,000,000 (10,000 FTEs x 40 hours per week x 50 weeks per year).

Trend of the number of recorded occupational injuries with days away from work



Trend of the number of incidents at work and occupational injuries with days away from work for the private industry. Occupational injuries for farms with less than 11 workers are excluded.

Source: BLS

Distribution of occupational injuries according to the number of days away from work

Number of days	2008	2009
1 day	160,190	140,400
2 days	118,600	105,900
3 to 5 days	192,180	168,500
6 to 10 days	127,920	120,370
11 to 20 days	126,060	110,590
21 to 30 days	73,370	61,600
31 days and over	279,830	257,630
<b>Total</b>	<b>1,078,140</b>	<b>964,990</b>

Source: BLS

Detailed 2008 and 2009 final data for non-fatal occupational injuries with days away from work of the private industry

Characteristics	2008	2009
<b>Total</b>	<b>1,078,140</b>	<b>964,990</b>
<b>Gender</b>		
Men	688,790	596,930
Women	384,930	363,930
<b>Age</b>		
Under 14 years	-	20
14-15 years	130	160
16-19 years	31,010	22,330
20-24 years	107,880	91,780
25-34 years	239,580	209,670
35-44 years	251,490	231,750
45-54 years	261,030	236,030
55-64 years	142,840	132,110
65 years and over	28,420	27,620
Non forwarded data	15,740	13,520
<b>Occupation</b>		
Management, business, financial occupations	26,310	26,240
Professional and related occupations	80,790	80,460
Services occupations	235,340	236,760
Sales and related occupations	69,410	68,290
Office and administrative support occupations	80,410	68,990
Farming, fishing, and forestry occupations	13,510	11,410
Construction and extraction occupations	120,890	90,060
Installation, maintenance, and repair occupations	93,880	84,290
Productions occupations	138,890	108,470
Transportation and material moving occupations	217,070	187,930
<b>Activity branch</b>		
Goods producing	311,890	241,310
Services providing	766,250	723,680
<b>Event or exposure</b>		
Transportation incidents	48,610	42,180
Assaults and violent acts	22,690	22,720
Contact with object or equipment	291,880	254,680
Falls to lower level / on same level	225,190	204,440
Overexertion	250,960	227,260
Fires and explosion	2,320	1,920
Exposure to harmful substances or environments	45,480	42,870
Slip, trip, loss of balance without fall	35,420	32,490
Repetitive motion	30,920	30,790
All other events	124,670	105,650

Source: BLS

These data do not include farms with less than 11 workers.



## 6.2 Fatal incidents at work

For all the following tables detailing fatal incidents at work, data include the workers of farms with less than 11 workers, self-employed workers, family workers, federal, state and local governments' workers.

These data come from the CFOI, Census of Fatal Occupational Incidents, and are published by the BLS.

### 6.2.1 Private industry, federal, state and local governments' workers' fatal incidents at work

Year	Fatal incidents
2005	5,734
2006	5,840
2007	5,657
2008	5,214
<b>2009</b>	<b>4,551</b>

### 6.2.2 Private sector fatal incidents at work frequency rate

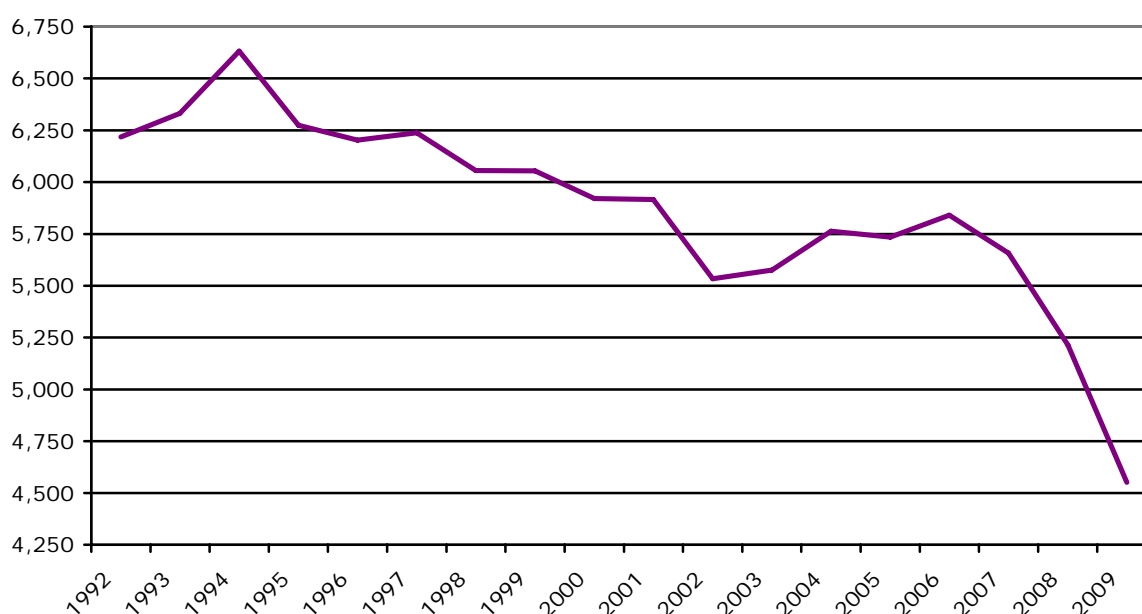
Year	Fatal incidents	Millions of worked hours	Frequency rate
2006	5,840	271,815	4.2
2007	5,657	275,043	4.0
2008	5,214	271,958	3.7
2009	4,551	254,771	3.5

Frequency rate per 100,000 workers

The frequency rate is the ratio of the number of fatal occupational incidents divided per 10,000 full-time equivalent workers (FTEs) and multiplied by 200,000,000 (100,000 FTEs x 40 hours per week x 50 weeks per year).

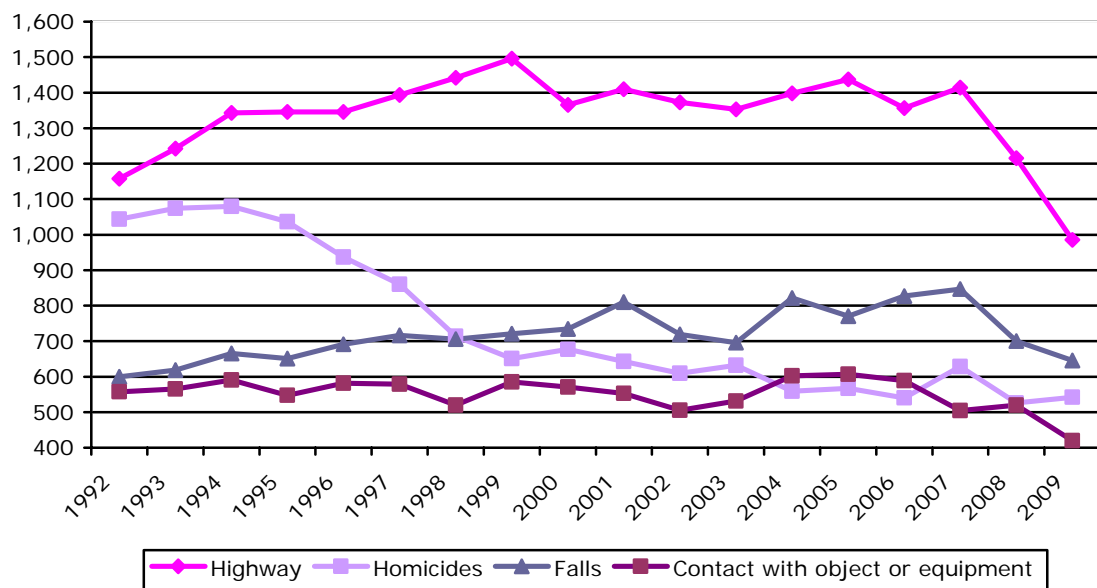
Source: BLS, CFOI for the number of fatal incidents at work  
Current population Survey (CPS) for the number of worked hours

### 6.2.3 Trend of the number of fatal incidents at work



Fatal incidents at work presented in paragraph 6.2 are those of the private sector, the federal sector, the state and local governments' workers. They include police personnel and firemen.

#### 6.2.4 The four main kinds of fatal incidents at work



From 2008 to 2009, the number of homicides within the working premises increases by 1 % as the total number of fatal incidents at work lowers from 17 %. 521 homicide cases were recorded in 2009 instead of 1,080 in 1994. About suicides within the working premises, 237 cases were recorded in 2009 against 263 in 2008.

### 6.2.5 Fatal incidents at work – final detailed data

Characteristics	2008	2009
<b>Total</b>	<b>5,214</b>	<b>4,551</b>
<b>Employment status</b>		
Private and public sectors' workers	4,183	3,488
Self-employed	1,031	1,063
<b>Gender</b>		
Men	4,827	4,216
Women	387	335
<b>Age</b>		
Under 16 years	11	13
16 – 17 years	23	14
18 – 19 years	66	57
20 – 24 years	353	275
25 – 34 years	850	704
35 – 44 years	1,113	908
45 – 54 years	1,292	1,173
55 – 64 years	920	853
65 years and over	580	551
<b>Occupation</b>		
Management, business, and financial occupations	553	538
Safety and protection	306	244
Sales and related occupations	275	290
Farming, fishing, and forestry occupations	286	239
Construction and extraction occupations	977	838
Installation, maintenance, and repair occupations	354	326
Transportation and material moving occupations	1,376	1,059
Military	57	75
Other	1,030	942
<b>Activity branch</b>		
Goods producing	2,234	1,827
Services providing	2,436	2,263
Public governmental activity	544	461
<b>Event or exposure</b>		
Transportation incidents	2,130	1,795
Assaults and violent acts	816	837
Contact with object and equipment	937	741
Falls	700	645
Exposure to harmful substances or environment	439	404
fires and explosions	174	113
Other events or exposures	18	16

Source: CFOI – Census of Fatal Occupational Injuries

## 6.3 Occupational illnesses – 2009 data

### 6.3.1 Definition

Occupational illnesses are defined as an abnormal condition or disorder caused by an exposure to factors associated with employment, other than incidents at work. It includes acute and chronic illnesses which may be caused by inhalation, absorption, ingestion, or direct contact with toxic natural or artificial materials.

Occupational illnesses are organized in five classes:

- Occupational skin illnesses or disorders (contact dermatitis, chrome ulcers, inflammation of the skin...);
- Respiratory illnesses (silicosis, asbestosis, chronic obstructive pulmonary illnesses...);
- Poisoning by lead, mercury, cadmium, benzol...;
- Hearing loss after an exposure to noise;
- And a group gathering all other illnesses: exposure to heat, to cold, effects of ionizing radiation, pathogenic illnesses...).

### 6.3.2 Recognition

In principle, to be recognized as an occupational illness, the condition must be listed as such by state legislation<sup>35</sup>. Each condition is normally listed alongside the type of employment or an activity. The two factors must be linked for there to be recognition. Open ended clauses allow for other potential cases to be covered.

In practice, however, recognition methods are more stringent than for incidents at work. This relates, essentially, to the time the illness takes to manifest itself and difficulties in characterizing the link between the condition and the employment. Certain analysts underline the fact that the legislature, employers and insurers have conspired to make recognition more difficult. However, case law has also contributed to this restrictiveness. These observers have been led to conclude that current legislation on compensating occupational illness is inappropriate and unfair<sup>36</sup>.

### 6.3.3 Statistical data

Statistical data is limited and it is difficult to isolate occupational illnesses with sick-leave from the main body of incidents and illness that give rise to sick-leave because they are compiled in identical places. Tables dealing solely with occupational illnesses are few and far between. For fatal cases, statistics are almost non-existent. At least in the state of Michigan, doctors are obliged to report occupational illnesses to health authorities. However, they do not have to report to insurers.

The absence of data is criticized, and feeds into the debate on under-reporting. In 1997, J. P. Leigh has estimated that the true figure for occupational illnesses was close to 860,000, with 60,300 deaths being attributable to an occupational illness<sup>37</sup>. The same author<sup>38</sup> notes that in 1999, cases of occupational illness giving rise to sick-leave only accounted for 7.88% of all incidents and illnesses giving rise to sick-leave. According to Leigh, the number of deaths related to occupational illnesses in 1999 was 67,100. Finally, he suggests that only a small proportion of victims are compensated. The compensation paid out would only cover 12% of the total cost, and 98.9% of fatal cases would not be compensated at all. Another study from 2003 puts the number of deaths stemming from an occupational illness somewhere between 32,200 and 78,200.

#### *Occupational illnesses with or without work stoppage – 2009 data*

Estimated number of occupational illnesses (with or without work stoppage) per type of industry and type of illnesses in thousands

In thousands	Skin illnesses or disorders	Respiratory conditions	Poisonings	Hearing loss	All other illnesses	Total
Goods producing	7.5	2.7	0.4	15.5	31.2	57.3
Services providing	18.4	11.9	1.6	4.0	73.0	108.9
<b>Total private industry</b>	<b>25.9</b>	<b>14.6</b>	<b>2.0</b>	<b>19.5</b>	<b>104.2</b>	<b>166.2</b>
State government	1.7	2.2	0.1	0.5	8.3	12.8
Local government	-	4.7	1.0	1.8	30.3	45.5
<b>Total State + local governments</b>	<b>-</b>	<b>6.9</b>	<b>1.2</b>	<b>2.2</b>	<b>38.5</b>	<b>58.3</b>
<b>Total</b>	<b>35.4</b>	<b>21.5</b>	<b>3.2</b>	<b>21.7</b>	<b>142.7</b>	<b>224.5</b>

- 1) Excludes farms with fewer than 11 employees.
- 2) Because of rounding, components may not add to totals.
- 3) - dash indicates data that do not meet BLS publication guidelines.

<sup>35</sup> The legislation varies from state to state.

<sup>36</sup> Coverage of Work-Related Illnesses by Workers' Compensation Programs. John F. Burton, Jr. Workers' Compensation Policy Review. Vol 5 Issue 3. May/June 2005

<sup>37</sup> See J. P. Leigh's estimates which look at the problem of under-declaration at : <http://www.haz-map.com/iceberg.htm>

<sup>38</sup> Occupational Illnesses and Workers' Compensation: Coverage, Costs, and Consequences. J. P. Leigh and John A. Robbins. The Millbank Quarterly, Vol. 82, No. 4, 2004, pp. 689-781

Estimated number of occupational illnesses (with or without work stoppage) per type of industry and per type of illnesses per frequency rate

Frequency rate	Skin illnesses or disorders	Respiratory conditions	Poisonings	Hearing loss	All other illnesses	Total
Goods producing	3.8	1.3	0.2	7.9	15.8	29.1
Services providing	2.6	1.7	0.2	0.6	10.3	15.3
<b>Private industry's rate</b>	<b>2.9</b>	<b>1.6</b>	<b>0.2</b>	<b>2.2</b>	<b>11.5</b>	<b>18.3</b>
State government	4.0	5.3	0.3	1.1	19.6	30.4
Local government	-	4.4	1.0	1.6	28.3	42.5
<b>State +local governments' rates</b>	<b>-</b>	<b>4.6</b>	<b>0.8</b>	<b>1.5</b>	<b>25.9</b>	<b>39.1</b>
<b>Total</b>	<b>3.4</b>	<b>2.0</b>	<b>0.3</b>	<b>2.1</b>	<b>13.5</b>	<b>21.3</b>

- 1) The frequency rate is the ratio of the number of fatal occupational illnesses divided per 10,000 full-time equivalent workers (FTEs) and multiplied by 20,000,000 (10,000 FTEs x 40 hours per week x 50 weeks per year).
- 2) Excludes farms with fewer than 11 employees.
- 3) Because of rounding, components may not add to totals.
- 4) - Dash indicates data that do not meet BLS publication guidelines.

Source of these two tables: BLS, USDL-10-1451, October 2010

#### 6.3.4 Remarks on musculo-skeletal disorders

Numerous states have put into law rules that mean that MSDs are treated as incidents at work (in particular, back pain) so as to ease recognition.

As such, statistics on MSDs concern instances where the nature of the injury is as follows: a sprain, twists, back pains, back injuries, carpal tunnel syndrome or hernias. These statistics also include cases where the causal factor, event of exposure that caused the injury or illness, is a bodily reaction to flexes and extensions, climbing or crawling, excessive turning or repetitive strains.

Cases of Reynaud's illnesses, carpal tunnel syndrome and herniated discs are not included, though they might be considered MSDs. The SOII survey puts them in a category including cases other than MSDs. Finally, the agency estimates that half of all MSDs are not recorded.

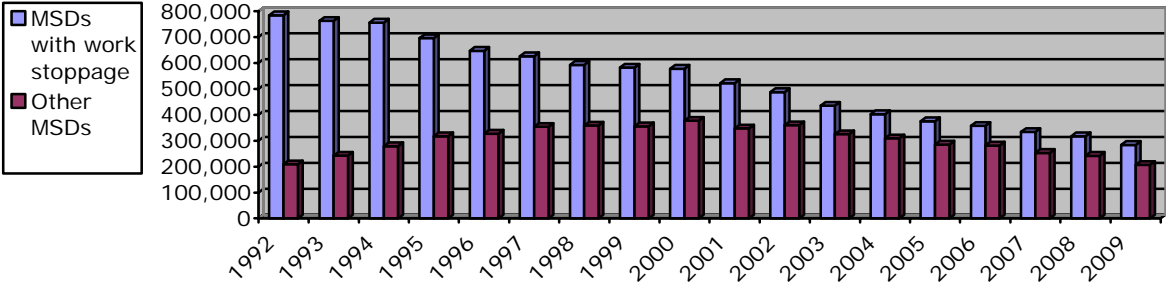
The result is that the BLS figures on MSDs form their own entirely separate category, mixing incidents at work and occupational illnesses in the same table, shown below.

*Number of MSD cases with at least one day away from work – 2009 detailed data*

Workers	Private sector	State government	Local government	Total
<b>Total number of occupational injuries with work stoppage</b>	<b>964,990</b>	<b>75,840</b>	<b>197,660</b>	<b>1,238,490</b>
<b>Of which MSD with work stoppage</b>	<b>283,800</b>	<b>18,330</b>	<b>46,610</b>	<b>348,740</b>
<i>Of which men</i>	<i>172,880</i>	<i>9,120</i>	<i>30,540</i>	<i>212,540</i>
<i>Of which women</i>	<i>110,330</i>	<i>9,180</i>	<i>15,980</i>	<i>135,500</i>
<b>Nature of injury, illness</b>				
Sprains, strains, tears	212,930	13,070	35,780	261,780
Carpal tunnel syndrome	9,140	620	1,020	10,780
Tendonitis	2,980	90	240	3,320
Soreness, pain, including back	41,710	3,900	8,010	53,620
<i>Of which back pain only</i>	<i>20,360</i>	<i>1,450</i>	<i>3,260</i>	<i>25,060</i>
All other nature	17,030	650	1,560	19,230
<b>Event or exposure</b>				
Overexertion	216,160	13,920	33,680	263,760
<i>Of which in lifting</i>	<i>110,800</i>	<i>5,830</i>	<i>16,270</i>	<i>132,900</i>
Repetitive movements	28,150	1,480	3,100	32,730
Others	39,480	2,930	9,840	52,240

Source: BLS – Because of rounding, components may not add to totals.

The following table shows the 1992 to 2009 trend of the number of MSDs with at least one away from work. The “Other MSDs” category gathers workers who have had to reduce their activity or change occupations.



Source: BLS

### 7.1 The OSHA agency

With the creation of the Occupational Safety and Health Agency, **OSHA**, the OSH Act of 1970 on health and safety at work instituted the first federal agency with national competencies in health and safety at work. Its mission is to encourage employers and employees to reduce risks at work and to put in place effective prevention programs<sup>39</sup>. To do this, the agency puts into effect the OSH Act and, through the National Emphasis Program (**NEP**), it defines its priorities for clearly identified sections of the workforce.

#### 7.1.1 The provisions of the OSH Act

The Act provides that employers must create and run a safe workplace. The OSH Act lists the employer's obligations. They have to:

- provide to their employees a working environment which has been expunged of all known risks;
- conform to safety standards set by the OSH Act, the application of which are controlled by the agency;
- identify and rectify health and safety problems;
- try, in the first place, to eliminate or reduce risks, before supplying appropriate individual safety equipment;
- make employees aware of chemical risks through training, information, proper labeling and other alert procedures;
- keep a record of incidents at work and occupational illnesses;
- conduct testing (on air quality, for example) as required by the OSH Act standards which set exposure limits;

<sup>39</sup> <http://www.osha.gov/dsg/topics/safetyhealth/index.html>

- organize medical tests as required by the OSH Act;
- display in the workplace notifications from the OSHA and information on incidents and illnesses in such a way that it is visible to employees;
- notify the agency of any fatal incidents and any incidents that require three people to be hospitalized within 8 hours<sup>40</sup>;
- not take any discriminatory action, or action by way of reprisal against employees that use the rights accorded to them by the OSH Act.

The OSH Act **standards** are regulations that employers are legally obliged to put in place; if not, they are fined. They set out standards that must be met so as to prevent occupational risks. They set, for example, an obligation to provide equipment to protect against falling from height, or to provide training for certain at-risk jobs.

Standards cover the construction sector, agriculture, maritime operations and industry generally. For other sectors, the general safety obligation applies, since the legislation in force requires employers to maintain a workplace that is free of serious known risks which might cause death or serious physical injury.

Any standard in the development stage can be commented on, so that it might be amended. Once it has been finalized, it can only be contested judicially.

<sup>40</sup> Deaths caused by heart attacks have to be reported. However, those caused by traffic incidents, on aeroplanes, trains, metros, or buses do not have to be notified.

The following example shows the role of the courts in the setting of these standards.

### **US LABOR Department fall protection directive upheld in US Court of Appeals**

The U.S Court of Appeals rejected a challenge by the National Roofing Contractors Association to the OSHA December 2010 directive on the use of fall protection in residential construction. The directive withdrew an earlier one that allowed certain residential construction employers to bypass some fall protection requirements. The BLS estimates that an average of 40 workers is killed each year as a result of falls from residential roofs.

"Fall protection saves lives" said OSHA Assistant Secretary Dr. David Michaels. "There are effective means available to protect residential construction workers from falls. We applaud the court's decision upholding this updates, commonsense directive." Construction and roofing companies have until June 16 to comply with the new directive.

In cases where there are repeated violations of security standards, the agency puts into action its Severe Violator Enforcement Program (**SVEP**). It concerns the means of inspecting employers who have demonstrated negligence as far as their legally defined obligations are concerned, by committing serious and repeated infractions and who have not reduced their frequency. The SVEP requires obligatory follow-up inspections, making the business aware of its obligations and ensuring that it fulfills them. The SVEP is backed up by having disputes settled in federal courts and a national procedure for classifying offences.

An important point on the OSH Act is that it creates a right for inspectors to **enter** workplaces to ensure that the law is being respected<sup>41</sup>. If the employer refuses to allow entry to an inspector, a warrant can be obtained from the appropriate judicial channels. If a violation is discovered, the inspector delivers a cease-and-desist, recommends a sanction and sets a timetable for the violations to be mended. Financial and custodial sentences can be handed down. The sanction is made public on the agency's website. The employer can challenge the agency's findings, as well as accepting them. If he accepts them, he will receive help from the agency in developing prevention and training programs.

The OSH Act's provisions allow employees to inform the agency of dangerous or unhealthy working conditions and to

request an inspection. The salary is protected when exercising this right.

The agency also publishes on the internet a weekly report, with statistics and descriptions of fatal incidents that have occurred throughout the country.

#### *7.1.2 OSHA Strategic Partnership Program, OSPP*

The OSHA Strategic Partnership Program, **OSPP**<sup>42</sup> was adopted in 1998. Through the OSPP, the agency takes part in a broad and voluntary cooperative process with employers, workers, workers' representatives and professional and union organizations so as to encourage, assist in and recognize work that has been done to eliminate serious risks and to achieve a high level of health and safety at work.

The partnership with the agency is considered useful for employers who want to do things properly but need assistance to reinforce health and safety standards in their business. These partnerships are arranged through an agreement which defines objectives and control mechanisms. They are presented as win-win arrangements, far from traditional control mechanisms and the naming and shaming of offenders.

This participatory approach allows the most serious risks to be identified, management systems to be put into place, and information to be shared. The majority of participants are small to medium sized businesses with fewer than 50 employees,

<sup>41</sup> In the same way, state legislation on compensation allows insurers to inspect workplaces and issue recommendations.

<sup>42</sup> See the [OSHA's Cooperative Programs](#) webpage for a description of the various programs.



which does not mean that larger enterprises cannot participate with good results, FORD being a case in point.

The links below describe two of the five OSPP partnership programs put in place by the agency. They are characterized by employers' wishes to take part in a system which will dispense them of frequent inspections by the agency and will improve productivity in the business. Being recognized by peers and by the community at large is an important incentive for employers who get involved in the programs.

#### *The VPP program*

Voluntary Protection Programs, (VPPs) which have been running for 20 years, bring together management, employees and the agency in cooperative and proactive programs that focus on preventing and managing risk, workplace assessment, training, and managerial and employee involvement.

Joining a VPP is voluntary. To take part, the employer hands in a dossier to the agency and has its workplace undergo a complete evaluation by health and safety experts. To remain in the program, participants are inspected every 3 to 5 years. So long as they retain their VPP status, participants are exempt from regulation inspections.

Joining a VPP requires negotiation with and the approval of the employee's unions.

For many employers, joining a VPP, with the health and safety benefits that result, has been advantageous. They enjoy a lower rate of turnover, increased productivity and a reduction in costs. Their individual accident and illness rates are lower than the BLS average for their branch of industry.

In June 2011, 2,443 business sites took part in a VPP. Big businesses were involved (including Lockheed Martin and Coca Cola), but it has not been possible to determine the number of employees covered. It is worth noting that even military establishments can participate for their civilian employees.

#### *The SHARP program*

The Safety and Health Achievement Recognition Program (**SHARP**) recognizes and honours small and medium sized businesses that have put in place exemplary systems for managing health and safety. Admittance into the SHARP program distinguishes a business as an example for others. In exchange, the business is exempt from inspections for two years initially, and three if the certification is renewed.

The philosophy of the SHARP program is to protect employees from risks and to collaborate with the agency to identify best prevention practice. The creation of a culture of safety at work is crucial to the program. SHARP participants have a role to play in their communities, and employees can spread the values of health and safety at work.

Apart from the financial benefits and the reduction in insurance premiums, acceptance into the program allows the employer to attract qualified employees and thus increase productivity.

However, participation in the program does not mean that the employer and its workers can ignore the provisions of the OSH Act. Inspections can still take place if the agency receives complaints, or if there are deaths or imminent dangers.

#### *7.1.3 The effectiveness of the agency's work*

The agency's arsenal consists of the number of inspections it undertakes, the number of infractions it publishes and the amount of fines it hands down.

The agency's effectiveness is the subject of debate. Its detractors make a number of points.

First, the number of inspections is very low, as well as the amount of fines, in relation to the number of workplaces that could be inspected. The probability of being inspected and receiving a severe fine is very small, meaning incentives to improve protection measures are limited in effect. Second, it can be noted that the agency's standards deal essentially with technical issues, whereas the majority of incidents result from a complex mix of factors: the job being done, the equipment and the

working environment. So, when the agency discovers a violation of a technical standard, it doesn't necessarily get to grips with this interaction of factors. As such, it can have but a limited influence on the likelihood of incidents and illnesses.

On the other hand, other studies have identified a drop in incidents and illnesses and the number of days away from work in the three years following an inspection, though they also show that the effectiveness of an inspection followed by a fine decreases with time. The suggested explanation for this is the rising cost of insurance, which will have forced employers into being more proactive in health and safety matters. This argument illustrates that the effect of the OSH Act is merely one factor in a web of many which contribute to the lowering of incidents and illnesses, the respective importance of which cannot be measured.

The debate concerns the means at the agency's disposal to do its job. In 2010, to conduct its inspections, the total number of inspectors was 2,218, of which 925 were federal inspectors and 1,293 were state level inspectors. The fact that the agency's 2010 budget has increased substantially, allowed it to recruit more inspectors.

However, this number is still considered to be very insufficient by the AFL-CIO which has calculated that, from BLS statistics, the number of years that it would take for the agency to inspect all of the workplaces in a state would be – at worst – 241 years in Florida and – at best – 23 years in Oregon. Put differently, these estimates give a rhythm of inspections of 129 man-years for a federal inspector and 67 for a state level inspector.

The following table gives the distribution per number of States of the necessary number of years for every working place to be inspected at the current rhythm of inspections.

From 0 to 49 years	5 States
From 50 to 99 years	22 States
From 100 to 149 years	17 States
150 years and more	6 States

At last, the AFL-CIO compared the number of inspectors in place per State with the ILO recommended number. The following table gathers the main data with the same two extreme examples already provided.

State	Number of workers	Number of Agency inspectors	ILO recommended number of inspectors	Ratio inspectors / workers
Florida	7,182,815	69	718	1/104,099
Oregon	1,607,915	86	161	1/18,697
Federal total	128,607,842	2,218	12,792	1/57,984

Source: AFL-CIO, Death on the Job. The Toll of Neglect, 20<sup>th</sup> issue, April 2011, pages 85 to 88

During the 2010 fiscal year, 98,339 inspections took place, 41,018 by 925 federal inspectors and 57,321 by the 1,293 state inspectors. These inspections include both scheduled inspections, and surprise inspections.

In 2010, OSHA identified 96,742 violations of the law or of safety standards, an increase of 15.3% on 2006 figures.

**Example of a notification published on the OSHA's Internet website:**

*A building contractor faces a total of \$243,360 in proposed fines for serious risks of fall from height.*

OSHA proposes to fine the roofing company Lessard Brothers Construction Inc. for a total amount of \$243,360 because of the serious and repeated law's infringements observed by OSHA during its inspection of the Lewiston site (Maine). OSHA previously had cited Lessard brothers Construction Inc. and its predecessor, Lessard Roofing & Siding Inc., 10 times for fall protection violations at various Maine work sites.

OSHA inspectors found employees exposed to potentially life-threatening falls from 23 feet while working without fall protection on a steep-pitched roof at a work-site. Due to management's knowledge of the hazard and the required safeguards, along with the company's extensive history of violations, the company was cited for four egregious willful violations. In addition, the company was cited for two violations for an electrical hazard, and for failing to train workers on electrical hazards and fall protection. The company was also cited for one repeat violation for a lack of hard hat protection.

This enforcement action qualifies Lessard Brothers Construction Inc. for OSHA's Severe Violation Enforcement Program, which mandates targeted follow-up inspections, to ensure compliance with the law.

## **7.2 The NIOSH Institute**

The NIOSH's mission is to develop knowledge in the field of health and safety and to put that knowledge to good use for the well-being of workers. It prepares draft standards for the agency, too. To fulfill its goals, the NIOSH undertakes scientific research, produces recommendations, publishes information and responds to requests to assess unhealthy working environments.

### **7.2.1 Research**

The NIOSH's research is coordinated in line with the National Occupational Research Agenda<sup>43</sup> (**NORA**). Launched in 1996 by the NIOSH, NORA is a public / private partnership which lists health and safety at work research priorities, as much for the NIOSH, as for other US bodies. To do so, it plays the role of coordinator between stakeholders and ensures that research is in line with current problems in the working world. This high-level research must have a measurable improvement on the lives of workers.

In its first decade of existence, NORA helped advance understanding in 21 distinct areas. In 2006, at the dawn of the second decade, NORA centered the nation's research on problems that are fundamental to employees, employers and health and safety practitioners in the agricultural, health, manufacturing, mining, services, commercial and transport sectors.

To put their research into practice for workers and their families, the NIOSH goes about its research in a practical manner. It works in close collaboration with its partners to translate research results, developing technologies and the information it collects into effective products and prevention policies that can be quickly adopted in workplaces.

The NIOSH has contributed to the development of university health at work clinics, by supporting financially the continued training of occupational health doctors.

<sup>43</sup> See <http://www.cdc.gov/niosh/nora/>.

### *7.2.2 Prevention through design*

Incidents caused by poorly designed equipment and working processes are common. However, standards that integrate health and safety from day one are rare. In 2007, the NIOSH launched a national initiative called "Prevention by design" to eliminate occupational hazards caused by design defects. The initiative aims to help engineers, architects, employers, owners and other implicated parties to identify design issues that impact upon safety and to try and get safety on the agenda from the beginning.

### *7.2.3 Evaluating health risks*

This area is crucial for the NIOSH. In response to requests from workers, their representatives, employers and other governmental organizations, the NIOSH conducts onsite tests to determine whether workers are exposed to harmful substances or to dangerous conditions and whether these exposures impact upon their health.

To do this, it assesses the working environment and the health of employees by looking at documentation, taking onsite readings, epidemiological surveys and medical tests.

### *7.2.4 Balance between health at work and health at home*

Combining health protection at work with the promotion of a healthy lifestyle is a winning formula for workers. The WorkLife initiative aims to maintain and improve the health of workers. This approach takes into account the complex web of factors that are and are not linked to work.

Moreover, the NIOSH is involved in projects that are aimed at specific professions. For example, having noticed that each year around 105 fire fighters are killed in the line of duty throughout the US, the NIOSH undertakes surveys on the majority of the deceased and produces recommendations for measures that could be taken by the fire services. Since 1988, more than 1,000 recommendations have been published following 300 surveys. Another sector that is particularly relevant here are workers in the nuclear energy industry and their protection against radiation.

### *7.2.5 NIOSH's work at state level*

In each state, the NIOSH directs action for the improvement of health and safety at work, notably:

- evaluating risks in businesses and producing recommendations when requested by employers, employees, state agencies or federal agencies;
- cultivating a culture of health and safety through grants and cooperation programs;
- financing research on a large range of subjects in universities and other organizations;
- Supporting training programs.

## *7.3 Medical surveillance, the services and bodies involved*

### *7.3.1 Medical supervision*

According to the sources that EUROGIP has consulted, a number of factors lead to medical intervention:

- concerns about the safety of employees and their general state of health;
- the financial benefits that come with increased productivity, fewer absences and decreased medical costs;
- legal obligations;
- legislation on equality;
- fears over litigation targeting the absence of medical surveillance or absence of supervision.

A number of dispositions provide that medical intervention is obligatory, for example, to monitor blood lead levels. However, the employee can refuse to be subject to this supervision when it involves invasive methods or methods that are intrusive for his or her private life. The employer's obligation is limited to offering the supervision without charge. Regulations do not require the employer to impose it. The employer must document any refusal and provide other tests that are acceptable to the employee.

To deal with refusals to a certain type of test, the employer can direct an employee towards a counselor or advisor who might be more persuasive. In the example of blood lead monitoring, the regulations do not allow for any test other than a blood-test.

Moreover, it must be remembered that the OSH Act standards are minimal standards that the employer may exceed. Tests can be made obligatory by an employer if the law permits or requires this.

### *7.3.2 The services*

The range and nature of services offered by an in-house or external team is variable.

Such services generally include:

- Evaluating employees' ability to carry out working tasks safely (a preliminary examination is the norm);
- Drug and alcohol testing, commonplace or even compulsory in certain professions;
- Compulsory medical surveillance where employees are exposed to dangerous substances as defined by the OSH Act legislation;
- Identifying common symptoms, suggesting illnesses that result from dangerous work, as provided for by the OSH Act, and conducting medical tests to this end; when symptoms are identified, the employee is monitored;
- Treatment and follow-up after an occupational illnesses or accident at work;
- Promoting well-being, personal health evaluations with courses of action proposed to cut out bad habits. Such programs can include cholesterol reduction, help quitting smoking, stress management and education in nutrition;
- Supervising health and safety policy and programs in the workplace.

### *7.3.3 Organizational structure*

On the subject of medical surveillance, the nature and structure of services are very varied. In some cases, only a preliminary at-work medical examination is undertaken, while in other situations, complete medical supervision, including health promotion at home and at work, is on offer. If there is no internal service, employers can call upon independent practitioners, clinics and hospitals. The size of the business is not the key criterion when choosing to bring occupational medicine in-house. Providers can be paid by reference to the amount of work they do, or by a set sum.

### *7.3.4 General health and well-being programs*

This example concerns employers' initiatives to improve the general health and well-being of employees. Such programs are often called "Employee Assistance Programs" (EAPs). Often employees' families and retired employees can take part, and in some cases the local community. The programs are based on the idea that the business will get a return on its positive investment because healthy workers are productive workers.

Such initiatives can be combined with other medical supervision, health and safety at work programs and measures put in place to implement regulations in force. The availability and content of the programs is not uniform. They can include health insurance, medical surveillance, advice on improving life style and family planning. Specific attention is paid to giving up smoking, preventing obesity and the abuse of addictive substances (alcohol and drugs). Individual programs to help quit smoking can be accompanied by smoking bans at work and by refunding any costs to employees.

As a general rule, it is big companies who put in place these programs (Citibank, Chevron Corporation, DuPont, etc.) because it is often difficult for small businesses to go above and beyond applicable regulations.

Similar programs can be arranged by insurance companies for their clients. They can only be delivered by health professionals; despite this they are considered less effective, particularly in cultivating a culture of health and safety in a business.

In 2008, according to the BLS, 52% of public sector employees and 25% of private sector employees had access to such programs.

### *7.3.5 Union organized activities*

Unions provide services, which are usually preventative in nature, for their members. Unions often have at their disposal experts in industrial hygiene, ergonomics,

occupational medicine and other health professionals who come in when a complaint is received from an employee. They undertake evaluations of workplaces.

They assist in interpreting medical statistics and where an employee contests the conclusions of a survey undertaken by the employer. They are active in informing and training employees, and take part in the political process that is responsible for producing regulations, especially when it comes to collective bargaining. Unions also help fund research.

### *7.3.6 University occupational health clinics*

Since the start of the 1980s, university occupational health clinics have sprung up as part of university hospitals. Some of them offer basic occupational health services, but their primary activity is diagnosing illness linked to work or to the working environment. They are centers of

expertise for occupational illnesses and for training in occupational health.

These clinics are usually not for profit organizations and are not formally linked to any employer. They are independent, and are usually consulted in complex or contentious cases.

Their recent development is attributed to finance granted by the NIOSH and considered to be a consequence of the 1970 OSH Act legislation. The improved status given to occupational health doctors has also contributed.

As an example see the "Occupational Medicine Center of the Loma Linda University Health Care" by Loma Linda in California:

<http://lomalindahealth.org/health-care/our-services/preventive-medicine/index.page>

## 8 Eurostat data

Implementing the framework directive 89/391/CEE, Eurostat (Statistical Office of the European Communities) provides harmonized incidents at work data according to the ESAW methodology (European Statistics on Incidents at Work) with a base 100 for 1998. To complete the European data, Eurostat computed rates for the United States.

2006 being the last available year, the related data are published at the following web address: [http://epp.eurostat.ec.europa.eu/portal/page/portal/health/health\\_safety\\_work](http://epp.eurostat.ec.europa.eu/portal/page/portal/health/health_safety_work)

### Index of the number of serious incidents at work per 100'000 persons in employment (\*) (1998 = 100)

Serious incidents	1998	1999	2000	2001	2002	2003	2004	2005	2006
EU (27 countries)	:	:	100	96	88	84	80	78	76
EU (25 countries)	100	100	99	95	87	82	79	77	75
EU (15 countries)	100	100	98	94	86	81	78	76	74
<i>France</i>	100	101	102	98	99	95	90	90	82
<i>Germany</i>	100	99	96	88	82	74	73	65	66
<i>Italy</i>	100	99	99	92	83	80	75	71	69
<i>Spain</i>	100	107	108	106	103	100	92	87	85
<b>United States</b>	<b>100<sup>(b)</sup></b>	<b>99</b>	<b>92</b>	<b>85</b>	<b>81</b>	<b>74</b>	<b>70</b>	<b>68</b>	<b>:</b>

(:) data not available

(b) break in series

### Index of the number of fatal incidents at work per 100,000 persons in employment (\*) (1998 = 100)

Fatal incidents	1998	1999	2000	2001	2002	2003	2004	2005	2006
EU (27 countries)	:	:	100	97	91	90	88	86	81
EU (25 countries)	100	88	87	85	80	78	75	72	72
EU (15 countries)	100	91	88	85	80	78	75	74	73 <sup>(p)</sup>
<i>France</i>	100	85	85	79	65	69	68	50	50 <sup>(p)</sup>
<i>Germany</i>	100	109	95	89	112	105	100	82	95
<i>Italy</i>	100	68	66	62	42	57	50	52	58
<i>Spain</i>	100	91	85	81	79	67	59	64	64
<b>United States</b>	<b>100</b>	<b>98</b>	<b>93</b>	<b>93</b>	<b>88</b>	<b>89</b>	<b>91</b>	<b>89</b>	<b>:</b>

(:) data not available

(p) provisory

(\*) The index shows the evolution of the incidence rate of fatal and serious incidents at work in comparison to 1998 (= 100). The incidence rate = (number of incidents with more than three days away from work or number of fatal incidents at work that occurred during the year/number of persons in employment in the reference population) x 100,000. An accident at work is a discrete occurrence in the course of work that leads to physical or mental harm. This includes incidents in the course of work outside the premises of one's business, even if caused by a third party, and cases of acute poisoning. It excludes incidents on the way to or from work, occurrences having only a medical origin, and occupational illnesses.

EU-15: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom

EU-25: EU-15 + Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Hungary, Slovenia, Cyprus (without the northern part of the island) and Malta

EU-27: EU-25 + Bulgaria and Romania.

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<http://www.allbusiness.com/human-resources/workplace-health-safety/2976265-1.html>
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### **Statistical resources**

Social statistics are published by the *Bureau of Labor Statistics* dependent on the *United States Department of Labor*.

<http://stats.bls.gov/home.htm>

As for occupational injuries statistics, several links are available:

- Main gate for the program *Injuries, Illnesses, and Fatalities* (IFF)  
<http://stats.bls.gov/iif/home.htm>
- Detailed data for non fatal cases with days away from work  
<http://stats.bls.gov/iif/oshcdnew.htm>
- Detailed data for fatal cases (*Census of Fatal Occupational Injuries*)  
<http://stats.bls.gov/iif/oshcfoi1.htm>
- Detailed data per branch of activity  
<http://stats.bls.gov/iif/oshsum.htm>

The statistical methodology in use is described in the BLS Handbook of methods. Chapter 9, Occupational Safety and Health Statistics

<http://www.bls.gov/opub/hom/homch9.htm#top>

### **Historical resources**

The job safety law of 1970: its passage was perilous.

Judson Mac Laury, historian at DOL

<http://www.dol.gov/oasam/programs/history/osha.htm>

See the DOL web column dedicated to the history of its action:

<http://www.dol.gov/oasam/programs/history/main.htm>

An introduction to the Health at Work in the United States

Sharon I. Morris and Peter Orris – ILO

[http://www.ilo.org/safework\\_bookshelf/french?content&nd=857170179](http://www.ilo.org/safework_bookshelf/french?content&nd=857170179)



Founded in 1991, EUROGIP is a French organization, whose activities are organized around five areas: enquiries, projects, information-communication, standardization and coordination of notified bodies. All have in common European aspects of the insurance or the prevention of accidents at work and occupational diseases.

[www.eurogip.fr](http://www.eurogip.fr)

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