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Worker Safety
Summary

Millions of workers risked their lives over the past two years to care for the United States’ sick and elderly and help put food on tables. The federal government should issue and enforce stronger protection standards in high-risk workplaces, update recommendations and guidance to reflect aerosol transmission, improve data collection, and enable workers to quarantine or isolate when necessary.

An Epidemic of Workplace Illnesses

Covid has been an unprecedented and massive worker safety crisis that resulted in an epidemic of workplace illnesses and deaths. Frontline workers in essential industries have valiantly risked their health and lives to get the job done. Hundreds of thousands of hospital and nursing home workers were infected by Covid at work and thousands died. Grocery store clerks, food processing workers, flight attendants and many others are taking similar risks. In the meat packing and poultry industry, where workers of color are disproportionately employed, at least 59,000 workers employed by just five companies were infected in the first year of the pandemic.108

Enormous numbers of workers in other jobs with crowded or public-facing work settings have been infected and sickened, and thousands died. Workers infected on the job go home to infect family members and neighbors, driving community transmission.109 More than two years into the pandemic, clusters of work-related cases continue to be reported at job sites across the country. Poor reporting and data collection systems mean the true number of worker infections, serious illnesses and deaths is unknown and likely never will be.

Millions of American workers spend 8 or more hours each day in indoor environments or vehicles where they are required to be in close contact with those potentially harboring infections, including coworkers, patients, clients, or the public. While vaccination is critical to prevent serious disease, Omicron has made clear that vaccinations alone will not stop transmission. Healthcare and long-term care facility workers, corrections officers, food industry workers, first responders and others employed in stores, warehouses, public transportation and many other settings are all at greater risk of Covid because of their jobs.

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Failure to control workplace exposures has wreaked havoc on the workforce. The results have been catastrophic for many who cannot work remotely. In addition to those who suffered severe Covid-related illnesses, millions of workers with mild or no symptoms have had to take time off of work after being exposed at work, and many workers debilitated by long Covid still drag themselves into work because they cannot afford to quit. The US Census Bureau estimates that, as of early February 2022, more than three million workers left the workforce due to concerns about getting or spreading the coronavirus to others. Many others likely have switched to jobs with lower risk of exposure.

Under the Occupational Safety and Health Act of 1970, employers are required to provide a workplace free of recognized, serious hazards. During the pandemic, OSHA has taken only limited steps to make the requirement for safe workplaces free of hazards a reality.

In June 2021 —16 months into the pandemic —OSHA finally issued a Covid-19 Emergency Temporary Standard covering only healthcare workplaces and then withdrew these protections in December 2021, saying that the law required that emergency protections be replaced by permanent rules within six months. OSHA has committed to issuing a permanent standard covering healthcare workers within an additional 6 to 9 months, although many workplace safety experts doubt the agency can meet the deadline.

OSHA also issued an emergency rule requiring employers outside of the healthcare industry with 100 or more employees to ensure that unvaccinated employees be masked and provide a negative test each week if they report to work. The rule was stayed by the Supreme Court and has been formally withdrawn by the agency.

A handful of states operate their own state OSHA plans for the private sector. Early in the pandemic, a few of these states issued requirements to protect workers in healthcare and other industries. However, only a few of those state-based protections remain in effect, leaving the overwhelming majority of workers with no workplace protections.

OSHA’s Respiratory Protection Standard requires employers to establish and implement a respiratory protection program for workplaces where respirators are necessary to protect the health of employees from certain inhalation hazards when higher forms of protection are insufficient. However, most workers are not covered by this standard and are in great need of respiratory protection. The absence of relevant standards limits OSHA’s ability to oversee employers who do not adequately control exposures to workplace hazards. The agency has attempted to address unsafe conditions through enforcement of some applicable regulations.
standards and the general duty of employers to provide safe workplaces, but it has focused primarily on healthcare workplaces where workers already died or high numbers were infected.

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OSHA’s enforcement capabilities are severely limited by its modest resources. Before the Covid pandemic, OSHA had enough inspectors to visit every workplace once every 162 years. The pandemic further strained its resources while leading to an enormous backlog of safety and health complaints and allegations of retaliation against workers who raised safety concerns.

Enforcement actions to ensure workplaces free of infection require data on workplace conditions. The limitations of the current systems to collect data about work-related Covid cases and deaths inhibit the ability of OSHA to target its enforcement and compliance assistance efforts. Some of the problems of data collection include the fact that for most Covid cases, no information on industry or occupation is collected. OSHA requires only employers in the healthcare industry to keep track of Covid cases, but even those employers only have to report cases serious enough to result in hospitalization. Employers in other industries only track those they believe are work-related within a narrow scope. Some states like California require employers to report workplace outbreaks, but most states do not. This lack of occupational health surveillance has severely restricted timely intervention in high-risk workplaces.

Paid Sick Leave, Ventilation, and Vaccinations

Like other workplace hazards, Covid exposures can be prevented and mitigated at work through government policy and workplace actions.

First, the federal government can directly reduce the workplace presence of infectious workers by establishing a national sick leave program. Early in the pandemic, under the emergency sick leave provision of the bipartisan Families First Coronavirus Response Act (FFCRA), workers employed by firms with less than 500 employees received up to two weeks of Covid-related sick leave. Researchers estimated these payments prevented about one case per day for every 1,300 workers covered.

There is currently no national requirement that employers provide wage payments or medical removal protection benefits to workers who are exposed or infected, or who have to take care of sick family members. A permanent national paid sick leave program covering these situations would remove incentives and requirements that workers come to work sick and risk infecting others.

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A policy requiring paid sick leave would address an important disparity that likely exposes lower-income workers and minorities to illness. Higher-income workers generally work at companies with existing sick leave policies. A national program would bring low-income workers sick leave parity, helping mitigate the health and economic burdens of Covid and other illnesses.

Second, the federal government should establish workplace standards regarding ventilation, appropriate PPE, physical distancing, and other basic public health precautions (see Chapter 4: Cleaner, Safer Indoor Air and Chapter 5: Personal Protective Equipment). Without these standards, OSHA is severely handicapped in requiring effective mitigation measures.

Boosting worker vaccination rates would also help protect employees who face significant risk of exposure to Covid and other respiratory viruses at work. To encourage vaccine uptake, the government can establish a federal paid time-off program for employees to get vaccinated or extend the federal sick leave program outlined above to include time to receive vaccinations and recover from potential side effects. Vaccination mandates can boost vaccination rates but can also increase strains on communities of color that have seen lower vaccine uptake.

Finally, the effectiveness of all workplace safety actions will be limited if there is not widespread public recognition of the importance of workplace precautions and the value of protecting frontline workers. Under the rubric of workplace safety parity and sick leave benefits, the Administration should lead a public educational campaign underscoring the right of workers to be safe at work and the responsibility of employers to provide safe workplaces, which can bolster OSHA and CDC regulatory efforts and recommendations.

Worker Safety Strategic Goals

1. Strengthen worker protections against Covid and other respiratory viruses through federal agency action and Congressional legislation.
   a. Enact legislation providing all workers with paid medical (sick) and family leave so that they can isolate, quarantine, or take care of a sick family member without loss of pay.
   b. Enact legislation providing all workers with paid medical (sick) leave so that they can be vaccinated against Covid.
   c. Ensure that costs of work-related Covid-19 testing are not borne by workers.
   d. Encourage or incentivize employers to require their workers to be fully vaccinated.
   e. Direct OSHA and the CDC to update guidance, recommendations, and enforcement directives to reflect the primary importance of aerosol transmission of SARS-CoV-2 and the need for employers to implement a comprehensive layered approach to limiting workplace exposures, including effective ventilation and air filtration and appropriate respiratory protection.
   f. Direct OSHA to issue a final, permanent Covid standard for all healthcare workplaces, including respiratory protection and ventilation requirements and mandated medical removal protection pay if a person is required to not work because of illness.
   g. Direct and fund OSHA to increase programmed inspections in high-risk industries where vulnerable workers are disproportionately employed.
   h. Require all establishments participating in OSHA’s Voluntary Protection Programs (VPP) or Safety and Health Achievement Recognition Program (SHARP) to follow OSHA and CDC guidance and ensure that all workers are fully vaccinated, with exceptions only for medical and religious reasons.
   i. Direct OSHA to issue a broader Infectious Disease Prevention Standard to protect healthcare and other high-risk worker groups and to prepare for future pandemics.

2. Direct OSHA and HHS to collaborate to educate employers, workers, and the public on controlling workplace exposures to airborne infectious diseases.
   a. Launch a national safe workplace campaign that stresses the importance of controlling workplace exposures to airborne infectious diseases and aerosols, and partner with private sector organizations to extend reach.
   b. Encourage employers to evaluate workplaces’ potential aerosol exposure risks and develop Covid safety management plans.
   c. Emphasize the value of worker input in controlling workplace exposures and remind employers that retaliating against workers for raising safety concerns is against the law.
   d. Require that employers provide high-quality face coverings--N95 respirators or equivalent--to workers in high-risk environments. (see Chapter 5: Personal Protective Equipment).

3. Require OSHA and the CDC to expand reporting of workplace infections to identify and prevent outbreaks.
   a. Direct OSHA to immediately issue regulations with new respiratory viral illness recording and reporting requirements, including employer reporting of respiratory viral clusters and outbreaks in their workplaces.
   b. Fund CDC/NIOSH to implement national surveillance of occupational infectious diseases, in coordination with OSHA, the Bureau of Labor Statistics, and the Council of State and Territorial Epidemiologists (CSTE).
   c. Increase CDC collection of infection and vaccination data on workers employed in high-risk industries.
   d. Direct the CDC to fund and require the standardized collection of industry and occupational fields on all Covid cases reported by state health departments. (see Chapter 9: Health Data Infrastructure).
4. Direct and empower OSHA to improve workplace indoor air quality and availability of workplace PPE.

a. Direct OSHA to issue an enforcement directive clarifying that the agency’s current Respiratory Protection Standard requires employers in high-risk industries to provide at least N95 respirators in situations where risk of airborne infectious disease transmission is high or where indoor working conditions are crowded or public facing (see Chapter 5: Personal Protective Equipment).

b. Direct OSHA to issue an enforcement directive enabling employers to require N95 face coverings use by workers not normally covered by OSHA’s Respiratory Protection Standard (RPS) and not employed in high-risk industries, without triggering the need to comply with the full RPS, as well as emphasize that mitigation measures must go beyond providing respirators and include a layered approach to reducing workplace exposure risk (see Chapter 5: Personal Protective Equipment).

c. Direct OSHA and CDC to incorporate ventilation and air filtration requirements for indoor work environments into OSHA standards and into OSHA and CDC guidance on preventing transmission of Covid and other airborne infectious diseases (see Chapter 4: Cleaner, Safer Indoor Air).

5. Fund OSHA and CDC research into prevention of workplace transmission of respiratory viruses.

a. Direct CDC/NIOSH to establish a research program on occupational airborne infectious disease prevention, including development of improved control technologies and respiratory protection.

b. Direct CDC/NIOSH to work with CSTE, NACCHO (the National Association of County and City Health Officials) and other organizations to improve local health departments’ capacity to respond to workplace infectious disease outbreaks, conduct hazard assessments, and contain and prevent disease spread. The CDC should also increase related funding for local departments.

c. Fund OSHA to augment its workforce of standards development experts, compliance officers, and whistleblower investigators.

d. Increase funding for state-based OSHA consultation programs that provide free guidance to small employers on reducing exposure risk.