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CHAPTER 10

HOW SAFE ARE CALIFORNIA'S WORKERS AND WHAT NEEDS TO CHANGE?

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California workplace injuries and illnesses reached their lowest rate in 1998 since data began being collected some 27 years earlier...The rate of non-fatal injuries and illnesses (I &Is) dropped to 6.7 per 100 workers, from 7.1 in 1997 and '96...The record low I & I rate was produced during a time of significantly higher employment - the sectors covered increased their aggregate workforce by 3.2 percent in 1998. (Cal-OSHA Reporter 2000)

I do not think the workplace is safer at all; we just aren't reporting as we should. Being good doesn't seem to be as important as looking good.
(Industrial Safety and Hygiene News 2000)

It is virtually impossible to determine the status of workers' health and safety in California, or in the U.S. for that matter, for a variety of reasons. Attempts have been made to consolidate government-generated statistics by the AFL-CIO in their annual reports, *Death on the Job: The Toll of Neglect* (AFL-CIO 2000). The U.S. Bureau of Labor Statistics issues annual reports on injuries/illnesses and fatalities of California's workers (www.stats.bls.gov/oshsum94.html 2000). Workers' compensation information can be obtained from the California Division of Workers' Compensation website (www.dir.ca.gov/workers'_comp.html 2000). And other, less formal, sources are available for review such as the California Fatality Assessment and Control Evaluation (FACE) reports from the State Department of Health Services and information gleaned from OSHA/Environmental Crimes units in some district attorneys' offices.

Looking at these end points, injury, illness, fatality is the common, though not the best, public health method for assessing the scope of the problem. It is important to be able to characterize health and safety conditions in the workplace in order to build a stronger case for workplace and governmental policies that improve such conditions for workers. With a clearer understanding of the extent of the problem, stronger arguments can be made for greater resource allocation to address this issue in the areas of: research, small business assistance, professional and employer/worker education, and other initiatives.

When most people hear the term "workplace health and safety," they think "regulation" - Cal-OSHA. There is definitely a role for this agency, but with approximately 220 inspectors for well over one million establishments, it has been estimated that it would take 104 years to inspect each workplace in California just once (AFL-CIO 2000). But, more important even than

the staffing issue is where should the emphasis be? To use an analogy, should employers be preparing for the test that is likely never to be given or should there be a firm commitment to creating a workplace free of injuries, illnesses and fatalities in which our working population spends approximately 40 percent of their waking hours each day?

In California, with the seventh largest economy in the world, we see too often these kinds of stories in our newspapers:

17 Injured by Nitric Acid Spill. *San Diego Union-Tribune*, 6 April 2000

Workers who helped assemble rockets at Rocketdyne's Santa Susana Field Laboratory died of lung cancer at twice the rate as other employees at the facility. *Los Angeles Times*, 17 April 1999

2 More Die From Blast at Tosco; Angry Supervisors Question Plant's Future. *San Francisco Chronicle* 25 February 1999

Tank Explosion in Dixon Kills Worker; 2 Others Hurt When Fertilizer Container Bursts. *San Francisco Chronicle* 9 February 1999

This chapter will look at the existing health and safety information sources for California's workplaces and the limitations of these sources. We will also make recommendations for new approaches to both ascertain the extent of the problem and the policy changes needed to prevent such casualties in the future.

First, it is time to revisit the two quotations at the beginning of this chapter. How do we reconcile these two differing pieces of information? One of the most common ways enforcement agencies make an assessment about the extent of the problem is to look at injury/illness/fatality statistics and note the way the trend is going. For example, Federal OSHA targets certain industries for scheduled inspections or training grants based on the Bureau of Labor Statistics' injury and illness rates; this year they are targeting construction, food processing and nursing homes based on the high injury rates in these sectors (www.osha.gov/).

Employers and their trade associations also look to these statistics as good indicators of the scope of the problem, particularly if the rates are decreasing. For example, Willie Washington, spokesperson for the California Manufacturers' Association, said, "The true measure (of safety in California) is the state's work injury rate, which has declined 28 percent since cresting in 1990-91. That trend takes on added significance considering that California's work force greatly increased" (*Sacramento Bee* 1999).

But, there are many reasons to be skeptical about these annual governmental reports. It is generally acknowledged that work-related conditions are under reported, particularly with respect to work-related illnesses. An occupational illness, or disease, is defined by Federal OSHA as "any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposures to factors associated with employment" (Department of Industrial Relations 1985). For a number of reasons work-related diseases are difficult to recognize. The numbers reported are just the tip of the iceberg (Leigh et al. 1997). estimate that there were 862,200 work-related illnesses in the U.S. in 1992. They arrived at this number by adding the work-related illnesses reported in the 1992 Bureau of Labor Statistics' Annual Survey (which includes private sector workers only), added the numbers reported by government employees,

and then added the proportions of cases attributable to occupation based on epidemiologic studies: 6-10 percent of all cancers, 5-10 percent of all coronary heart disease, 5-10 percent of cerebrovascular (e.g., strokes) diseases, 10 percent of all chronic obstructive pulmonary (lung) diseases, and 1-3 percent of all kidney-related diseases (Leigh et al. 1997).

If we were to assume that California has approximately 10.5 percent of the public and private sector workers in the U.S. (U.S. Census 1998), that the number of cases were equally spread around the U.S. in proportion to the number of workers and that the number of illnesses did not change much over the period from 1992-98, then using Leigh's estimates, a conservative estimate for the number of occupational diseases in California would be approximately 90,531 work-related illnesses annually in California. Instead, our Division of Labor Statistics and Research lists 55,400 cases, 39 percent less than that projected by Leigh (Cal/OSHA 00-7306 2000). Why the discrepancy?

Work-related diseases are hard to track for many reasons. Generally, they do not have unique pathologies, so that a lung cancer caused by cigarette smoking may not look different from one caused by a workplace carcinogen. Also, work-related diseases can be confounded by other factors, such as a worker who drinks alcohol excessively and is also exposed to a solvent that can cause kidney or liver disease. If the doctor considers etiology at all, they will most likely ascribe the problem to alcohol. Most physicians in the United States do not receive any training in work-related diseases. They do not take an occupational history to determine whether the disease could be work-related, and they do not know the type of work-up to do if there is an indication of work-relatedness. Furthermore, most doctors do not know they have an obligation to fill out a "Doctor's First Report" form and send it to our State Division of Labor Statistics and Research if they do suspect a job relationship.

Another factor that contributes to underreporting of occupational diseases is the long latency period of many such diseases. That is, an exposure to a workplace toxin today may not result in disease symptoms until many years later. Consequently, the connection between exposure and disease is not made either by the worker or the medical provider (again, no occupational history having been taken). These factors all result in underreporting on Death Certificates and on the Employers' Cal-OSHA Log 200 where they are required to report annual injuries and illnesses incurred in the workplace.

The expected number of deaths from work-related injuries, projecting down from Leigh et al's national statistics, would suggest that in California there would be approximately 683 injury-related deaths each year. In 1998, 617 deaths were reported to California's Division of Labor Statistics and Research. (AFL-CIO 2000). At first glance, this is not such a great discrepancy. However, this California number includes reported deaths due to injuries AND those due to occupationally related diseases. Leigh et al. project that each year there are 60,300 deaths due to work-related disease (Leigh et al. 1997); for California that would translate into 6,332 such deaths. Compare this with 3,259 gun deaths in California in 1998, something which gets a lot more coverage in the media (CA Dept. of Health Services 2000). A work-related injury death is hard to "cover up" and there are a number of agencies that get involved when one occurs: the county coroners' offices, Division of Workers' Compensation, and Cal-OSHA, who is to be notified immediately when such a death occurs. In 1991 Cone et al. examined deaths due to injury on the job for a one-year period and found that county coroners identified 69 percent of such deaths, workers' compensation records identified 48 percent and Cal-OSHA investigated a little over 21 percent of these deaths. The authors recommended that all these files be combined to "provide a more complete ascertainment of on-the-job fatalities" (Cone, et al. 1991). To date,

this consolidation has not occurred. A work-related illness fatality is usually not recognized for the reasons already discussed earlier.

The number of non-fatal injuries reported in California for 1998 were 724,100. Leigh would have predicted 1,386,000 such injuries, a possible underreporting by 48 percent (Leigh et al. 1997). Why is there such a discrepancy? In some cases it is unintentional; small businesses, in particular, are not aware of the reporting requirements or they do not understand the fairly complicated procedure they have to go through to report. More importantly, there are many disincentives to report injuries in the workplace.

From the employers' perspective, more reported injuries and illnesses may impact them negatively vis a vis workers' compensation premiums and at the time they experience a Cal-OSHA inspection. Most employers are "experience rated" by our state workers' compensation system, such that if their injuries/illnesses increase they are at risk of experiencing an increase in the annual workers' compensation premium that they will have to pay. If they are self-insured, they will have to use the money set aside for such purposes, and that money will not be available for other "more productive" purposes by the company or agency. When Cal-OSHA conducts an inspection of a workplace, one of the first things they ask to look at is the Cal-OSHA Log 200 of Injuries and Illnesses. If the inspector perceives the incidences to be high in certain areas, they may decide to focus on those areas for the inspection, in addition to the ones that were targeted by the complainant who requested the inspection.

Workers are often reluctant to report injuries and illnesses for fear of being seen as a "complainer" or "weak." In fact, there are commercial services that keep databases of workers who have filed for workers' compensation, which employers can refer to when they are considering to hire someone. For example, a service called "CompData" allows users to electronically access claimants' records by Social Security number. And, some employers automatically require drug or alcohol tests for workers if they report an injury or illness, under the pretext that they were "under the influence" at the time the incident occurred. This is another deterrent for the worker.

Another phenomenon which may be contributing to lower injury and illness rates is the adoption of "Safety Incentive" programs by employers, a practice that appears to be increasing. In a 1998 review of the literature on safety incentives programs, the reviewers found that during the 1970s and 1980s companies relied on positive feedback to induce workers to implement safe work practices. In the 1990s they put more emphasis on providing material rewards rather than positive feedback. "These newer incentive programs often measure reductions in reported injuries rather than improvements in safe work practices" (Dennison Associates 1998). In these programs, employers give workers rewards if they do not suffer an injury during a certain time period. Companies have sprung up which sell such programs to employers. Seth Marshall, the founder of Santa Monica-based "Safety Pays," started a safety incentive program that was so popular among his 70 employees that he decided to sell it to other businesses. On the "Safety Pays" website (www.safetypays.com) it is described as a "low-cost incentive program designed to reduce workers' compensation claims in virtually any commercial or industrial environment."

Some programs are set up like the game "Bingo." Every worker has a chance to win. The employer creates a small jackpot of \$100 or less, and distributes bingo cards to all workers. A number is drawn on each injury free day. The jackpot is increased each of these days. When a worker has enough numbers in a row for a "bingo," he wins the jackpot. After the win, a new game is started with a jackpot that reverts to the previous game's final value. However, when any lost time injury of 24 hours or more occurs (a "lost time" injury under Cal-OSHA rules), the

jackpot returns to the original amount of money. The proponents of these programs contend that "peer group pressure is felt by workers to avoid short-cuts and similar unsafe actions" (Dennison Associates 1998). There are many testimonials in trade journals, the popular press, and on company websites that the use of such "Safety Incentive" programs has significantly reduced workplace accidents and workers' compensation costs.

Such programs may, in fact, have an effect on reducing injuries and illnesses. But it has also been reported by workers that individual workers and work teams both have strong disincentives to report because they will lose their individual or team bonuses, prizes or rewards if they report an injury or illness. Research conducted in 1996 in wood products mills found "the extensive use of bonus or incentive schemes." These schemes give out rewards that range from dinners or jackets to money based on either the individual or work team going a certain number of consecutive days without a lost time accident. "In one extreme, but still illustrative example of the power of these bonus schemes, a worker who lost the tip of his finger in an industrial accident returned to work from the hospital on the same day saying, 'I don't want to lose my \$50'" (Grunberg and Greenberg 1996). Needless to say, these kinds of programs could have a profound effect on injury and illness statistics.

Another method employed to reduce the number of lost day injuries/illnesses is to put workers on restricted, or "light duty." This practice was described numerous times at this spring's Federal OSHA Ergonomics Standard hearing in Portland Oregon. Injured workers reported they were asked to go to "Wellness Rooms" to watch safety videos, read safety pamphlets, fill out safety quizzes for days, and sometimes, weeks on end. In other cases they were removed from their regular work and asked to paint walls over and over until they felt they were able to go back "on the line." Two safety professionals who have worked for private workers' compensation companies in California over the past 15 years acknowledged that, "There is an emphasis in the past 5-8 years to return workers to "light duty" to reduce workers' compensation costs, a practice that can actually benefit the worker if done legitimately, if an individual's wages are significantly more than workers' compensation...The open question is whether this 'return to work' program is managed the way it was intended and is not a tool to wear down a worker to get them to quit" (interviewed by Brown 2000). These practices keep the injuries off the Employer's Log 200 as a "lost time" injury because the worker stays on the worksite. A "lost time" injury is seen, by OSHA and insurance companies, as a proxy for the severity of an injury. The more "lost time" injuries there are, the more likely the company/agency will be viewed as having some serious safety problems.

As noted at the beginning of this chapter, the 1998 workplace injury and illness rate in California dropped to 6.7 from 7.1 for the previous two years (Cal/OSHA 2000). At the same time, there was a 3.2 percent increase in the workforce. Other data tell us there was also about a 9 percent increase in the number of businesses between 1997 and 1998. Knowing that 80 percent of California's businesses have 6 or fewer employees (www.calmis.cahwnet.gov), we can assume that many of those new businesses were small. This raises the question of whether those new businesses, many of them small, were apprised of their responsibilities to keep records of injuries and illnesses and report them to the Division of Labor and Statistics. They may, in fact, have never received information about this obligation.

In addition to the increase in the number of small businesses, over the past 15 years there has been a significant increase in the number of "contingent workers," those who are self-employed, work part-time or are temporary. Nationally, it is estimated that 25-35 percent of those who work fit this category now (www.dol.gov/). Although exact percentages for

California are not available, we can assume similar rates here. Those who are self-employed are not required to report injuries/illnesses on the job, and those who work part-time or temporary may be reluctant to report injuries/illnesses for fear of job loss. These workers are unlikely to be represented in the workplace and injury/illness statistics. In addition, there are many more workers working at home. Those who work at home and are self-employed are not required to report injuries/illnesses. Those who work at home for a company/agency, such as garment workers or circuit board assemblers, are supposed to be included in the statistics, but may, in fact, get "overlooked" by the employer.

The relatively new extended work hours of Americans also affects one's sense of well-being, and, it can be argued, one's health. According to a national study by the Families and Work Institute, those who worked full-time jobs in 1997 put in an average of 47.1 hours a week, up from 43.8 hours in 1992 (Wilgoren 1998). The same study found that 63 percent wanted to work less. Most said they had to work very hard (68 percent) and very fast (88 percent), and that they still did not have time to get everything done (60 percent). This kind of "speed up" can affect both mental and physical health. Along these lines, a report released in August 1999, found that "As many as one in four U.S. workers may be chronically angry on the job, with irate employees also more likely to be bored, have low energy and feel 'stuck' in their posts" (*Los Angeles Times* 1999). The study found that workers were most likely to be angered by a supervisor or co-worker who was not being productive while they worked under tight deadlines and heavy workloads. These "psychosocial factors" may have a "broad influence on worker safety and health and may contribute to occupational injury, work-related muscular disorders, cardiovascular disease and other occupational health concerns such as indoor air quality complaints" (www.cdc.gov/iosh/nrsoce.html).

In the case of cardiovascular disease (CVD), the number one cause of morbidity and mortality in the industrialized world, it has not been generally associated with working conditions. There is one exception. When police or firefighters suffer from CVD, there is a presumption that condition is at least partially work-related under California's Workers' Compensation Law. Only in the past several years has there been more attention given to the connection between social factors such as workplace stress and CVD. The work of Robert Karasek at the University of Massachusetts at Lowell and Peter Schnall and his colleagues at the Center for Social Epidemiology in Santa Monica has raised our awareness about these relationships. The latter group introduced the term "econeurocardiology" to describe how social factors, such as work stress, are perceived and processed by the central nervous system, resulting in changes in the body that can increase the risk of CVD. Again, if, in fact, there is this relationship, then many more of those with CVD should be diagnosed as having a "work-related disease." Currently those workers are not included in any workplace injury/illness databases.

As the elderly population continues to grow faster than the general population, we should expect a corresponding rise in workplace injury/illness and fatality rates. Because of slower reaction times, decreased stamina, likelihood of falls, greater susceptibility to chronic diseases and other factors, older workers are at greater risk. In 1993, the rate of fatal traumatic injuries was 15 per 100,000 for workers aged 65 and older, compared to 5 per 100,000 for workers aged 25 to 34 (www.cdc.gov/iosh/nrsoce.html). The aging workforce is another reason we might expect injury/illness/fatality rates to be increasing.

There are some unique conditions in California, in particular, which would suggest that injuries/illnesses/fatalities are not decreasing. We lead the country in the number of immigrant workers, many of whom are undocumented. An estimated 5 million undocumented immigrants

were residing in the United States in October 1996. California was the leading state of residence, with 2 million (Statistical Yearbook of the Immigration and Naturalization Service 1997). Undocumented workers are not likely to report injuries/illnesses to their employer for fear of losing their job or suffering some other repercussions. Also, many immigrants, documented or not, work in the informal sector which involves legal goods and services but which is not effectively covered by state regulations. Examples include selling oranges to passing motorists or providing care to an elderly woman in her home.

As Mitchell and Wu report in this book, part of the current employment growth in California can be explained by growth in our business service sector. And some of this growth is due to outsourcing of activities such as office cleaning, building security, and indoor/outdoor flower tending. Unskilled workers who do this kind of work are likely to be recent immigrants, employed by small employers who are less likely to report injuries/illnesses.

There are many reasons to be suspicious about the “official” worker injury and illness statistics. A number of those reasons have been elucidated herein such as disincentives to report, current work organization and workforce trends (i.e., changing demographics) in the U.S., and trends more specific to California. In order to know the extent of the problem of how many workers are at risk of injury/illness/fatality and to take steps to prevent such outcomes, there are certain policy initiatives that need to be adopted now.

One of the most important needs is for a comprehensive injury/illness/fatality data system that integrates information reported to California’s Division of Labor Statistics and Research and the Workers’ Compensation Information System. An independent task force and accompanying staff is needed to design such a system. Electronic records from this integrated system must be accessible to governmental agencies and others as appropriate, meeting stringent privacy considerations. California is unique in the nation in the scope of physician reporting requirements for injury and illness. Unfortunately, since 1992 analysis and publication of this data was terminated due to lack of funding (Worksafe! 1999). The system must ensure that electronic data collection is comprehensive, accurate, timely and available for use for (1) occupational injury and illness prevention activities, (2) epidemiologic and other research, (3) standards development, and (4) Cal-OSHA enforcement. The system should be a comprehensive database of injury, illness and exposure data from such sources as: employers’ and doctors’ first reports, Log 200 forms from employers, data in the workers’ compensation information system, data from the Workers’ Compensation Insurance Rating Board, data from the Department of Health Services’ surveillance programs, etc. Employers are currently required to provide biological monitoring results if their workers are victims of lead poisoning. Other biological monitoring results should also be required for poisonings related to carbon monoxide, metals, etc. Some have argued that there should be similar reporting requirements for workers with back injuries, which “cause significantly more pain/suffering/income loss/etc. for workers in California than lead poisoning ever will, and yet we are doing nothing about this at the state level” (Rudolph, telephone interview 1999). We should also consider whether results of workplace environmental monitoring for toxic substances should be included in such a comprehensive database. The state Division of Labor Statistics and Research and the Department of Health Services should have adequate staffing and resources to develop and manage this data.

Also needed is an ongoing way to solicit information from workers on the shop floor about their perceptions of the health and safety conditions where they work. The workers and workplaces should remain anonymous, but the information gathered would be helpful in getting an “in the trenches” sense of how conditions are and what needs to be addressed through training

and policy changes. Such a survey could be done annually or biannually as a “Voices from the Shop Floor on Health and Safety” report.

Safety and health professionals who work in this field need more training. A study released this year by the Institute of Medicine concluded that the nation's universities are not producing enough Ph.D.s and M.D.s who specialize in occupational safety and health to teach and train other health and safety professionals (Institute of Medicine 2000). Of course, the medical providers who most often see a worker with an injury or illness actually are family practitioners or internists; medical schools and continuing medical education courses need to be developed to reach these professionals. The report did conclude that there are enough graduates each year with industrial hygiene and nursing specializations. That may be true, but there is a need for these specialists who also have language skills other than English and interpersonal skills so that they can talk to workers to find out about health and safety problems in the workplace. Of the 200-plus Cal-OSHA inspectors, currently only a handful have the needed language skills.

California is one of the few states in the nation that has a requirement that all employers have an injury and illness prevention program which requires: (1) there be a designated person responsible for the program, (2) a system for ensuring employee compliance with the safety rules, (3) a system for communicating health and safety information with employees, (4) procedures (i.e., inspections) to investigate occupational injuries/illnesses, (5) procedures to investigate if injuries/illnesses occur, (6) methods for correction of unsafe/unhealthful conditions, (7) training and instruction for staff in the appropriate language, and (8) records be kept to document compliance for companies with 10 or more employees. Unfortunately, this is the Cal-OSHA standard which is most often violated, according to Cal-OSHA reports. There is a need to put more teeth into this standard, and more resources should be made available for small businesses so they can comply with this standard.

This standard should also contain the requirement that in all workplaces with a certain number of employees there be worker health and safety representatives, and for all employers with a larger number of employees there be employer/worker occupational safety and health committees. The health and safety representatives' task would be to represent the employees on occupational safety and health matters and to work with management to achieve satisfactory health and safety conditions. The representatives would carry out their duties during working hours, while retaining the same employment benefits as usual. They would receive introductory training on how to identify and control hazards in the workplace, and would receive annual refresher training. If the workers and/or their representatives speak a language other than English, materials and trainings would be provided in the language they understand best/feel most comfortable with.

In those places where there is a health and safety committee, labor and management representatives would also receive such introductory training and annual refresher training. The committee would meet at least quarterly, or monthly for employers on Cal-OSHA's high hazard list. The committee would have broad oversight over workplace safety and health, including conducting an annual evaluation of the employer's safety and health program as a whole. It would review the employer's periodic, schedule worksite inspections, conduct its own inspections as needed, recommend corrective actions, keep a list of all action items, and have the authority to stop a work activity if a hazard existed that constituted an imminent danger to life or health. These committees would also have the authority to review/evaluate the injury/illness

recordkeeping system the company institutes and make recommendations for changes if there were underreporting or errors in reporting.

Along with this, there is an urgent need for “whistleblower” protections for California’s workers. That is, workers who speak out about health and safety issues need strong protections against employer retaliation. A recent Federal OSHA report criticized the Cal-OSHA program for their abysmal record on this (Cal/OSHA 2000b). Between January 1, 1995 and September 30, 1998, there were 636 cases where workers charged the employer with such discrimination and took their cases to the state Labor Commissioner. Five-hundred-and-thirty-two of these cases were investigated by the Commissioner’s office. In only three cases did the Labor Commissioner rule for the worker. Such protections must be there for workers or they will be afraid to speak up as a safety representative, a health and safety committee member, or as someone on the shop floor who identifies a health and safety problem. This protection is the linchpin for workplace health and safety; without it, workers, especially those not protected by a union, put themselves at serious risk of losing their job.

Last, the public needs to be made more aware of the hazards at work and what can be done to reduce such injuries/illnesses/fatalities. There is already a strong, broad-based public consciousness about improving our general environment (i.e., air, water, soil). But, too often bettering the workplace environment is not a consideration. Increased awareness can happen through public awareness campaigns and the issuance of a yearly “report card” on the state of the workplace environment in California. A statewide advisory committee should be convened to recommend what indicators should be used to create such a report card. Currently available statistics should be reviewed, and combined with other new sources such as the “Voices from the Shop Floor” survey suggested earlier in this chapter.

In conclusion, there are a multitude of reasons why one must be skeptical about reports that suggest the workplace is becoming more safe and healthful. More reliable methods for reporting hazards, injuries and illnesses are needed. Without these, it will be difficult to document the extent of the problem in order to build the case for more attention and resources dedicated to this important public health problem. Once the seriousness of the problem is better documented, it will be easier to advocate for more trained health professionals, a greater emphasis on getting employers to implement effective injury and illness prevention programs, requirements for health and safety representatives and committees and much stronger whistleblower protections than we have today.

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