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areas, and provides the basis for escalating conflict in an unstable, unplanned economy with its fluctuating high rates of unemployment.

Perhaps of even greater relevance than these studies of the impact of strikes on health status are those yet to be made, i.e., studies which define and describe mechanisms that can make health system bureaucracies more responsive to the needs of patients and health workers, both present and future. This offers an exciting challenge to those of us with technical skills who also regard ourselves as reformers or as agents of social change, working for the betterment of public health. It is also a constructive approach toward neutralizing the traditional consumer-provider dichotomy, and to breaking down the class, racial and ethnic, and sex barriers that have divided health workers over the years.

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Occupational Health Standards: What Are the Priorities?

The Occupational Safety and Health Act was passed in 1970 with a grand promise to provide for the improvement of working environments in the United States. The results to date, however, reflect the problems of regulation in a highly charged political environment. Both the National Institute of Occupational Safety and Health and the Occupational Safety and Health Administration created by the Act have received varying degrees of support during three different Presidential administrations. Recently OSHA has suffered serious judicial set-backs. Additionally, there are annual efforts in Congress to amend significantly or to repeal the Act. Finally, during the eight years that the Act has been in force, there have been four OSHA Assistant Secretaries, as well as one interim period during which there was no Assistant Secretary. During this same period there have been three NIOSH Directors and, during 1978, several Acting Directors. Cooperation between NIOSH and OSHA has been affected by these personnel shifts, by changes in administration, and by the personalities of the leaders themselves. Certainly, for the Act to be functional, the nation needs stability in leadership as well as mutual cooperation and trust between NIOSH and OSHA.

The attitudes of the current leaders of the two agencies, however, suggest that the future is not without promise. Both Eula Bingham (OSHA) and the recently appointed Anthony Robbins (NIOSH) appear to be committed to the protection of the health and safety of workers as their underlying goal. Neither sees a particular type of regulatory activity as uniquely effective. They are each seeking the best ways to protect workers' health in the context of our current economy. Furthermore, they appear eager to work together to reach these goals.

In this light the report by Perkins and Rose[1] published in this issue of the Journal is particularly interesting. They discuss how NIOSH initially established priorities for health standard documents and the evolution which led to the implementation of the current plan for development of documents on industries, occupations, chemical classes, and general industrial processes, as well as on individual toxic agents. They also point out how concern for chronic effects, especially carcinogenicity, has grown during the past seven years.

In their analysis Perkins and Rose do not address the question of how priorities for NIOSH criteria documents relate to or modify priorities for OSHA standards. Nor do they examine the problem of how OSHA and NIOSH might coordinate their activities. The 1970 Act charges OSHA with the responsibility for issuing health and safety standards, and in carrying out this charge OSHA is to consider health effects, as well as technical and legal feasibility of standards to be set, and the relative importance of the risk. NIOSH is to provide support by considering primarily the matter of health effects. Logic would seem to dictate that the priorities for standards should be determined by OSHA and NIOSH in

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concert, after which these priorities would be used by NIOSH to determine which criteria documents are needed and what research is required.

But, to date, the process has been the opposite: NIOSH criteria documents have attempted to promote OSHA standards. The reasons for this are not discussed by Perkins and Rose, but it should be understood that the development of criteria documents and the research associated with them continue to consume more than 50 per cent of NIOSH's research funds. In 1972, these documents cost less than $30,000 each. Some of the more recent documents have approached costs of $400,000 each. These latter costs have completely outstripped the rate of inflation, and their increase cannot be attributed to improvement in the quality of the documents produced. At present, criteria documents often contain uncritical compendia of the scientific literature on a particular topic.

If such documents are to continue to be produced, then they should contain critically analyzed scientific information necessary to determine both acute and chronic biologic effects. The conclusions of a criteria document should not necessarily result in a numerical exposure standard.

As witnessed by the OSHA standard setting process, a standard is a combination of social, economic, and political as well as scientific issues. NIOSH should remain the scientific branch of the input. It is hoped that this will result in a highly selective approach to criteria document development designed to provide the scientific basis for a health standard instead of merely producing numerous bibliographies which are submitted to OSHA but which remain largely unused. One important benefit of such a redirected effort in criteria documents would be a significant increase in NIOSH funds available for other long-term research goals of the agency.

It is satisfying to know that the two agency heads are already discussing ways to cooperate much more fully in standards development.

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Erratum

An error was made in one of the references in the article "Adult Leukemia Following Diagnostic X-rays?" *American Journal of Public Health* 69:137-145, 1979. Reference number 50 should read:

50. Fajardo LF: Radiation-induced coronary artery disease. Chest 71:563-564, 1977.

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