Effects of Social, Economic, and Labor Policies on Occupational Health Disparities

An Issue Paper for Discussion at the Eliminating Health and Safety Disparities at Work Conference, Chicago, Illinois, September 14 and 15, 2011

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Discussion Questions

The authors propose the following questions for discussion at the conference:

1. The authors describe a variety of labor, economic and social policies with potential effect on occupational health disparities, but they identified few studies that attempted to quantify the effect. After reading the paper, are you able to describe a specific research question that could be explored using available data sources with which you are familiar?

2. The authors identify several groups of workers who have been intentionally and historically excluded from certain labor, economic and social policies. What labor, economic and social arguments could be made TODAY to end these exclusions?

3. What labor, economic and social policies were not included in the white paper that should be? Is there evidence illustrating the policy (ies) impact on occupational health disparities?

4. Given the paucity of evidence in the peer-reviewed literature on the impact of labor, economic and social policies on occupational health disparities, are you aware of private or public funders who would support empirical research examining it?

INTRODUCTION

The present U.S. protections for workers' health and safety resulted from more than a century of efforts to ensure that all workers in America can make their contributions to our social fabric and economy without risking their health, safety, or lives. Working conditions for many U.S. workers are greatly improved from what they were a century ago. Nonetheless, the still intransigent inequalities in our society leave many workers without adequate health and safety protections, resulting in occupational health disparities. This paper will describe the major laws, government agencies and programs, social policies, and non-governmental efforts regarding workers' rights, health and safety, and security. None of these laws and policies specifically aims to reduce or eliminate occupational health disparities, but all of them influence either the existence and nature of occupational health disparities or the efforts to reduce and eliminate those disparities. A brief summary of the advance of progressive labor and social reforms since the early Twentieth Century will help set the stage for this discussion paper.

On March 25, 1911 the Triangle Shirtwaist Factory burned – a completely preventable industrial accident that took the lives of 146 garment workers - most of whom were young, immigrant women. Two weeks later, Crystal Eastman addressed a conference of social scientists and activists. Eastman was a researcher on the 1907 Pittsburgh survey documenting the social and economic effects of 526 job related fatalities in Pennsylvania. She described "Three Essentials for Accident Prevention:

"…Information, complete and accurate information about the accidents that are happening."
"a (government) department for enforcing the accident prevention laws, commensurate in equipment and in power with the importance of its duty."
"a new system of liability, known as workmen's compensation, which makes every serious accident a considerable cost to an employer and thus insures his invaluable cooperation with the labor department in promoting safety" (Eastman, 1911).

Eastman and others advocated for government to hold employers responsible and accountable for workplace safety and health, and to put in place incentives for employers to invest in measures to prevent occupational injuries, illnesses, and fatalities. These measures were to be deployed universally across all sectors of industry. This was the core of Progressive Era efforts to establish health and justice for U.S. workers. In 1912, the U.S. Bureau of Labor Statistics began collecting information about industrial accidents, "…but it was not until the late 1930's that injury recordkeeping was sufficiently uniform to permit the collection of nationwide work injury data" (Bureau of Labor Statistics, 2010a).

The Triangle Shirtwaist Fire led to Progressive Era safety and health reforms that continued through the 1930s and 1940s with the New Deal reforms. The United States Congress passed several landmark pieces of legislation to protect workers' rights and ensure safe and healthy work environments. The 1935 National Labor Relations Act (NLRA) guaranteed workers the right to form labor unions, strike and engage in concerted action and collective bargaining. The 1935 Social Security Act established unemployment and health insurance programs for the aged, disabled, and children. The 1938 Fair Labor Standards Act (FLSA) established a national minimum wage, required overtime pay for certain jobs and prohibited most forms of child labor.

Created during periods of mass industrial production in the United States, these and other labor protections were predominantly focused on regulating large scale, factory-type workplaces of the formal economy and often involved unions as the negotiating force with employers (EWC, 2010). The New Deal had established a network of federal and state labor and public health agencies that conducted research and investigations aimed at reducing workplace injuries, illnesses, and fatalities. Several labor unions established health and safety initiatives in major industries. Following the Triangle disaster, stronger government oversight and unionized workplaces led to improved wages, safer work environments, and reduced occupational injuries and fatalities for many workers (Mishel, 2003; Bernardo, 2009; OSHA, 2011).

After the New Deal there was a conservative backlash against advances for workers and unions, African Americans, other minority populations, and women. This backlash resulted in the Taft-Hartley Act, which amended the NLRA and reduced the rights and capacities of workers who chose to organize unions. It also led to dismantling the Fair Employment Practices Commission which had been established by President Roosevelt to protect the rights of black and female workers. Government protection of minority workers was greatly weakened as a result. Women's World War II era expansion into the workforce was curtailed, with many fired as returning male veterans received hiring preferences. Nonetheless, the political and economic power of the working class had significantly increased from the beginning of the Great Depression to the late 1940s (LeBlanc, 1990).

Still, by the 1960s, injury rates remained high in many industries and the occupational illness toll of working with toxic chemicals introduced post World War II was becoming evident. Some in the labor movement joined up with the new social movements of the 1960s and 1970s (civil rights, women, students, peace, consumer protection, public health, environment, and others) and pushed for federal workplace health and safety measures. Measures to protect workers' health and safety, as well as environmental health, became part of the national policy changes that followed the Civil Rights Acts of 1964 and 1968 and other Great Society measures.

Prompted by a series of coal mining disasters and recognition of inconsistent and lax state worker protection regulations, the Congress passed and President Nixon signed the Coal Mine Health and Safety Act in 1969 and the Occupational Safety and Health Act (Public Law 91-695) in 1970. These laws created the Mine Safety and Health Administration (MSHA), the Occupational Safety and Health Administration (OSHA), and the National Institute for Occupational Safety and Health (NIOSH). OSHA was placed in the U.S. Department of Labor and is responsible for developing and enforcing workplace safety and health regulations. MSHA, also in the Labor Department, sets and enforces safety and health regulations specifically for the mining industry. NIOSH is part of the Centers for Disease Control and Prevention in the Department of Health and Human Services, where it helps to assure safe and healthful working conditions through research, education, and training of occupational health professionals. The Act also expanded the surveillance and reporting of statistics by the Bureau of Labor Statistics (BLS), coming much closer to achieving the goal set by Crystal Eastman in 1911.

Although these and other laws and policies have contributed to a decline in work-related injuries and fatalities in the U.S., widening disparities in worker health and safety continue to occur.

Over the past half century, major shifts in the organization of political and economic power have dramatically changed the work environment for workers in the United States and internationally. As noted by Quinlan and Sokas (2009), "The implementation of neoliberal policies like downsizing, outsourcing, and privatization, and of altered business practices, such as global supply chains and lean production practices that cut labor and other costs, have resulted in the growth of job insecurity and precarious work arrangements that have had serious adverse impacts on occupational health and have produced health inequalities more generally." Today, a significant number of workers are excluded either in policy or in practice from labor protections provided to other workers (Bernhardt, 2009; Milkman, 2010; Liebman and Augustave, 2010). Recent research demonstrates that these exclusions impact not only the excluded workers, but other workers, employers, and the public. Unregulated and unsafe workplaces worsen preventable health disparities (Landsbergis, 2010; Lipscomb, 2006; Murray, 2003), increase cost-shifting from employers to individual workers and social safety nets (Zabin, 2004; Dembe, 2001), and force "high road" employers to cut corners and violate labor standards in order to stay economically viable (ROC, 2005; Bernhardt, 2008). These economic trends and labor practices, along with the global rise in international migration and shifts in the organization of work and employment relationships, challenge the relevance, capacity, and impact of the labor protections established in the 1930s and 1940s to protect 21st century work environments (Bernhardt, 2008; EMCONET, 2007; EWC, 2010).

This paper discusses a number of key policies and laws passed over the past century to protect workers and improve workplace safety and health and details barriers, exclusions, enforcement gaps, and implementation obstacles that weaken worker protections. The paper also reviews efforts at the state and local levels to enact laws and policies to address these gaps and obstacles, and describes evaluation tools to examine the impact of laws and policies on occupational health disparities. The paper concludes with a list of opportunities for future research. Several case studies help illustrate the limitations of these federal protections. The appendices provide additional resources, including a summary of key laws and policies. Although charged to discuss the impact of laws and policies on occupational health disparities, the authors found that discussion of occupational health disparities required inclusion of family and community outcomes and dynamics. Workers' lives include all their daily activities – work, family, community, relaxation, recreation, and social involvement. At some points in this paper, health disparities in working populations are discussed even when these may be indirectly associated with workplace experiences. The public health goal of reducing and eliminating occupational health disparities requires no less than a holistic view of workers' lives.

KEY FEDERAL and STATE LAWS and POLICIES

Federal and state labor, economic, and social laws and policies that improve the quality of life for workers and their families and communities were established throughout much of the 20th century and into the first decade of the 21st century. As a result of this long time span, the scope of those laws and policies varies. Responsibility for their implementation and/or enforcement has been assigned to different agencies at the federal and state levels. This section will cover core components of these laws and policies, particularly as they relate to the reduction and elimination of occupational health disparities.

Federal and State Occupational Safety and Health Laws

The Occupational Safety and Health Act (OSH Act) was passed to "...To assure safe and healthful working conditions for working men and women" (Public Law 91-596). Politics at the time prohibited this coverage for *all* working people, setting in place a key barrier to eliminating occupational health disparities. But the Act's general duty clause, section 5(a)(1) states that the duty of all private sector employers is to provide a workplace "...free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees" (Public Law 91-596). OSHA's general duty clause establishes, as national policy, the intent that no workplace should be less healthy and safe than any other.

The federal Occupational Safety and Health Administration (OSHA) directly administers health and safety programs in 26 states and the District of Columbia, and oversees and assists State Plans in 25 other jurisdictions. OSHA conducts workplace inspections in response to fatalities, worker complaints, imminent danger situations, and referrals in addition to regularly scheduled or programmed inspections (OSHA, 2010). However, OSHA is chronically underfunded and understaffed. In fiscal year 2009, federal and state OSHA programs conducted 100,020 inspections in private and public sector workplaces, amounting to less than 1 percent of all U.S. workplaces.[1] About 59% of federal OSHA inspections and 43% of state OSHA inspections were conducted in the construction industry (OSHA, 2010; OSHA, 2009).

The 135 million workers covered by the OSH Act have the right to receive information about the hazards in their workplaces, training on safe work practices and education on OSHA standards that apply in their workplace. Worker training must be provided in a language that the worker can understand. Workers also have the right to obtain copies of the results of any exposure monitoring tests conducted in the workplace (e.g., air sampling for contaminants, noise-level readings), copies of their own medical records maintained by the employer (e.g., hearing loss tests, blood tests for lead poisoning, chest x-rays), as well as the employer's record of work-related injuries or illnesses.

The OSH Act prohibits employers from discharging or discriminating against employees who exercise their rights, whether done so for themselves or another person. Workers who believe they have been retaliated against for exercising their right to report workplace hazards, or "whistle blowing rights" may file a complaint with OSHA. However, deadlines for filing workplace health and safety complaints are short (30 days) compared to other federal whistleblower protection statutes (90 days or 180 days).[2] This abbreviated filing deadline places

[1] The OSHA State Plan States conducted a total of 61,016 inspections (http://www.osha.gov/dcsp/osp/inspections_2009_bystate.html) and federal OSHA a total of 39,004 inspections.

[2] e.g., 90 day filing deadline under the Asbestos Hazard Emergency Response Act (AHERA), the Wendell H. Ford Aviation Investment and Reform Act for the 21st Century, the Corporate and Criminal Fraud Accountability Act of 2002; 180 day filing deadline under the Surface Transportation Assistance Act, the Energy Reorganization Act, and the Pipeline Safety Improvement Act of 2002.

an undue burden on workers seeking health and safety protections. OSHA is also responsible for investigating discrimination allegations under whistleblower laws. In 2009 Federal OSHA investigated only 24% of the whistleblower complaints made and OSHA State Plans investigated only 19%.

In cases where OSHA fails to investigate within 90 days, finds no merit in the case, or otherwise fails to act, the whistleblower complaint is closed. The complainant has no private right of action. These OSHA provisions establish barriers for workers seeking to raise concerns about workplace hazards. In contrast, the Mine Safety and Health Act (MSHA) gives workers a private right of action whether or not the Department of Labor (DOL) decides to take the case. Moreover, if retaliation against a mine worker involves discharge from employment, as long as the complaint is not frivolous, the worker is entitled to temporary reinstatement until the case is adjudicated.

In addition to OSHA and MSHA, the Environmental Protection Agency (EPA) has some worker health and safety protection obligations. The Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) directs EPA to promulgate health and safety standards for workers on farms and in forests, nurseries and greenhouses to protect them from the adverse health effects of workplace pesticide exposures. The EPA is also required to protect the health and safety of public sector and other workers who are not protected by OSHA's Hazardous Waste Operations and Emergency Response standard (Slatin and Siqueira, 1998).

Wage and Hour Laws

Income is broadly regarded as a key social determinant of health and is earned by the vast majority of workers as wages paid by employers (Lipscomb, 2006; Braveman, 2011). The most important law that regulates wage and hours conditions in the U.S. is the Fair Labor Standard Act (FLSA). The Act requires that employers pay covered nonexempt workers at or above the federal minimum wage and not less than time and one-half their regular rates of pay for hours worked over 40 in a workweek. In addition rest and meal breaks are required under the law. More than 130 million workers are covered by this Act; however, there are notable exceptions. Executive, administrative, and professional employees, for example, are exempt from minimum wage and overtime pay requirements, while farmworkers, domestic workers who reside in their employers' residences, and certain commissioned employees of retail and service businesses, among others, are exempt from overtime pay requirements.

The first regulations regarding child labor were promulgated under the FLSA and apply to employers who hire anyone under age 18. Initially the regulations were restricted to youth employed in non-agricultural jobs. Regulations for youth employed in agriculture were enacted in 1970, but they are less protective than for youth employed in non-agricultural settings. Teens can legally perform far more dangerous activities and at a younger age in agriculture than they can in non-agricultural settings. Actually, children are permitted to work in agriculture as young as 12 years of age. Children of farm owners are completely exempt from the FLSA (Miller, 2010).

The federal minimum wage was increased to $ 7.25/hour in July 2009. Seventeen states, including California, Massachusetts, Florida, and Illinois, have established minimum wages higher than the federal standard. Minimum wage laws apply to full or part-time workers regardless of how they are paid (by the hour, piece rate, weekly pay, etc.). According to the Bureau of Labor Statistics (BLS, 2010b), 4.36 million workers, 63% of whom are female, are paid hourly wage rates below or at the minimum wage. Workers under age 25 represent only one-fifth of hourly-paid workers, while they make up about half of those paid the Federal minimum wage or less. Seven percent of African-American workers earn hourly wages at or below the minimum wage compared to 5.9 percent of White workers (BLS, 2010).

A large national survey of 4,387 low-wage workers in Los Angeles, Chicago and New York conducted in 2008 (Bernhardt, 2009) found that 26% of workers surveyed were paid less than the state's minimum wage requirement in the previous work week. Sixty percent of workers were underpaid by more than $1 per hour. Over 25% of those surveyed worked more than 40 hours during the previous week, while 76% of them were not paid the overtime rate mandated by state laws. Minimum wage violations were most common in apparel and textile manufacturing, private households, and in personal and repair services. 30% of women in the sample had minimum wage violations, compared to 20 % of the men. Childcare workers had 66 % and 90% violation rates for minimum wages and overtime, respectively. Cashiers had a minimum wage violation rate of 21 % and an overtime violation rate of 59%. Foreign-born Latino workers had the highest minimum wage violation rate (31%), while African-American workers (30.2 %) had triple the rate of White workers (10.1%). Workers without a high-school degree of GED had higher minimum wage violation rates (37.2%) than workers who attended college (23.1%).

Violations of wage and hour laws, commonly termed "wage theft", increase economic instability, making it difficult for workers and their families to meet basic needs, such as rent, healthy foods, access to healthcare, and educational opportunities. Government efforts to prevent wage theft can improve financial, physical and emotional stability for workers and their families. Such enforcement measures are likely to have a positive impact toward reducing occupational health disparities.

In its 2007 final report, the World Health Organization's Employment Conditions Knowledge Network noted that precarious jobs (temporary, insecure, and often low-income) are associated with more hazardous working conditions and increased social income inequality. They further noted that "in recent decades income inequality has been increasing in the United States." (EMCONET, 2007). The report noted that "temporary workers suffer from a higher risk of occupational injuries compared with permanent employees."

Workers' Compensation

When injuries and illnesses are due to workplace events and exposures, the extent to which workers are compensated influences their families' economic situations, which in turn affects their health. The laws governing employers' responsibility to compensate workers who are injured or killed on the job can serve as incentives for employers to maintain safe workplaces.

In 1972, President Nixon's National Commission on State Workmen's Compensation Laws, which was created as part of the passage of the OSHA Act, issued a report declaring that workers' compensation laws and programs were inadequate and failed to establish equity for workers (Widman, 2006). Today, 100 years after the founding of the first U.S. state workers' compensation system, the promise of an incentive system that effectively helps prevent injuries and illnesses on the job is still a dream.

Workers' compensation systems inadequately compensate workers suffering from occupational diseases due to hazardous workplace exposures. Many cases of work-related disease fail to enter the workers' compensation system due to questions of causation and because many of the illnesses manifest themselves only after a long latency period. When employers are not saddled with the costs of occupational diseases, they have no incentive to eliminate the exposures that caused the diseases.

The workers' compensation system in many states has become increasingly difficult for workers to use. Studies indicate that many workers, particularly those with lower wages, limited job security, and lacking union protection, do not file for workers' compensation benefits due to fear of employer retaliation, such as harassment, reduction in wages or job termination. When employees do not report workplace injuries, their employers may falsely believe that workplace conditions are healthy and safe and fail to implement needed workplace injury and illness prevention measures. Workers' reluctance or inability to use the compensation system can result in workplace conditions that increase occupational health disparities (Shannon and Lowe, 2002; Biddle et al., 1998.)

Another element that inhibits workers from using the workers' compensation system is that the case by case administrative and judicial determinations of causation deprive many workers of benefits if they cannot show, by applicable standards, that their illness was job related. Some states require that injuries or illnesses are uniquely job related, thus disqualifying workers whose condition may have been compounded by off the job exposures. Because virtually no workers' compensation system collects reliable information on race, primary language and ethnicity, it is extremely difficult to document any differential effects for immigrants or non-English speaking workers. However, as long as some workers receive nothing after job related injury and illness, and others get benefits at a discounted level, the full prevention incentives are lost.

Most workers' compensation systems require a minimum number of lost work days before providing injured/sick workers access to partial income replacement benefits. Workers whose injuries do not meet that lost work day threshold are usually eligible for medical-only benefits, with no wage replacement for lost time. If a system does not include these medical-only benefits, workers who are injured enough to require treatment, such as hospitalization, may not have lost sufficient workdays to receive wage-replacement benefits. Often, though, neither workers nor employers are aware of the medical-only benefits, leaving eligible workers without medical cost coverage.

Workers' compensation systems can affect occupational health disparities through mechanisms to ensure timely, adequate, and appropriate provision of occupational medical services that support optimal recovery and return to work. Also, provision of adequate lost wages ensures that

workers can support themselves and families throughout treatment of their injury/illness. Workers who have become disabled by an occupational injury or illness require adequate disability wage compensation and medical services to avoid assuming dangerous jobs that could result in more severe adverse health outcomes.

The fairness and adequacy of workers' compensation benefits must be reviewed for different categories of cases. Are the workers' compensation benefits fair and adequate for the families of the 4,500 workers per year who are killed on the job? Are they adequate for those workers whose job leaves them with a permanent and total disability, unable to continue working in any way, or a permanent partial disability in which ability to use some part of one's body is reduced forever? How about for workers who suffer a temporary total disability but who return to work within a few days, weeks, or months? What about the workers who are relatively lucky enough that their injuries only required medical care and don't involve more than 3-7 days of days lost from work? Unless there is argument that a person wanted to get injured on the job, most people agree that people would rather work than get hurt. Is anything short of full compensation fair to workers who want to work?

Many things complicate an easy assessment of adequacy. Each state has a different system of payment and adjudication, with different thresholds of allowable cases in terms of what kinds of injury are covered, how many days of "deductible" time off occur before payment of benefits (generally from 3 to 7 days), or whether there are benefits for hearing loss. There are also commonalities, such as a benefit amount of two-thirds of pre-injury wage, limited to a maximum amount and length of time and usually keyed to the average wage in the state. For the highest paid industrial and construction workers, who often are in hazardous jobs, maximum weekly benefits keyed to average wages do not sustain one's pre-injury lifestyle. Through inconsistencies that present barriers to fair and adequate benefits across the states, the workers' compensation systems themselves become a source of occupational health disparities.

Even if benefits are fair and adequate, there appear to be increasing numbers of workers who are not covered at all under workers' compensation because they are considered self-employed or independent contractors. Sometimes these distinctions are real, but too often they are means of reducing a worker's access to benefits. Most states do allow compensation claims from all workers. Several states, however, either already restrict or are proposing restrictions to benefits based on immigration status, with benefits denied for those who work without authorization. Many workers are exempted because the state in which they work restricts certain industries, such as agriculture, from coverage (Farmworker Justice, 2009; Munoz, 1975). As a result of such exclusions, large portions of workers are not covered for compensation after a work related injury (Nicholson, 2008). Therefore, too much of the burden of required medical care after an injury is shifted to injured workers without coverage (Dong, 2007).

When workers are excluded from the workers' compensation system, incentives for employers to maintain healthy and safe workplaces are weakened. For example, if undocumented workers, many already facing disproportionate risk in the workplace, are restricted from getting workers' compensation benefits after injury on the job because their work is regarded as "illegal", the incentives to prevent their injuries are lost. When workers are labeled "independent contractors"

and required to cover their own risks, employers have fewer incentives to improve working conditions

Workers' compensation insurance carriers have an unmet potential to be part of prevention interventions. In many states, the law requires those insurers to offer health and safety or "loss control" services to policyholders. Insurers could be a force for reducing workplace injuries and illnesses if they integrated with public health surveillance and morbidity and mortality prevention efforts. A percentage of the collected workers' compensation premium could support monitoring of preventable workplace hazards. Insurers could target these efforts to identify and reduce occupational health disparities. Premium funds could also support professional resources to assist employers to establish healthy and safe workplaces. This is not inexpensive, and insurers who do this now limit the services offered to small and medium sized employers, or simply give out written materials, and only provide onsite consultation and health and safety recommendations to larger policyholders.

In many cases, insurers' professional safety and industrial hygiene services are used to determine who will be denied coverage. A rule of thumb for the portion of premium devoted to loss control was once about 2% of the value of the premium, which in a $60 billion market would put $1.2 billion of insurer resources into health and safety. In contrast, the entire federal OSHA budget, covering consultation, enforcement, standards development, etc, is less than half that amount. With a focus on reducing occupational morbidities, mortalities, and hazards, insurers could shift purpose from loss control to achieving the goal of healthy and safe workplaces and move employers to reduce and eliminate risks.

Workers' compensation has beneficial effects of providing a modicum of economic security to many workers and their families in the event of injury, illness, and fatalities. Also, it reduces the risks of liability for employers. Unfortunately, though, as currently established and operated, the workers' compensation system does not protect many of the most vulnerable workers. Thereby, it may exacerbate the disparities for young or old workers, for workers of color, or those in the most hazardous work.

Case Study: Workers' Compensation and Misclassification

Avelino Carvalho, a 31-year-old immigrant from Brazil, began working in 2007 for a home remodeling contractor called C. Smith Builders.* Most of the firm's jobs were performed in the suburbs of a major U.S. city. Mr. Carvalho did not write or speak English, and relied on co-workers to help him communicate with the construction supervisor, Charles Smith, who was also the owner of the firm. Under the state's law, Smith, as the supervisor, was responsible for directing Carvalho's and the other worker's tasks on the job. Carvalho would tally up his hours each week and Charles Smith would pay him in cash.

In the fall of 2009, Carvalho was working on a job for C. Smith Builders when he fell from a ladder. He was hospitalized for five days with a fractured L1 vertebral body and right inferior pubic ramus. Physicians considered Carvalho totally disabled because of his injuries. The workers' compensation fund refused to pay Carvalho's medical bills and wage loss benefits because Charles Smith claimed he was a "consultant" not a contractor; as a "consultant" he is not required to carry workers' compensation insurance. Smith also erroneously claimed that Carvalho negotiated the job directly with the homeowners, ignoring the fact that Carvalho did not speak English or even know how to drive a car to get to the jobsite. In reality, it was C. Smith Builders that took out the necessary building permits on its projects, negotiated contracts with homeowners, and paid their employees, including Carvalho, for their efforts.

Under the state's workers compensation regulations, an employee is defined as "every person in the service of another under any contract of hire, express or implied, oral or written, excepting…(g) a person whose employment is not in the usual course of the trade, business, profession or occupation of his employer…" Mr. Carvalho was clearly an employee of Charles Smith.

Mr. Carvalho's work-related injuries were severe, and he is unable to work and support his family. They are relying on local charities, including a church's food bank, have no savings to fall back on, and will soon be evicted from their apartment. Not only has Mr. Carvalho's physical health been adversely affected by work, but also his mental, emotional, and social well-being, as well as that of his family.

*Names and details have been modified to protect the actual worker's identity.

Collective Bargaining

The rights for workers to organize unions and bargain collectively with employers, provided through the National Labor Relations Act (NLRA), have proven effective in reducing the risks of injury and illness to workers who are covered by collective bargaining agreements (APHA, 2006). Unions fought for the forty hour work week and other worker rights, and were crucial in passing the OSH Act and strengthening OSHA (MacLaury, 2010). Worker health and safety policies and practices in high-hazard industries with underserved workers, such as coal miners, farm laborers, janitors, health care workers, and building trades, have improved due to the

existence of a collective bargaining agreement (Yates, 2009; Lofaso, 2011). Collective Bargaining Agreements often contain the mandatory establishment of health and safety committees, with equal worker/management representation. These committees may include rights for worker representatives to inspect and investigate workplaces (Reilly, 1995). Improvements in working conditions gained by collective bargaining can affect the general population of workers, whether or not they are union members (Mishel, 2003). These can be strong measures to help reduce and eliminate occupational health disparities.

U.S. labor laws and policies have established many barriers to organizing a union and gaining a negotiated contract. Lack of union representation may disadvantage low wage workers more than the general working population, resulting in reduced access to remedies to improve workplace health and safety conditions. Since the 1970s, employer and political support for workers' rights under the NLRA has greatly weakened. Employer domination of the NLRA election process has been cited as a major obstacle to the growth of unions (HRW, 2000). Current union membership is at an all-time low of 11.9% overall -6.9% in the private sector and 36.2% in the public sector (BLS, 2011a). Recent attacks on the collective bargaining rights of public sector workers have the potential to decrease protections for these workers.

Immigration Policies

U.S. immigration and border enforcement policies are important factors that may shape occupational health disparities among foreign-born workers (APHA, 2009). Fear of deportation, and the high financial costs and life-threatening risks to re-enter the U.S., have created a workforce that is less likely to report workplace safety and wage violations, to have access to training and protective equipment, and to seek medical attention (Dunn, 2009; APHA, 2005; Striffler, 2002; Saucedo, 2006; Water et al., 2004; Marin et al., 2009; Moure-Eraso et al., 2004; Quandt et al., 2006; Azaroff et al., 2004; Sakala, 1987). This lack of reporting is particularly problematic since the jobs primarily available to foreign-born workers are in high risk occupations such as agriculture, food processing, and construction. Additionally, foreign-born workers in sectors such as healthcare, industrial laundries, and building maintenance services are generally hired into the most high-risk in those sectors. The annual work-related injury death rate for Hispanic workers exceeded the rate for all U.S. workers every year during 1992-2006, with the exception of 1995. During 2003-2006, the work-related injury death rate for foreign-born Hispanic workers was 5.9/ 100,000 workers, compared with a rate of 3.5 for U.S.-born workers (MMWR, 2008).

U.S. immigration policies do not address the root causes of migration, which include the growing socioeconomic disparities in sending countries, coupled with the demand for low-skilled, low-wage workers in the U.S. Although some unauthorized migrants enter the U.S. to seek asylum, most enter for economic reasons. Per capita incomes in the U.S. are 5 to 7 times higher than those of Mexico and most Central and South American countries (World Bank, 2005; Sapkota et al., 2006). Various studies also suggest that the implementation of the North American Free Trade Agreement (NAFTA) and the related intensified liberalization of the Mexican economy have resulted in increased migration from Mexico to the U.S. (Andreas, 1999; Massey and Espinosa, 1997; Nevins, 2007).

There are few means for legal entry into the United States for low-skilled, low-wage workers. Thus, many immigrants end up working without legal authorization. For instance, more than 50% of hired farmworkers do not have legal authorization to work in the U. S. (Carroll, 2005). Immigrant workers that are authorized to work in the US generally obtain visas through two guest worker visa programs for temporary unskilled labor: the H-2A visa program is for agricultural work and the H-2B visa is for non-agricultural work. It is important to note that H-2 visa holders make up a small portion of the total farmworker population. In 2009, 150,000 individuals entered the United States with an H-2A visa (U.S. Department of Homeland Security, 2010]. Guest workers with H-2 visas are permitted to work only for the employer who petitioned for the visa and may not remain in the US when their employment ends. Several reports describe the poor working and living conditions endured by guest workers, raising important human rights concerns for visa holders (Farmworker Justice 2011; Bauer, 2007). However, studies conducted in North Carolina that compared the occupational safety and living conditions of guest workers with H-2A visas with immigrant workers without authorization found that work and living conditions are better for farmworkers with H-2A visas (Whalley et al., 2009; Arcury et al., 1999; Robinson et al., 2011; Vallejos et al., 2011). Experience for H-2A visa holders in North Carolina may differ from other places, as the Farm Labor Organizing Committee, the union representing many North Carolina farmworkers, monitors the visa program (Robinson et al., 2011; Farmworker Justice, 2011).

EMPLOYMENT BENEFITS: HEALTH INSURANCE and PAID LEAVE

Federal law does not currently require employers to provide health insurance or paid leave to workers, but many employers do offer them as employment benefits. Employers' decisions about providing these benefits influence the extent to which workers and their families can avoid or recover from illnesses and injuries. Great variability exists both in the health insurance and sick-leave benefits employers provide to their workers and in the requirements States place on employers for compensating workers and their families after on-the-job injuries or deaths. In many cases, workers who are undocumented, work part-time, or earn low wages are likely to receive the least from their employers and face the greatest hardship when a work-related injury or illness occurs.

Health Insurance and Health Care

Health insurance plays an important role in workers' health. Uninsured people have worse health and die sooner than people with health insurance (Committee on Health Insurance Status and Its Consequences, 2009). The U.S. relies heavily on employer-sponsored health insurance (ESHI). In 2009, 57% of the non-elderly population was covered by an employer plan (Statehealthfacts.org, 2009), but employer-sponsored insurance is less common among low-wage workers and those employed by small firms. Some workers may forego ESHI because they are unable to afford their share of premium costs. In 2009, 19% of people under age 65 were uninsured (Statehealthfacts.org, 2009). ESHI also plays an important role in workers' total compensation because the value of health benefits is excluded from workers' taxable income.

Over the past decade, the percentage of the population covered by ESI has fallen. Those less likely to have ESHI include Hispanics, African Americans, foreign-born individuals, those with

only a high school education or less, and those in the lowest fifth of household income (Gould, 2009). However, workers in all segments of the population have been affected by the decline in ESHI. The causes of the decline include fewer workers being offered coverage and fewer of those who are offered coverage accepting it. In both cases, rising premiums are a major factor in the decline. As premiums for ESHI more than doubled between 1999 and 2009, employers' contributions increased by 131%, while wages increased only by 38% and workers' premiums increased 128% (Kaiser Family Foundation and Health Research & Educational Trust, 2009). Workers with limited ability to pay for good quality healthcare face a double jeopardy in their health status – greater likelihood of impaired health that makes them more vulnerable to health hazards in the workplace.

Workers not insured through an employer or a state program such as Medicaid may try to obtain coverage through the individual market. They often do not succeed. A Commonwealth Fund survey found that, between 2004 and 2007, 73% of those who sought coverage on the individual market did not end up buying plans, either because they could not find affordable plans or because they were denied coverage due to preexisting medical conditions (Doty et al., 2009).

The workers least likely to have ESHI, such as low-income, Hispanic, African-American, and foreign-born individuals, also tend to be those at high risk of occupational injuries and illnesses. The workers' compensation system commonly fails to provide adequate medical benefits to many workers with job-related injuries and illnesses. When workers' compensation falls short, medical costs shift to private health insurers and to workers and their families, as well to Medicare and Medicaid (LaDou, 2010). Workers without health insurance coverage must pay a larger share of these shifted costs. When the costs are unaffordable, they may forego treatment. Lack of ESHI can both intensify existing occupational health disparities and make it more difficult for workers to attain and maintain good overall health.

The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010, is designed to make affordable health insurance easier to obtain for both individuals and small employers. Starting in 2014, Medicaid eligibility will be extended to all individuals with incomes below 133% of the federal poverty level. Subsidies will be offered to those with incomes between 133% and 400% of the poverty level who purchase insurance through state-sponsored health-insurance exchanges. (Kaiser Family Foundation, 2010). The extent to which the PPACA succeeds in decreasing the number of people without health insurance remains to be seen.

Paid Leave

The Bureau of Labor Statistics (BLS) defines paid leave as paid time off work, including vacations, holidays, and personal and sick leave (BLS, 2011b). Even though it is not a legally required benefit, many employers choose to offer some paid leave to workers. Paid leave may be legally required in certain localities. For example, paid sick leave (PSL) is required for all employees in San Francisco and the District of Columbia. Access to paid leave varies by worker, employer, occupation, and industry. In 2010, BLS reported that part-time workers, nonunion workers, and low-wage workers were offered less paid leave, including holidays, sick leave, vacations, personal leave, and family leave than full-time, unionized and higher wage workers (BLS, 2010c). Although there are significant variations by occupation and industry, in

general workers employed in private industry are less likely to be offered paid leave benefits than state and local government workers nationwide. Part-time and private industry workers are less likely to have access to any benefits, including paid leave, and more likely to have a lower hourly wage than full-time and government workers (BLS, 2010d). Boushey et al (2007) provided evidence of differences in access and use of leave benefits between lower and higher wage workers. Low-wage workers without access to PSL take less sick leave than high- wage workers without access to PSL.

Variations in access to and use of leave (and other benefits that depend on many worker, employer, occupation, and industry characteristics) influence workers' ability to meet their own and their dependents' needs. There is evidence that this results in and exacerbates health disparities that affect workers and their families. Collins et al (2004), for example, stated that PSL facilitates access to the health care system by allowing workers to visit their doctors during working hours and take time off work to recover from illness. In 2003, only 56% of U.S. workers reported they could take paid time off during the day to see their doctor. Only 36% of workers in the lowest compensated jobs had paid time off to see doctors during work hours, compared with 73% of workers in the higher compensated jobs.

Heymann et al (1996) examined how often the children of working parents get sick and whether parents receive enough paid leave to care for their sick children. The authors found that, between 1985 and 1990, one in three families experienced a family illness of two or more weeks per year, but 28% of mothers had no sick leave during that period. Employed mothers of children with chronic conditions had less access to sick leave than other employed mothers, while 36% of mothers whose children had chronic conditions lacked sick leave benefits. Thirty-eight percent of parents who lived in poverty lacked sick leave, compared with 20% of working parents who did not live in poverty. In addition, 23% of working white parents lacked PSL, compared with 31% of nonwhite parents. The authors concluded that because the Family and Medical Leave Act (FMLA) could only be used to care for major illnesses, such as those requiring hospitalization, it did not seem to address the majority of children's sick care needs.

Asfaw et al (2010) examined whether working under stress due to an adverse family health event resulted in severe occupational injuries. They found that family hospitalization within 15 days before occupational injury increased the likelihood of a severe injury. These severe occupational injuries were associated with 40% higher wage replacement or indemnity costs and 50% higher medical costs provided through workers' compensation.

A few studies have examined how employers are impacted by government mandates to provide paid leave benefits. Applebaum and Milkman (2011) examined consequences of the implementation of the paid family leave policy in California and concluded that the policy, funded by worker contributions to taxes, resulted in no extra costs for employers, who reported either positive or no noticeable effect on productivity (89% of employers), profitability/performance (91%), turnover (96%), and employee morale (99%).

Health impact assessments (HIA) may be a tool available to researchers to examine the relationship between PSL and occupational health disparities (Dannenberg et al., 2009). A HAI examined the impact of a 2009 law adopted in San Francisco, California that allows employees

to accumulate at least one hour of PSL for every 30 hours worked. The analysis linked individuals' access to PSL to health outcomes, but stopped short of examining specific occupational health impacts (HIP&SFDPH, 2009).

Case Study: Domestic Workers and Health Impact Assessments

Maria is a domestic worker in California who provided 24 hour care to an elderly client with Alzheimer's. She lived in her employer's home and was paid $120 per week. Her client would wake up frequently during the night, and she always needed to attend to his needs, even though sometimes he was verbally abusive. As a personal attendant, she is legally not entitled to overtime pay nor are there any existing requirements for sleep, meal, or rest breaks. Like many domestic workers in California, Maria is a recent immigrant who is afraid of losing her employment since she supports family both in the United States and her home country. However, working such long days in difficult circumstances makes Maria depressed, isolated, and unable to manage her diabetes.

In 2011, California Assembly members Tom Ammiano and Manuel Perez introduced AB 889: The Domestic Work Employee Equality, Fairness and Dignity Act, which was modeled after the New York Domestic Worker Bill of Rights that passed in 2010. This legislation would raise domestic worker labor standards to those of other workers. The bill would require overtime pay, meal and rest breaks, and coverage by state OSHA and workers' compensation laws, as well as establish requirements related to sleep, paid vacation, and the use of kitchen facilities.

Recognizing the occupational hazards of domestic work and building on previous research and collaboration with San Francisco domestic workers and their support organizations, the San Francisco Department of Public Health (SFDPH) conducted *a Health Impact Assessment* (HIA) of AB 889. The purpose of the HIA was to help inform decision-makers about the potential health impacts of the legislation upon domestic workers in California. SFDPH staff analyzed the size, working conditions and vulnerabilities of the California domestic worker population and examined the health benefits of a minimum standard for sleep and enhanced rights to workers' compensation benefits. The SFDPH HIA of AB 889 found that:

- Domestic workers routinely report under- and non-payment of wages and other violations of existing legal labor rights, negatively impacting their ability to meet basic health needs.
- Domestic workers in California experience over 4000 work-related injuries and illnesses annually.
- Up to 620 domestic workers would be eligible for workers' compensation benefits and treatment of occupational injuries under the workers' compensation system, which is likely to prevent long-term disability among workers and may reduce job turnover.
- Sufficient sleep would reduce the risk of premature death, chronic disease, and depression for 24-hour and live-in caregivers. Sleep deprivation among domestic

workers also creates potentially severe health risks for care-recipients.

If AB 889 passes, barriers to utilization of these laws by domestic workers still need to be addressed.

Improved data on the occupational health outcomes of domestic workers are needed.

Similar to other labor laws that aim to protect the rights of immigrant and low-wage workers, AB 889 will likely lead to significant improvements in worker health. However, these health impacts are not routinely considered in the decision-making process. Decision-makers are often presented with the economic impacts of labor laws and policies to employers, but are not informed about the public health impacts of the proposed decisions upon workers, their families, and the broader community. HIA is one method to help inform decision-makers about the potential health impacts of proposed laws, policies, projects, and plans. HIAs can involve quantitative and/or qualitative data analysis and usually involves stakeholder engagement of impacted populations, like Maria.

HIA is defined as "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population" (WHO 1999). Although the majority of HIA's in the United States have focused on land use, built environment, housing and transportation related topics, HIA's can be conducted on labor policies, economic development plans, budget decisions, and other decisions that impact workers' health, safety, and economic well-being.

Findings from the SFDPH HIA were presented to the local Human Rights commission and it is anticipated that the research will be used by many stakeholders engaged in improving health and welfare for domestic workers in California. For more information and to download the report, please visit: http://www.sfphes.org/Work_DWHIA.htm

EXCLUSIONS and LIMITATIONS of FEDERAL and STATE LABOR, ECONOMIC, and SOCIAL LAWS and POLICIES

Various researchers have noted that the historical legacies of racism and discrimination in the United States have contributed to the exclusion of certain workers from labor, economic and social laws, and the concentration of minority workers in more hazardous occupations (Boris, 2008; DWU, 2006; Strong, 2005; EWC, 2010). Researchers have also noted how societal context (e.g. socioeconomic position, race/ethnicity, nationality, gender, age, immigration and citizen status) impact risk and vulnerability to occupational injuries and illnesses (Krieger, 2010; Azaroff, 2002; Quinn, 2007). Collectively, these explicit and implicit exclusions disproportionately impact minority and immigrant workers compared to white and non-foreign born workers and contribute to occupational health disparities by ethnic group, immigration status, and occupation, among other factors (Lashuay, 2007; Azaroff, 2002; Shor, 2006).

Although many of the policies discussed above were created with the intent of protecting workers and preventing occupational injuries and illnesses, many workers remain vulnerable to avoidable hazardous working conditions. As described below, millions of workers are explicitly excluded from labor, economic and social laws and policies, while a great number are implicitly excluded by the ways these policies are implemented or laws enforced. While exclusions do vary by law or policy, state, and sometimes by employer, there are a few categories of workers, such as agricultural and domestic workers or public sector employees, who were systematically left out of legal protections covering the majority of the U.S. workforce.

Agricultural and Domestic Workers

In the 1930s, legislative supporters of the NRLA and FLSA agreed to exclude domestic and agricultural workers from the labor protections in order to win the support of Southern Democrats for the New Deal legislation. At the time, domestic and agricultural workers were predominantly African-American and their unregulated labor was a key component to the South's economic production (Boris, 2008; Hiller, 2009). In the past several decades, new federal and state legislation was introduced to improve labor protections for these workers, including the federal Migrant and Seasonal Agricultural Worker Protection Act (MPSA) and the New York Domestic Workers' Bill of Rights (A. 1470B/ S. 2311-E). However, significant gaps remain, and both agricultural and domestic workers across the United States are largely unprotected by the labor provisions afforded many other workers.

These exclusions may significantly contribute to occupational health disparities. Farm workers represent just 3% of the total labor force in the U.S. but account for 13% of all workplace fatalities (Wallace, 2007; Holley, 2000). Domestic workers who work as personal attendants and home care aides are nine times more likely to be assaulted than the average worker (Gaydos, 2011). Surveyed agricultural and domestic workers earn very low wages, experience wage theft or denial of payment for hours worked, are regularly exposed to preventable occupational safety and health hazards, and face job insecurity (DWU, 2006; MUA, 2007; U.S. DOL, 2005).

Currently, the federal Occupational Safety and Health Act excludes private homes as workplaces covered by OSHA standards. Thus, domestic workers are not entitled to safe workplaces and there is no requirement to document injuries and illnesses (NELP, 2009). Employers and farms with ten or fewer employees are also exempt from OSHA injury and illness recordkeeping requirements. Although the Department of Labor has stated that it intends to revise the exclusions of personal attendants from overtime, meal and rest break laws (U.S. DOL, 2010), this revision has yet to occur.

Case Study: Agricultural Workers

Agricultural workers suffer some of the highest rates of injury in any industry, but are afforded substantially fewer protections than workers in other industries. For over 75 years, U.S. labor laws and health and safety standards have consistently offered less protection to farm laborers than to workers in other industries. There is a systematic pattern of "agricultural exceptionalism" under the law that furthers occupational health disparities in one of the most hazardous occupations in the U.S. (Liebman and Augustave, 2010; Schell, 2004).

An estimated 3-4.5 million people earn their living from agriculture. There are between 1 and 2.5 million hired laborers and the other 2.05 million include self-employed farmers and their unpaid family members (Kandel, 2008; Martin, 2006). The hired agricultural workers are largely immigrant, non-English speaking, and often unauthorized to work in the United States. The combined workforce is essential to the modern production of food, fuel, and fiber in the United States.

Workers in the agriculture sectors are excluded from the New Deal era labor laws that changed the lives of industrial workers. The FLSA does not require small farm employers to pay minimum wage, exempts overtime pay requirements for all agricultural employees, and permits child labor in agriculture (Fair Labor Standards Act 1938, 29 U.S.C. § 203, et seq). The NLRA offers no federal protection for agricultural workers to bargain collectively, but some states do permit agricultural workers to unionize (National Labor Relations Act 1935, 29 USC § 151; and Schell, 2004). Moreover, only 13 states require employers to provide workers' compensation coverage to migrant and seasonal agricultural workers to the same extent as other workers (Liebman and Augustave, 2010).

The Occupational Safety and Health Administration (OSHA) specifically excludes agriculture from a number of standards (OSHA 29 C.F.R. § 1928). In 1987, nearly 17 years after its creation, OSHA promulgated regulations regarding sanitation for agricultural workers, but only after a decade of litigation (Schell, 2004). Currently there are only seven general standards that apply to agriculture (OSHA 29 CFR § 1928.21) and six standards that apply solely to agriculture. Standards that apply to other industries such as those dealing with ladders, working surfaces, personal protective equipment, confined spaces, noise, ventilation and certain chemicals are noticeably absent for agriculture (OSHA 29 C.F.R. § 1928). Moreover, the federal funding appropriated to OSHA specifically restricts the agency's enforcement work in agriculture. OSHA is prohibited from using federal funds to enforce or inspect in agricultural operations with fewer than 11 workers unless a temporary worker housing is present on the property. With a few exceptions, OSHA cannot require such operations to participate in injury reporting. Some of the state level occupational safety and health programs, however, include agriculture.

Regulatory standards addressing worker protection from pesticide exposure are overseen by the US Environmental Protection Agency (EPA). The EPA Worker Protection Standard (WPS) involves pesticide safety training, notification of pesticide applications, use of personal protective equipment, restricted entry intervals after pesticide application, decontamination supplies, and emergency medical assistance (Worker Protection Standard. 40 CFR §170). WPS is a risk-based standard, not a health based standard, and is notably weaker than similar

regulatory standards for occupations other than agriculture. WPS is poorly enforced (Arcury et al., 1999; GAO, 2000; Whalley et al., 2009). Furthermore, unlike OSHA, which in multiple standards requires that employers conduct medical monitoring of workers exposed to harmful substances (Silverstein, 1994), the EPA has no requirements for monitoring of workers exposed to pesticides. Washington State and California require cholinesterase biomonitoring for some pesticide applicators dealing with organophosphate and carbamate pesticides. These biomonitoring programs have helped to reduce pesticide overexposure by removing workers from ongoing exposure (Hofmann et al., 2010; Ames et al., 1989) and identifying flaws in worker protection activities (Hofmann et al., 2010).

Tipped Workers

Other categories of workers, including restaurant workers, taxi drivers, and day laborers, are also routinely excluded from labor standards through policy exclusions. Tipped workers, such as restaurant workers, parking attendants, nail salon workers, barbers, car wash workers, bellhops, and baggage porters, are currently entitled to a tipped minimum wage, which is 29% of the federal minimum wage ($2.13/hr in 2011). If tips do not bring the worker pay up to minimum wage level, employers are responsible for making up the difference. However, recent studies of tipped workers found that these workers regularly earn less than the minimum wage (ROC, 2011; USW, 2008; Bernhardt, 2009) and that as many as 20-30% of restaurant employers illegally take tips from workers (ROC, 2005; CPA, 2010). Compared to non-tipped workers, tipped workers are twice as likely, and waiters are almost three times as likely, to fall under the federal poverty line (Allegretto, 2011). This paper has already discussed the associations found between low wages and health disparities.

Public Sector Workers

State and municipal government employees work in a variety of jobs, from correctional officers, vehicle mechanics, and skilled construction workers, to school teachers, fire fighters, and health inspectors. Beginning in 2008, the national survey of occupational injuries and illnesses conducted by the Bureau of Labor Statistics (BLS) included public sector workers. The BLS estimated nearly 940,000 injury and illness cases among state and local employees in 2009, a rate of 6.3 per 100 workers. The rate for all private sector workers was 3.9 cases per 100 workers (BLS, 2009). In 2009, the rate among public sector workers was 5.8 cases per 100 workers, compared to 3.6 cases per 100 workers for all private sector workers (BLS, 2010e).

More than eight million public sector employees are not covered by the OSH Act because they are employed in states that do not operate their own OSH programs. The DOL's Inspector General (IG) examined the type and extent of health and safety protections provided to these public sector employees in lieu of coverage under the OSH Act. Among other things, the IG reported that: (1) eleven of the 26 states had adopted legislation and provided staffing for an OSH plan similar to what is provided in the OSHA State Plan States; (2) two states (Alabama and Delaware) had no recognizable health and safety program for public employees; (3) three

states had neither legislative nor executive branch authority to establish an OSH program; and (4) twelve states had no method for compelling compliance with health and safety standards (DOL/OIG, 2000).

Immigrant Workers

Currently, all workers considered "employees" are protected by federal and state labor and employment laws, including workers' compensation benefits, regardless of their immigration status. Despite having these formal legal protections, immigrant workers routinely face obstacles against exercising their right to unionize, to be paid minimum wages and overtime, and to work in a safe and healthy workplace free of discrimination (NILC, 2007). Immigrant workers are vulnerable to exploitation and exclusion due to factors such as citizenship status, language barriers, educational attainment, lack of job training, poor enforcement of labor laws, and threats of retaliation and deportation (Lashuay, 2006; Bernhardt, 2009). Fear of retaliation likely also keeps some workers from applying for workers' compensation benefits after job-related injuries.

According to the Bureau of Labor Statistics, 15.5% of the 2009 U.S. civilian labor force age 16 and over (23.9 million people) are foreign-born (BLS, 2010f). Research studies demonstrate that foreign-born workers are more likely to work in riskier jobs (Orrenius, 2009), are paid less (BLS, 2010f) and experience a minimum wage violation (Bernhardt, 2009) more often than U.S.-born workers. In addition, immigrant workers have less access to protective equipment, safety training (Lashuay, 2006), health insurance and other benefits (Kullgren, 2003; Shor, 2006; Azaroff, 2002). Undocumented immigrants are particularly vulnerable to wage and labor exploitation (Mehta, 2002).

According to a 2005 report by Human Rights Watch, "Federal laws and policies on immigrant workers are a mass of contradictions and incentives to violate their rights" (HRW, 2004). For example, according to a 2002 U.S. Supreme Court ruling, although undocumented workers are covered by employment laws, if their rights are violated and they are fired, they are not entitled to back pay or reinstatement (*Hoffman Plastic Compounds, Inc v. NLRB,* 122 S. Ct. 1275). While guest worker programs, which are policy descendants of the U.S. - Mexico Bracero programs of the 1940s, create opportunities for immigrants to be lawfully employed and lawful residents, they do not allow guest workers to change employers (EWC, 2010).

Since September 11, 2001, the Department of Homeland Security's Immigration and Customs Enforcement (ICE) has significantly increased the number of raids in worksites and communities, leading to record numbers of arrests, detentions, and deportations of workers. In 2008, ICE made over 6000 worksite enforcement- related arrests, of which only 135 were employers. Other forms of worksite enforcement include worksite audits and investigations, social security administration "no-match" letters, and social security number verification E-Verify and IMAGE programs. Although the Obama administration has made some effort to increase penalties and enforcement of employer violations (DHS, 2009), and to separate labor and immigration enforcement activities (U.S. DHS/DOL, 2011), worksite-based immigration enforcement continues to impact immigrants' ability to exercise their rights to minimum wage and other protections established under the law (NILC, 2007; Bernhardt, 2008).

Case Study: Excluded Workers Organizing

In June 2010, nine sectors of workers convened at the U.S. Social Forum in Detroit to form the Excluded Workers Congress. The nine sectors includes domestic workers, farm workers, taxi drivers, restaurant workers, day laborers, guest workers, workers from Southern right-to-work states, workfare workers and formerly incarcerated workers. These workers convened to draw attention to their exclusion from labor, health, and safety policies either through explicit exclusion from specific laws or through practice via lack of enforcement, misclassification of employment status, and/or precarious economic and legal status. In December 2010, the Excluded Workers Congress released a report that defines excluded workers, provides snapshots of how the exclusions impact workers in different industries, profiles current campaigns to expand workers' right to organize, and identifies concrete steps to help modernize labor laws and strengthen and expand the labor movement. Some of their key recommendations include:

- Eliminate explicit exclusions that limit workers' right to organize in the workplace.
- Eliminate exclusions that bar many categories of workers (including restaurant workers and other tipped workers, farmworkers and home health care workers) from minimum wage protections.
- Work to raise and index the minimum wage at both the state and federal levels.
- Document how protecting all workers' right to organize helps raise the floor for all workers, including excluded workers.
- Support ongoing state and national campaigns, such as the California Domestic Workers Bill of Rights, the Direct Care Workforce Empowerment Act, the POWER Act, and national organizing against the criminalization of immigrant communities, which would improve the conditions of excluded workers in specific sectors.

For more info please visit: http://www.excludedworkerscongress.org/

Misclassified Workers

Worker misclassification occurs when an employer improperly classifies a worker as an independent contractor rather than an employee, classifies payments as non-taxable income, or fails to report employee wage payments (Michigan, 2007). While workers are in some instances complicit in misclassification, more likely it is foisted upon them (Harris, 2010). State reports indicate that 10 to 30% of employers misclassify workers and hence several million workers are misclassified (NELP, 2010). For example, 44% of audited employers in Wisconsin, 38 to 42% in New Jersey, and 34% in Colorado, misclassified workers (NELP, 2010). The practice is particularly prevalent in the construction industry, where many of the studies were conducted (NELP, 2010). In Maine, for example, 14% of employers in the construction industry misclassified workers studied between 1999 and 2002, while the rate in other industries was 11% (Carre and Wilson, 2005). Comparable rates in New York were 15% in the construction industry and 10% in other industries (NELP, 2010). A 2010 study found that 82% of 110,000 truck drivers were also misclassified (Smith et al., 2010).

To get a sense of the number of workers affected, studies that extrapolate audit data estimate that 704,785 workers in New York are misclassified, while 580,000 in Pennsylvania and between 125,725 and 248,206 workers in Massachusetts are misclassified. With states auditing less than 2% of employers each year, these numbers are likely low estimates (NELP, 2010). Ohio reported a greater than 50% increase in the number of workers reclassified from 2008 to 2009 after audits identified classification errors (NELP, 2010). This data could be indicative of trends nationally.

Misclassification has significant implications for workers. Misclassified workers lose the protection and benefits of laws that apply to employees, such as the minimum wage and overtime provisions of the FLSA, job accommodation provisions of the Americans with Disabilities Act (ADA), leave provisions of state and Family and Medical Leave Act, and the right to organize afforded by the NLRA, as well as coverage from child labor and health and safety laws. Independent contractors do not qualify for health and pension plans and other employee benefits. They are ineligible for unemployment insurance and workers' compensation. Misclassification also lowers labor standards for all workers.

Workers employed as taxi drivers, truck drivers, day laborers, and messengers are routinely exposed to dangerous occupational hazards and are at higher risk of occupational fatality (Hendricks, 2007, Morocco, 2000, Seixas, 2008, Valenzuela, 2006). Yet, these workers are often excluded from government benefits because they are considered independent contractors (Valenzuela, 2006, Bernhardt, 2008, Milkman, 2010).

Misclassification also has significant implications for employers, taxpayers, and the government. The Government Accountability Office noted in a 2009 report that "...employers have financial incentives to misclassify employees as independent contractors" (US Government Accountability Office, 2009) Employers who misclassify can avoid paying income taxes, FICA taxes, unemployment taxes, and workers' compensation premiums. One study showed employers can reduce their labor costs by 20 to 40% by misclassifying workers (Harris, 2010). Misclassification therefore creates an uneven playing field and gives improperly classifying employers an unfair advantage over law-abiding businesses that have higher costs and can be underbid.

Limited or Lack of Enforcement, Funding, and Accountability

Federal and state agencies responsible for labor and occupational safety and health law enforcement are significantly under-resourced. Given current federal and state funding, it is estimated that there is one inspector for every 60,723 workers and it would take 137 years for federal OSHA and 63 years for state OSHA programs to inspect every workplace once (AFL-CIO, 2010). A recent investigation of the Department of Labor's Wage and Hour Division (WHD) complaint intake process found that overall the processes were "ineffective" and "responded inadequately to complaints," often taking months and sometimes years to respond (GAO, 2009). Given the current two year statute of limitations, delays in WHD responses may limit workers' ability to seek retribution for wage violations.

In addition to lack of staffing, researchers and advocates have asserted that the penalties assessed by enforcement agencies are too low to deter labor and occupational safety and health violations.

Recent congressional testimony reveals that federal prosecutors have prosecuted only one workplace fatality for every 3,000 cases (Michaels, 2010). In 2009, the average penalty for a federal OSHA investigated fatality was $6,750 and for a serious OSHA violation it was $965 (AFL-CIO, 2010).

Although the Department of Labor's (DOL) current administration has expressed new commitments for workplace standards and their enforcement (Michaels, 2010, Kaplan, 2010, Greenhouse, 2009), achieving adequate local, state and federal agency capacity to monitor and enforce labor and occupational health policies is not imminent (Lashuay, 2006, Bernhardt, 2008). According to the Government Accountability Office (GAO), the DOL has taken limited steps to find and address worker misclassification. Most cases are an indirect result of investigations of FLSA violations, rather than targeted misclassification (GAO, 2009). According to the GAO, "A lack of targeted investigations coupled with the reluctance of misclassified workers to complain may result in less effective enforcement of proper classification" (GAO, 2009).

Standards Setting

Both the Mine Safety and OSH Acts give the Secretary of Labor the authority to issue new standards to advance the goals of the statutes. Both statutes set a high bar for health protection, instructing the agencies to set standards "which most adequately assure, to the extent feasible,[3] on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity even if such employee has regular exposure to the hazard…for the period of his working life." Standards are informed by the scientific evidence on health risks but are ultimately crafted to be economically and technologically feasible for the affected industries. OSHA's standard on 1,3 butadiene, for example, reduced the permissible exposure limit from 5 to 1 ppm, but even at this improved level, the agency's quantitative risk assessment projected 1.3 to 8.1 excess cancers per 1,000 workers (OSHA, 1996). OSHA's methylene chloride rule projected 1.7 to 3.62 excess cancer cases per 1,000 workers at the more recent 25 ppm exposure limit (OSHA, 1997). MSHA's standard on diesel particulate matter reduced miners' exposure substantially, but the agency projected a risk of at least 15 excess lung cancer deaths per 1000 workers even at the new exposure limit (MSHA, 2001).

The process of developing and issuing a health or safety standard can take years. Therefore, there are many occupational hazards for which feasible controls exist but the agencies have not issued rules to address them. Crystalline silica is one of the oldest occupational health hazards, yet OSHA's exposure limits date back to 1962 (ACGIH). In 1995, OSHA engaged in a year-old priority planning process that identified 18 workplace hazards in need of regulatory action,

[3] In the Mine Act, the phrase "to the extent feasible" is not included in this paragraph, but instead appears in a subsequent sentence that reads: "In addition to the attainment of the highest degree of health and safety protection for the miner, other considerations shall be the latest available scientific data in the field, the feasibility of the standards, and experience gained under this and other health and safety laws." (Section 101(a)(6)(A))

including solvents, asphalt fumes, diesel exhaust, synthetic mineral fibers, and oil/gas drilling and servicing. Fifteen years later, only one of these hazards was addressed with a final rule, while new hazards demand OSHA's attention. Standards are not the only regulatory tools that help to prevent workplace injuries, illnesses, and fatalities; they are a critical tool for guiding employers to ensure healthy and safe workplaces. The inconsistent quality of work environments that result from insufficient standard setting increases the likelihood of occupational health disparities.

LOCAL and STATE EFFORTS THAT MAY REDUCE OCCUPATIONAL HEALTH DISPARITIES

Emerging state, county, and municipal labor and public health policies, laws, and programs may help to reduce occupational health disparities. This section summarizes a variety of efforts at the local and state levels that aim at increasing wages and job opportunities, improving employment conditions, enforcing regulations, or organizing workers to redress violations of labor laws. While these efforts differ in the scope, breadth, and impacts on the lives of low income workers, they may contribute to directly or indirectly changing labor market conditions for low income workers, which in turn may reduce occupational health disparities.

Living Wage Laws

The declining real value of minimum wages in the U.S. since 1968 triggered the creation of a living wage movement to improve the working and living conditions of low-wage workers. This movement defines living wage as a wage level that enabled workers to support a family of four at a livable standard of consumption and to participate in civic life and leisurely activities (Fairris and Reich, 2005; Pollin, 2005). Some living wage ordinances are "contractor-only" laws which only affect contractors who deliver services to or receive subsidies from cities. Others are "area-wide" ordinances, which apply to all businesses of a specified size within a geographic area (Pollin, 2005). Since the first contractor-only living wage law was enacted in Baltimore in 1994, over one hundred living wage ordinances or "business assistance" living wages laws have been passed and implemented throughout the country (Fairris and Reich, 2005; Lester and Jacobs, 2010).

Studies that have analyzed the impact of living wage laws on wages have found both an increase in pay for low-skilled workers and related effects for higher skilled workers. Furthermore, there is strong evidence that wage structures in firms become narrower, reducing the income gap between low and high-skilled jobs, and that turnover is reduced (Fairris, 2005). While there is still controversy regarding the impact of living wage laws on employment growth, the majority of studies found that they did not decrease the number of low-wage jobs in cities that adopted them (Adams and Neumark, 2005; Brenner, 2005; Fairris, 2005; Reich et al., 2005; Lester and Jacobs, 2010).

Wage Theft Legislation

Wage theft legislation seeks to protect workers from not getting paid fully for hours worked. These regulations seek to address and prevent minimum wage, off-the-clock, overtime, meal and

rest break, and other pay-related violations as well as misclassifications of workers as independent contractors. Laws may include penalties for employer violations of wage payment, notification and/or recordkeeping requirements, enhanced enforcement, worker protection from retaliation, employer accountability, worker education, and guarantees that workers can collect from their employers (Bernhardt, 2008). Wage theft increases economic instability, making it difficult for workers and their families to meet basic needs, such as rent, healthy foods, access to healthcare, and educational opportunities. Ending wage theft can improve workers' financial, physical and emotional stability, positively impacting health.

Case Study: Wage Theft

Wage Theft is the illegal underpayment or non-payment of workers' wages by employers (IWJ, 2010). Examples of wage theft include not paying minimum wage or overtime, misclassifying employees as independent contractors, forcing workers to work off the clock, not providing final paychecks, and not paying workers at all (Bernhardt, 2009; MUA, 2007; Valenzuela, 2006).

A survey conducted of over 4,000 workers in New York, Chicago, and Los Angeles found that 68% of workers in low wage industries, or roughly 1.1 million workers in the three cities, have experienced at least one pay-related violation in the last pay period, causing over $56 million per week in lost wages for front line workers in low wage industries (Bernhardt, 2009). Another study in San Francisco's Chinatown found that 50% of restaurant workers were paid less than minimum wage and 70% did not receive overtime pay for hours worked (CPA, 2010).

Loss of income due to wage theft results in less funds to meet one's basic needs such as paying for housing, food, heating, child care, transportation, or health care. This can result in increased homelessness, overcrowding, hunger, decreased mobility, and/or difficulty accessing health care and paying medical bills (Bobo 2008; Collins 2004; Valentine 2005; SFDPH 2004). Employers who violate minimum wage and other labor laws are less likely to offer health insurance and paid sick days (Bernhardt, 2009) or comply with health and safety standards (ROC-NY 2009).

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The following is excerpted from ***Check, Please!*** a report by the Chinese Progressive Association in San Francisco examining the health and working conditions in San Francisco's Chinatown Restaurants (CPA 2010). "Li Jun is a recent immigrant who worked in a restaurant as a dim sum seller. She was paid $900 a month while working 7 to 8 hours a day, six days a week (averaging $5 per hour with no overtime). For 5 months, she was not paid at all.

I came to the U.S. one year ago for my daughter's future. She is 17 years old and it's hard for her to adjust. My husband works in construction and he has been unemployed for a long time. We live in a SRO room in Chinatown. It's about 12 by 12 square feet. Ten families share two toilets and one shower. There's no kitchen in my building, so I just cook in my room with an electric stove. Rent costs $470 a month. I start work at 7 or 8 am and I get off at 3pm. I am off one day per week. When I get home I cook for my family. After dinner I attend my evening ESL class. After not getting paid for months, my coworkers and I finally decided to stand up to the boss and fight for our pay. It was hard because I was still working there, but that is how we got the boss to pay us back the wages he owed us {$900 a month for five months}. Initially, I didn't want to pursue back wages because I had compassion for my boss. He, however, did not have any compassion for me.

Community Benefit Agreements

Community benefit agreements (CBAs) are legally enforceable agreements between developers and community groups to ensure that residents affected by major developments share in the benefits of the project. CBAs are specific to the local context and may include requirements for first source, local or minority hiring, jobs with living wages and/or health insurance, affordable housing, and allocations of funding or land for child care, parks, public art, transit, pedestrian improvements, housing, or other community needs. CBAs also can be written to ensure that businesses and contractors who have a history of workplace safety or labor violations are ineligible for contracts or property leases/tenancy (Gross, 2005). CBAs have become more popular recently, but their impact on wages and working conditions is more limited than living wage laws or ordinances, because they affect fewer businesses and are more tied to local market wages (Lester, 2010). As a result, they do not influence as much local business or employment conditions.

Local Hire Policies

Local hire policies establish the percent of local residents that must be hired during the creation of new construction projects and/or guarantee permanent jobs for particular development projects. The goal of local hire policies is to promote long-term job opportunities and training among communities impacted by economic development. Policies may be included as part of a community benefit agreements or established as a city or county policy that is applied to all city-funded public works and improvement projects. Local hire policies can potentially address occupation- and income-related racial/ethnic health disparities by increasing access to employment and job training for historically marginalized populations, such as formerly homeless or incarcerated individuals, individuals with limited English or educational attainment, or individuals living in low-income, high unemployment areas (Mulligan-Hansel, 2008).

Coordinated and Targeted Enforcement Efforts

National and local efforts to improve enforcement of occupational safety and health regulations have been attempted through coordinated and targeted enforcement efforts. Both state and federal government agencies lack sufficient staffing to routinely and pro-actively monitor workplaces (AFL-CIO, 2010). Recognizing this limited capacity, some agencies have explored alternative arrangements to support enforcement including conducting targeted sweeps of specific industries (CA EEC; Lashuay, 2006) and partnering with other government and community agencies (such as tax collectors, health departments, or worker centers) to monitor conditions or bring forth cases of employer violations. Increased monitoring of workplace conditions can help increase documentation of workplace health and safety violations and help promote employer and government accountability for safer workplaces. Partnering with community organizations can increase capacity to monitor compliance with labor laws and bring forward cases of labor law violations (CPA, 2010; NY DOL, 2009).

Several states have established creative efforts to address these issues. Examples include the creation of inter-agency task forces and committees to study the problem of worker misclassification (GAO, 2009). New York's targeted investigations found 12,300 instances of

misclassification with approximately $12 million in related unpaid wages recovered, and $157 million in unreported wages (GAO, 2009). The New York Task Force uses a multi-agency approach to address misclassification and is far more effective than unemployment insurance audits (GAO, 2009). Michigan's Unemployment Insurance Agency is working with the IRS to audit employers for misclassified workers (Michigan, 2007). Massachusetts has enacted legislation that standardizes the definition of employee and penalizes employers for misclassification, regardless of whether or not it was intentional. The Massachusetts legislation authorizes the Attorney General to impose penalties and bans violators from obtaining state public work contracts (GAO, 2009). California has created an Economic and Employment Enforcement Coalition to target, cite and prosecute the most adverse business offenders operating in the underground economy; it has also provided education to those who wish to learn how to come into full compliance with state and federal labor law (EEEC, 2010.) Other states have enacted legislation that presumes "employee status" (Harris, 2010).

Occupational Health Care Services for Marginalized Populations

Although few states have comprehensive occupational health programs, state and local public health agencies may play a key role in addressing the needs of underserved worker populations and emphasizing the role of the work environment in health disparities data and interventions. Integration of occupational health and public health activities can promote more robust surveillance, improved access to care, and more effective interventions in certain target populations (Davis, 2009). Coordination of care between community clinics, legal and other referral agencies, workers' compensation systems, hospitals, and other stakeholders can provide more wraparound support for vulnerable workers. The Massachusetts Coalition for Occupational Safety and Health (MassCOSH) worked with the Greater Boston Physicians for Social Responsibility and the Massachusetts Department of Public Health to develop a clinician's guide to occupational injuries and illnesses. The guide explains common occupational and environmental hazards and health effects and helps providers refer patients to occupational medical services as well as sources of support for addressing underlying causes of injury and disease (MassCOSH, 2004). Efforts such as this can help medical practitioners guide underserved populations to receive needed occupational medical care, as well as navigate the workers' compensation system or enforcement networks.

Worker Centers and Coalitions for Occupational Safety and Health (COSH groups)

Worker centers may be defined as "community-based and community-led organizations that engage in a combination of service, advocacy, and organizing to provide support to low-wage workers" (Fine, 2005). In general, worker centers serve non-unionized, minority and immigrant populations (AFL-CIO, 2006). Over the past decade, worker centers have offered a variety of services, including, legal aid for unpaid wage claims, English classes, and access to health care. Worker centers advocate for workers by exposing individual and industry-wide employer violations and by pressing for individual, industry, and government changes, and improved working conditions. Worker centers can provide culturally and linguistically appropriate health and safety training, promote worker awareness and organizing, and advance policies that address occupational health disparities (Lashuay, 2006). Some worker centers have conducted industry

research to document working conditions faced by their members. These studies have helped highlight the need for increased data collection, oversight, enforcement of labor and health and safety laws, and worker organizing (ROC, 2005, 2010; DWU, 2006; MUA, 2007; CPA, 2010).

COSH groups have existed in different states since the late 1970s. These are labor and community based occupational safety and health advocacy organizations. They originally helped local unions provide members with health and safety resources. These have included training about workplace hazards and how to organize for safer workplaces, help with building effective health and safety committees, and hotline services that assist with access to government health and safety services and worker-friendly medical and legal professionals. By the end of the 1990s, many COSH groups had set new priorities to address the needs of low-wage and immigrant workers who were less likely to be union members yet quite likely to be employed in dangerous work settings. COSH groups have been a link between labor unions and environmental organizations, helping to bring a focus on the work environment as a source of health hazards in the workplace and community. Some have helped environmental groups understand work environment justice, while others have moved environmental groups to focus on environmental justice issues within industrial sectors, such as identifying racial disparities in Superfund cleanup efforts (Zoller, 2009). COSH groups have long championed the effort for workers and communities to have the Right to Know about toxic and hazardous chemicals in their environment (Mayer, 2009). In the past several years, COSH groups have worked with immigrant rights networks and unions to help immigrant workers attain union contracts and strong workplace health and safety protections in various service sector settings. Examples include a successful effort in the building services sector in Boston (Pechter, et al, 2009). A COSH group worked with Brazilian immigrant groups to create a cleaning cooperative that uses green cleaning products to provide healthy working conditions as well as home environments in the community (Siqueira, 2009). COSH groups are valuable local and state networks dedicated to reducing and eliminating occupational health disparities. In the past decade a national network of COSH groups has been established, and it works closely with unions and the public health and environmental movements.

The above examples of local and state efforts that may reduce occupational health disparities suggest that, while much still needs to be done to significantly reduce occupational health disparities in the U.S., progress has been made in a number of jurisdictions across the country, such as the cities of San Francisco or Los Angeles, and the states of New York and Massachusetts. It remains to be seen whether or not these initiatives will expand and become strong enough to impact life and employment conditions of low income workers nationwide.

KEY FINDINGS

1) Many Workers Excluded from Labor Protections

When first established, some labor laws including the OSH Act, FLSA, and the NLRA intentionally excluded particular groups of workers due to the economic and political interests of particular politicians and industries. Even though these laws were passed between the 1930s and 1970s, the exclusions remain, legally permitting substandard protections for too many workers.

2) Immigrant Workers not Protected

All workers who meet the definition of an "employee" are protected by federal and state labor laws regardless of their immigration status. Despite these protections, immigrant workers are routinely excluded from exercising their rights because of language barriers, educational attainment, unresponsive enforcement agencies, threats of retaliation and deportation, among others. In addition, workers' compensation systems can't provide wage replacement for unauthorized immigrants who experience a workplace injury in the U.S.

3) Many Barriers to Utilizing Workers' Compensation Systems

Although often considered a "universal right," some workers such as agricultural workers and day laborers are excluded from workers' compensation, while many others who are legally entitled to compensation experience numerous social, economic, and workers' compensation system barriers to obtaining the medical care and wage-replacement benefits needed for full recovery. The current compensation insurance system largely fails to provide meaningful incentives to prevent work-related injuries and illnesses, especially those caused by chronic exposure to ergonomic hazards and toxic substances.

4) Significant Lack of OSHA Anti-Retaliation Protections

The Occupational Safety and Health Act of 1970 provides insufficient legal protection to workers who experience employer retaliation for exercising their right to a safe and health workplace. The time period for filing a complaint is only 30 days. In cases where the Department of Labor lacks the resources to investigate the complaint, workers have no private right of action, even when their case has merit.

5) Workers' Rights to Organize Eroded

Workers' conditions of employment, including protections from injuries and illness, have improved in workplaces where workers have a collective bargaining agreement with their employer. Over the last 40 years, anti-union court decisions and federal policies have eroded workers' right to organize, and now fewer than 7 percent of private sector workers are members of labor unions.

6) Increasing Misclassification of Workers as Independent Contractors

Federal laws mandating safe workplaces, minimum wage and overtime pay, workers' compensation, and collective bargaining rights apply when there is an employer-employee relationship. Some employers avoid complying with these laws as well as paying employee-related taxes, such as the Federal Insurance Contributions Act (FICA), by hiring workers as independent contractors.

7) Enforcement Agencies Underfunded

The federal and state agencies responsible for enforcing labor laws, including health, safety and minimum wage standards, are significantly understaffed and underfunded. For example, the number of OSHA inspectors per million workers in 2007 was less than half the number of OSHA inspectors per million workers in 1977. Underfunding limits the amount of proactive enforcement activities the agencies may conduct in high-risk industries.

RECOMMENDATIONS

The following recommendations are grouped together according to which social actor has the predominant authority to implement the recommendations. However, the authors acknowledge that many stakeholders play an important role in approving, implementing, and enforcing legislation and policies. These include labor unions, worker centers, COSH groups, faith and immigrant rights organizations, legal and labor advocates, public health advocates, foundations, the media, students, and academics, among others.

Federal and State Agencies or State Legislatures

- Document the number of workers currently excluded by the FLSA, NLRA, and OSHA and the economic, social, and health consequences of exclusion on the excluded workers.
- Increase penalties for knowingly misclassifying an employee as an independent contractor.
- Develop an online, publicly accessible database documenting proven violations of employer misconduct, enforcement and compliance activities, details of the violation, and penalties assessed and paid to workers and government agencies.
- Explore the expansion of unique workplace identification numbers, such as those used by EPA and MSHA, to identify and track employers' employment history and link parent firms and transferred ownership.
- Certify workers' unions if a majority of the workers sign a document indicating their membership in the worker group.
- Increase employer penalties for retaliating against workers for organizing unions.
- Develop a set of screening criteria to determine whether or not a health impact assessment should be conducted to supplement statutorily required regulatory analyses.
- Support the expansion of worker centers, union and community organizing efforts to educate workers and employers about existing legal protections, rights, and responsibilities.
- Require that healthcare practitioners who are independent of the employer or the insurance provider determine an injured worker' eligibility and severity for medical-care and wage-replacement benefits under workers' compensation.
- Ensure that workers' compensation wage-replacement benefits do not reduce a workers' level of income while the worker recovers from injury or illness. This should apply to all workers with eligible workplace injuries and illnesses, and should meet their basic needs.

Congress

- Introduce legislation to sunset the current FLSA, NLRA, and OSHA exclusions within five years.
- Require any labor legislation that explicitly excludes particular subsets of workers to provide valid, substantial, scientifically sound evidence demonstrating that the inequity in legal protections is morally justifiable and will not contribute to adverse economic, social, or health consequences for the affected workers.
- Fund education and training programs in worker centers, unions, community organizations, and community colleges that provide culturally and linguistically accessible materials and training about health and safety and workers' rights.
- Increase funding for enforcement of laws to protect workers' health and safety, wages, and right to discuss and organize around conditions of work, regardless of workers' immigration status.
- Ensure that the Department of Labor's whistleblower protection enforcement program has sufficient resources to thoroughly investigate workers' complaints of retaliation in a timely manner.
- Revise OSH Act whistleblower protection provisions to be consistent with more modern federal whistleblower statutes.
- Amend the Fair Labor Standards Act to prohibit an employer from knowingly misclassifying an employee as independent contractor.

Researchers

- Conduct health impact assessments of major labor and economic policies to provide the public and lawmakers with more robust information on the potential consequences of policy decisions.
- Collect data on workers' use of paid and unpaid leave by occupation, industry, and worker demographics.
- Monitor rates of health insurance coverage, characteristics of those who remain uninsured, and barriers to obtaining health insurance, following the implementation of the PPACA.
- Use community-based participatory research to assess occupational health disparities, develop new modes of qualitative data collection, and validate survey instruments within workers' communities.

CONCLUSION

This paper has examined U.S. labor laws and policies and the government structures established to implement and enforce them, and how they set the context for occupational health disparities. The concept of social determinants of health is longstanding and well-grounded in evidence. Therefore, health disparities should be expected when social and economic disparities exist. Public health evidence derives from surveillance and research that examines lived experiences across and between populations. Establishing such evidence is challenging when data either is

not collected or when social circumstances lead to insufficient data collection or questions about the reliability and accuracy of the data. This paper has presented a set of such barriers to attaining the evidence of the relationships between labor/management and social protection laws and policies and occupational health disparities.

We cannot, however, delay taking action while waiting for further evidence. To do so would deny the historical basis for these health disparities. The U.S. Constitution originally permitted slavery as a labor/management dynamic and the gross exploitation of a large percentage of workers. Early on, our nation was built on the premise that the protection of workers' health was a matter of individual employer concern and not a social responsibility. It took nearly a century before slavery was finally made illegal. That did not eradicate the notion that in the context of the workplace employees are to some extent the property of employers. That concept infiltrates our labor/management relations policies and laws. This is evidenced by court determinations that workers' first amendment free speech rights can be restricted in the workplace because it is an employers' property.

The efforts to expand workers' rights since the Civil War and through the Progressive and New Deal Eras (including the 1960s and 1970s) have sought to eradicate the resistant labor/management policy legacy of the slavery period. One goal has been to establish worker health and safety protections as workers' individual and collective rights and employers' and society's responsibility and duty. As this paper has demonstrated, however, the goal of healthy and safe workplaces for all workers set forth in the OSH Act has not yet been fully achieved. The law itself excluded protection for large segments of the workforce.

The ability of labor and other progressive social movements to secure measures to achieve that goal has met strong challenges. The restructuring of the U.S. economy that has taken shape since the mid-1970s has changed the political power balance between labor and employers from what it had become by the mid-1960s. Labor unions have been weakened and labor laws have been set, implemented, and/or interpreted to shift greater advantage to employer discretion. Economic restructuring, coinciding with advances in communication, transportation, and industrial production technologies, expanded globalization of trade, and industrial and labor migration, has resulted in the largest period of immigration to the U.S. in nearly a century as well as a broad transformation of the industrial landscape. Racism, nativism, and inadequate immigrant rights laws all add to inequalities in social and public health protections between the general U.S. population and these new immigrant populations and their expanding communities. These new communities of workers now experience morbidity and mortality rates that far exceed those for the general population. These health disparities are similar to those for too long experienced by U.S. populations that have suffered discrimination and disparate protection – primarily African Americans, but also other low income populations.

This has been the social policy context for the occupational health disparities noted in this and the other white papers written for the NIOSH conference. These policies affect workers' health not only in the workplace but also in their communities. As discussed here, legally established jurisdictional boundaries for protecting public health in the workplace, communities, and through environmental protection establish a false set of life divisions. No health effects firewalls exist between these settings. Consequently, studying health disparities separately in the workplace and

community will present incomplete evidence of their determinants. Nonetheless, it is imperative that we come to understand the sets of legal and policy contexts that are key determinants of occupational health disparities.

This paper presented an introduction to the primary legal and policy contexts for occupational health disparities. Also presented are key gaps in our knowledge and health promotion practice, as well as future research that can provide the evidence to fill those gaps. Our next steps must be to further build the coalitions and collaborations to command the resources necessary to identify, and then reduce and eliminate occupational health disparities by establishing healthy, safe, and just work for all.

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Appendix A

Table 1- Federal and State Economic, Social, and Labor Laws and Policies that Impact Occupational Health

Law	Year First Enacted*	Description
Safety and Health		
Occupational Safety and Health Act of (OSH Act)	1970	To assure safe and healthful working conditions for working men and women. Read more: www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=OSHACT&p_id=2743
Federal Mine Safety and Health Act (Mine Act)	1977	To provide for the protection of the health and safety of persons working in the coal mining industry. Read more: www.msha.gov/REGS/ACT/MineActMerged.pdf
Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and Workers Protection Standards	1947, 1992	To regulate the marketing, sale and distribution of pesticides. Read more: www.epa.gov/pesticides/regulating/laws.htm#fifra The Food Quality Protection Act of 1996 resulted in substantially amending FIFRA. Read more: www.epa.gov/pesticides/regulating/laws/fqpa/backgrnd.htm#fifra FIFRA directed the Environmental Protection Agency (EPA) to promulgate the Worker Protection Standards (1992) to protect employees on farms, forests, nurseries, and greenhouses from occupational exposures to agricultural pesticides. Read more: www.epa.gov/pesticides/health/worker.htm
Motor Carrier Safety Improvement Act	1999	To reduce the number and severity of crashes involving large trucks. Read more: www.fmcsa.dot.gov/documents/rulesregs/rulemakings/mcsimproveact.pdf
Wage and Hour		
Davis Bacon Act and state prevailing wages	1931	Requires individuals contracted for construction work by or with the assistance of the federal government to be paid no less than the local prevailing wage. Read more: www.dol.gov/compliance/laws/comp-dbra.htm Similar state laws require prevailing wages for construction and building services work performed under contract with state and local agencies. As of December 2010, 18 states did not have wage prevailing laws. Read more: www.dol.gov/whd/state/dollar.htm#1
Fair Labor Standards Act (FLSA)	1938	Establishes minimum wage, overtime pay, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in federal, state, and local governments. Read more: www.dol.gov/compliance/laws/comp-flsa.htm
Equal Pay Act	1963	Prohibits sex-based wage discrimination between men and women in the same establishment who perform jobs that require substantially equal skill, effort and responsibility under similar working conditions.

		Read more: www.eeoc.gov/laws/statutes/epa.cfm
Civil Rights Act, Title VII	1964	Prohibits employment discrimination based on race, color, religion, sex and national origin. Read more: www.eeoc.gov/laws/statutes/titlevii.cfm
Migrant and Seasonal Agricultural Worker Protection Act (AWPA)	1983	Extends certain protections to migrant and seasonal farmworkers regarding recordkeeping, wages, supplies, housing, and working conditions. Read more: www.dol.gov/whd/regs/statutes/0001.mspa.ht
Trafficking Victims Protection Act	2000	Prohibits "involuntary servitude, peonage, debt bondage, or slavery." All those involved in the process, including both traffickers and employers, can be held responsible under the law. Read more: www.state.gov/documents/organization/10492.pdf www.acf.hhs.gov/trafficking/about/TVPA_2000.pdf
Meal and Rest Breaks		While federal law does not require employers to provide meal or rest breaks, some state laws require employers to give uninterrupted 30-minute meal breaks and 15-minute rest breaks; employers are not required to pay. Read more: www.dol.gov/dol/topic/workhours/breaks.htm
Deductions		Federal and state laws limit the types and amount of deductions employers can take from covered workers' paychecks (e.g. for shortages, breakage, or tools and uniforms). Read more: www.dol.gov/whd/regs/compliance/whdfs16.pdf
Collective Bargaining		
Clayton Act	1914	Protects organized labor from penalty under antitrust laws. Read more: www.justice.gov/atr/public/divisionmanual/chapter2.pdf
National Labor Relations Act (NLRA/Wagner Act)	1935	Gives workers the right to organize unions. Read more: www.nlrb.gov/national-labor-relations-act
Labor-Management Relations Act (Taft-Hartley Act)	1947	Prohibits the "closed shop," excludes "supervisory" employees from protections under the NLRA/Wagner Act, and prohibits and restricts certain union actions. Read more: www.law.cornell.edu/uscode/html/uscode29/usc_sup_01_29_10_7.html
Immigration		
Immigration and Nationality Act (INA)	1952	Consolidates the provisions of several guest worker programs regarding the recruitment, certification, and hiring of workers. Read more: www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=f3829c7755cb9010VgnVCM10000045f3d6a1RCRD&vgnextchannel=f3829c7755cb9010VgnVCM10000045f3d6a1RCRD
Immigration and Reform and Control Act (IRCA)	1986	Establishes a national worker verification system and sanctions against employers who knowingly hire undocumented workers. Read more: www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextchannel=b328194d3e88d010VgnVCM10000048f3d6a1RCRD&vgnextoid=04a295c4f635f010VgnVCM1000000ecd190aRCRD
Safety Net		
Family and	1993	Requires certain employers to offer their employees up to 12 weeks of

Medical Leave Act (FMLA)		unpaid leave during a 12-month period for certain family and medical conditions without penalty in wages, benefits, or position. Read more: www.dol.gov/whd/regs/statutes/fmla.htm Short-term, non-work-related disability programs are offered in California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island. California and New Jersey offer paid family leave via these programs. Read more: http://www.edd.ca.gov/disability/Paid_Family_Leave.htm http://lwd.dol.state.nj.us/labor/forms_pdfs/tdi/fli_poster.pdf
Workers' Compensation		Four disability compensation programs provide wage replacement benefits, medical treatment, vocational rehabilitation, and other benefits to federal workers or their dependents who get injured or become ill at work. Read more: www.dol.gov/dol/topic/workcomp/index.htm State workers' compensation boards can provide information to workers who get injured while employed by private companies or state and local government agencies. Read more: www.dol.gov/owcp/dfec/regs/compliance/wc.htm#AL
Social Security Act	1935	Provides retirement income to covered workers, as well as other benefits such as long term disability insurance and survivors' benefits. Read more: www.ssa.gov/OP_Home/cfr20/cfrdoc.htm, www.ssa.gov/disability/
Federal Unemployment Tax Act (FUTA)	1939	Provides, with state unemployment systems, payments of unemployment compensation to workers who have lost their jobs; most employers pay both a federal and a state unemployment tax. Read more: www.irs.gov/businesses/small/international/article/0,,id=104985,00.html
Medicare and Medicaid Act	1965	Provides federal health insurance for people 65 and older or people with disabilities. Read more: www.ssa.gov/history/tally65.html
Employee Retirement Income Security Act (ERISA)	1974	Protects employees' pension benefits by establishing rules about disclosure, vesting, participation, and funding. Read more: www.dol.gov/dol/topic/health-plans/erisa.htm
Paid Sick Leave		Requires employers to provide paid sick leave for employees to recover from illness or injury, seek medical care, or care for sick child, spouse, domestic partner, or parent. The State of Connecticut requires paid sick leave for individuals employed in specified service industry occupations. Read more: http://www.cga.ct.gov/2011/ACT/PA/2011PA-00052-R00SB-00913-PA.htm San Francisco County and the District of Columbia require paid sick leave for all employees. Read more: http://sfgsa.org/index.aspx?page=419 http://www.dccouncil.washington.dc.us/images/00001/20080311113451.pdf