MEDICAL AND LEGAL ISSUES RELATED TO THE RECOGNITION OF OCCUPATIONAL DISEASE

A BRIEFING PAPER

ISSUE

This briefing paper discusses medical and legal issues related to the recognition of occupational disease under the Workers Compensation Act. It focuses on section 6 and associated provisions in section 55 and Schedule B. The provisions of section 7 and Schedule D, dealing with compensation for non-traumatic hearing loss, although alluded to, are not discussed at length.

HISTORY

Pre - 1942

In 1910, Ontario appointed Sir William Meredith to study the plight of workers injured and disabled as the result of occupational accidents and diseases. Meredith's recommendations, enacted into law in 1914, provided compensation for occupational diseases, (then called industrial diseases), as well as for accidental injuries. He addressed this issue at page 14 of his report.

> By my draft bill, following in this respect the British Act, industrial diseases are put on the same footing as to the right of compensation accidents.. The diseases to which the Act is to be made applicable are six in number and are enumerated in Schedule 3 to my draft bill, but the power is given to the board by its regulations to add to the schedule. It would, in my opinion, be a blot on the act if a workman who suffers from an industrial disease contracted in the course of his employment is not to be entitled to compensation. The risk of contracting disease is inherent in the occupation he follows and he is practically powerless to guard against it. A workman may to some extent guard against accidents, and it would seem not only illogical but unreasonable to compensate him in one case and to deny him the right to compensation in the other.[1]

In B.C., the Committee of Investigation on Workmen's Compensation Laws, headed by Avard V. Pineo, concurred in the view that occupational diseases, for the purposes of compensation, should be considered "the equivalent of a personal injury by accident."[2] As a result, compensation coverage for disease

[1] Final Report on Laws Relating to the Liability of Employers, 1913, p.13.
[2] Report of the Committee of Investigation on Workmen's Compensation Laws, March 1, 1916, p.16.

resulting from employment was incorporated into the first British Columbia Workmen's Compensation Act of 1916.

The original Act defined "industrial disease" as "any of the diseases mentioned in the Schedule and any other disease which by the regulations is declared to be an industrial disease". The definition of "regulation" included rules and regulations made by the Board.

Then, as now, the Schedule took the form of a list of diseases with an accompanying column specifying processes or industries. Where a worker suffered from an occupational disease recognized in the first column of the Schedule, the descriptions provided in the second column had the same legal significance as under the British Act, which was that:

> Instead of the workman having to prove that the disease was due to the nature of his employment, as he would have been obliged to do under the ordinary provisions of the Act, he was given the benefit of a presumption that it was so due if he was employed in one of the processes specified in the Act in relation to the disease 'at or immediately before' the date of disablement.[3]

The original Schedule listed 6 diseases. No diseases were recognized by regulation. By 1942, the legislature had added three more items to the Schedule and the Board had added 14. Although there is some doubt as to the power of the Board to add diseases to the Schedule prior to 1954,[4] the W.C.B. dealt with claims on the basis that it's additions to the Schedule were validly made.

1942 - 1968

The Royal Commissions on workers' compensation conducted by Mr. Justice Gordon Sloan in 1942[5] and 1952[6] focused attention again on the issue of occupational disease. Following the first Commission, one disease was added to the Schedule by the Legislature in 1943. Another three were added by the Legislature in 1954 following the second Commission. Between 1917 and 1954, the Board added approximately 60 diseases.

In 1954, the Legislative Assembly delegated authority to the Board to amend the Schedule "subject to the approval of the Lieutenant Governor in Council, on such

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[3] Industrial Diseases: A Review of the Schedule and the Question of Individual Proof, Oct. 1981 (Report by the Industrial Injuries Advisory Council), p.10.
[4] John P. Berry, Chief Solicitor of the Board, in the course of his evidence before the Commission of Inquiry conducted by Mr. Justice Tysoe had expressed this opinion. At page 228 of his final report, issued in 1966, Mr. Justice Tysoe stated: " I share that doubt."
[5] See Report of the Commissioner Relating to the Workmen's Compensation Board, 1942.
[6] See Report of the Commissioner Relating to the Workmen's Compensation Act and Board, 1952.

terms and conditions and with such limitations as the Board may deem adequate and proper".[7]

In 1959, the definition of "industrial disease" was broadened to include any disease which the Board by regulation "or otherwise" designated or recognized as an industrial disease. The Board was also given authority to "designate or recognize any disease as being a disease peculiar to or characteristic of a particular process, trade, or occupation on such terms and conditions and with such limitations as the Board may deem adequate and proper."[8] It appears that this latter provision was intended to allow the Board to recognize occupational diseases in specific cases.[9] The broadening of the definition of "industrial disease" was consistent with that intent.

In 1966, Mr. Justice Tysoe delivered his Royal Commission report[10] indicating that confusion had resulted from the fact that the published Schedule listed only the 13 diseases that had been approved by that time by the Legislature. It did not include diseases added to the Schedule by the Board. He pointed out:

> This situation could very well operate to the detriment of workmen. Cases can arise in which, because a disease added to the Schedule by the Board does not appear in the Schedule to the Act itself, there is no awareness of the workman's entitlement to the benefit of the presumption... There may even be cases where it is wrongly thought that a particular disease is not compensable.[11]

The Commissioner also found that the Board had not been diligent in keeping the Schedule updated. He recommended that the Schedule be revised and consolidated "in one place available for all to see."[12] These recommendations were implemented in 1968 and the new Schedule was incorporated in the legislation as Schedule B. Another recommendation was that the Board alone have the authority to amend the Schedule. Legislation removing the need for Cabinet approval was subsequently enacted in 1968.

Changes Since 1968

A new section and Schedule dealing with compensation for non-traumatic hearing loss were added to the Act in 1974. That same year, the definition of "industrial disease" was amended to add that "disease" includes "disablement from exposure to contamination". In 1975, the Board recognized 17 occupational diseases by regulation.

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[7] Workmen's Compensation Act Amendment Act, 1954, section 8(3)(a).
[8] Workmen's Compensation Act Amendment Act, 1959, section 8(3)(c).
[9] See discussion in footnote 20.
[10] Commission of Inquiry- Workmen's Compensation Act- Report of the Commission, 1966.
[11] Ibid., p. 232.
[12] Ibid.

Few changes were made to Schedule B until 1980, when a major revision was undertaken. The process generated some criticism because the Board drafted the revisions without advice or input from adjudication staff, rejected a call for public hearings into the proposed changes and gave no published reasons for the specific amendments.[13]

In 1983 the definition of "industrial disease" was changed to clarify that the term included those diseases listed in Schedule B as well as those diseases recognized by the Board by regulation "of general application or by order dealing with a specific case".

In 1992, following restructuring of the Board's governance in 1991, a permanent Industrial Diseases Standing Committee (later called the Occupational Diseases Standing Committee[14] or ODSC) was constituted. This committee was made up of 2 worker representative Governors, 2 employer representative Governors and one public interest representative Governor. The Chair of the Board of Governors chaired the Committee. Later, the President of the Board was added as an ex officio member of the Committee.

The Committee's primary role was to review the Board's policies on occupational diseases and make recommendations for change to the Governors. One of the specific responsibilities listed in the Committee's Charter[15] was to completely review all entries listed in Schedule B (which then included approximately 50 diseases) and make recommendations to the Governors for updating the Schedule. Another responsibility was to review the list of occupational diseases designated or recognized by the Board by regulation. The number of these diseases totalled 19.

In 1994, following an extensive public consultation process which included a public hearing, the Committee recommended that an additional 15 diseases be added to the list of occupational diseases recognized by regulation of the Workers' Compensation Board. They also recommended adoption of revised policies dealing with compensation for occupational disease. These recommendations were adopted by the Board on November 7, 1994.[16]

With respect to Schedule B, the Committee recommended that, except for six items,[17] each of the diseases as well as the description of the process or

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[13] Dennis Campbell, Briefing to Panel of Administrators, Subject-Schedule B, Oct. 31, 1995, p.6.
[14] Name changed by Governors' Decision #64, published at 10 WCR 305. The term "occupational disease" was substituted for "industrial disease" by the Workers Compensation Amendment Act, 1994.
[15] Governors Decision #19, published at 8 WCR 135.
[16] Governors Decision #77, published at 10 WCR 761. The Regulation recognizing the additional occupational diseases became effective January 1, 1995.
[17] These were Schedule B Items #3A (bilateral diffuse pleural thickening or fibrosis), #5 (heart injury or disease), #8(respiratory irritation), #12 (bursitis), #13 (tenosynovitis, tendinitis) and #16 (vascular disturbances of the extremities).

industry associated with each disease be retained without change. Regarding the six remaining items, the Committee recommended that it undertake a further process of assessment and review to determine whether the descriptions contained in the Schedule were consistent with the current level of scientific knowledge. The Committee recommended that, pending completion of the review, the six items remain in the Schedule. On April 11, 1994 the Board approved these recommendations. The Committee began a review of the six outstanding items by seeking independent medical/scientific assessments and, in some cases, independent expert peer reviews of those assessments. It had begun to discuss the assessments and peer reviews received on two of the items, as well as draft language for possible amendments, when the Governors ceased holding office on July 13, 1995. The Committee has not been reconstituted and its tasks remain unfinished.

CURRENT LEGISLATION AND POLICY

Requirements for Compensability

Section 6(1) provides that:

> Where
> (a) a worker suffers from an occupational disease and is thereby disabled from earning full wages at the work at which he was employed or the death of a worker is caused by an occupational disease; and
> (b) the disease is due to the nature of any employment in which the worker was employed, whether under one or more employments, compensation is payable...as if the disease were a personal injury arising out of and in the course of that employment. A health care benefit can be paid although the worker is not disabled from earning full wages at the work at which he was employed.

The Board's published policy[18] interprets the wording of this section to mean that for diseases to which section 6(1) apply, there are three basic requirements for compensability. To be entitled to benefits other than health care benefits:

- The worker must be suffering (or in the case of a deceased worker have suffered) from a disease designated or recognized by the Board as an "occupational disease";
- The disease suffered by the worker must be or have been "due to the nature of any employment" in which the worker was employed; and
- The worker must be "disabled from earning full wages at the work" at which he or she was employed as a result of the disease. In the case of a

[18] Rehabilitation Services & Claims Manual, Item #25.10.

> deceased worker, his or her death must have been caused by such disease.[19]

The Definition of an Occupational Disease

Section 1 defines “occupational disease” as:

> any disease mentioned in Schedule B and any other disease which the Board, by regulation of general application or by order dealing with a specific case, may designate or recognize as an industrial disease, and ‘disease’ includes disablement resulting from exposure to contamination.

Subsection 6(4)(a) gives the Board the power to amend Schedule B by adding or deleting diseases or processes or industries. Subsection 6(4)(b) provides that:

> Notwithstanding paragraph (a), the board may designate or recognize a disease as being a disease peculiar to or characteristic of a particular process, trade or occupation on the terms and conditions and with the limitations the board deems adequate and proper.

These provisions have been interpreted to mean that an occupational disease means a disease recognized by the Board:

- by inclusion in Schedule B;
- by regulation of general application; or
- by order dealing with a specific case.[20]

Establishing Employment Causation

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[19] This requirement does not apply to silicosis or pneumoconiosis claims for which there are separate provisions under section 6, or to claims for non-traumatic hearing loss which are compensable under section 7.

[20] Board policy conflicts on this point. Decision #326 (published at 5 WCR 78), as well as Decision #238 (published at 3 WCR 104), are based on the premise that there are 3 ways in which the Board may recognize an occupational disease. However, Item #26.02 of the Rehabilitation Services and Claims Manual states that there are 4 methods of recognition. The fourth method is described as "limited designation or recognition" as a disease peculiar to or characteristic of a particular process, trade or occupation. Section 6(4)(b) of the Act is cited as authority for this additional method. The former Chief Appeal Commissioner analyzed the language and history of section 6(4)(b) and concluded that it was the source of the Board's power to designate occupational diseases by regulation of general application or by order in a specific case. She did not interpret the section as providing any additional powers. As support for this interpretation she pointed out that the Commissioners invoked section 6(4)(b) in Decision #231 (published at 3 WCR 87) to recognize osteoarthritis of the first carpo-metacarpal joint of both thumbs as a disease peculiar to or characteristic of the claimant's occupation as a physiotherapist. However, the Commissioners qualified this recognition by specifying that recognition of the disease was limited to factual situations which were substantially the same as that claim. The former Chief Appeal Commission found that "(t)his amounts to recognizing a disease for the purpose of an individual claim under Section 6(4)(b) which is consistent with the interpretation found in Decision No. 238." Her analysis can be found at 10 WCR 257, starting at p.275.

There are two main methods for establishing causation.
Section 6(3) provides:

> If a worker at or immediately before the date of disablement was employed in a process or industry mentioned in the second column of Schedule B, and the disease contracted is the disease in the first column of the schedule set opposite to the description of the process, the disease shall be deemed to have been due to the nature of that employment unless the contrary is proved.

The effect of this section is to create a rebuttable presumption that the disease is due to the nature of the employment, when the worker is suffering from one of the diseases listed in the first column of Schedule B and, at or immediately before the date of disablement, the conditions in the second column of the Schedule are met. Where the conditions set out in the second column are not met, that simply means the presumption does not apply to the adjudication of causation. The condition itself is still a scheduled occupational disease.[21]

In cases where the requirements of section 6(3) are not met, the decision on whether the disease is due to the nature of any employment is determined on the merits and justice of each case. The Board is governed by section 99 which provides:

> The board is not bound to follow legal precedent. Its decision shall be given according to the merits and justice of the case and, where there is doubt on an issue and the disputed possibilities are evenly balanced, the issue shall be resolved in accordance with that possibility which is favorable to the worker.

The proper application of this section is discussed in published policy as follows:

> Under the old English system, which was an adversary system of worker's compensation, there was a burden of proof imposed on the worker, but that is not the correct practice here. The adjudicator must not start with any presumption against the worker, but neither must he start with any presumption in his favour. The correct approach is to examine the evidence to see whether it is sufficiently complete and reliable to arrive at a sound conclusion with confidence. If not, the adjudicator should consider what other evidence might be obtained, and he must take the initiative in seeking further evidence. After that has been done, if, on weighing the available evidence, there is then a preponderance in favour of one view or the other, that is the conclusion that must be reached. If it appears upon the weighing of evidence that the disputed possibilities are

[21] Decision #250, published at 3 WCR 142.

evenly balanced than the rule comes into play of giving the benefit of the doubt to the worker or dependent.[22]

In addition to these two primary methods of establishing causation, the Act has special provisions which apply "where a deceased worker was, at the date of his death, under 70 years and suffering from an occupational disease of a type that impairs the capacity of function of the lungs, and where the death was caused by some ailment or impairment of the lungs or heart of non-traumatic origin". In such a case, section 6(11) provides that "it shall be conclusively presumed that the death resulted from the occupational disease." The effect of this section is to create an irrefutable presumption that the death resulted from an occupational disease, once the age of the worker and the conditions set out in the section have been established.

Disabled From Earning Full Wages

There is no definition of "disability" in the Act. According to the Board's published policies, the phrase "disabled from earning full wages at the work at which he was employed" means that there must be some loss of earnings from the work at which the worker was regularly employed, on the date he or she was disabled.[23]

Statutory Time Bars

Under section 55, a worker or dependent must file an application for compensation within one year after the date the worker is disabled or dies from an occupational disease. However, the section also provides that, where the Board is satisfied that there are special circumstances that precluded the filing of an application within this time limit, it may pay compensation on certain terms and conditions. This section was amended in 1994 to allow payment of benefits retroactive to the date of disablement, when new medical and scientific evidence becomes available to the Board which is sufficient to permit it to recognize an occupational disease. However, the application must be filed within three years of the date that evidence becomes available to the Board. Where the application is filed outside this time limit, the Board may only pay compensation retroactive to the date the application was received by the Board.

Section 6(3) Time Limit

The second time limit affecting occupational disease claims is contained in section 6(3). This section provides that, in order to take advantage of the statutory presumption afforded to diseases recognized in Schedule B, a worker must have been employed in the specified process or industry "at or immediately before the date of disablement". The policy interpretation of the phrase

[22] Decision #52, published at 1 WCR 221.
[23] Rehabilitation Services and Claims Manual, Item #26.30.

"immediately before" indicates that these words are intended to deal with those situations where someone has been employed in the process or industry described in the Schedule, and has left that employment a very short time prior to the onset of the disease. However, the policy states that:

> [a]n exception to this is where the medical and scientific evidence has established that there is a long latency period between exposure to the process, agent or condition of employment and the time the disease first became manifest.... [I]n a claim filed by a worker who suffers from a recent onset of a cancer listed in Schedule B but who has not worked in the process or industry described opposite such cancer for a number of years, it may be appropriate to conclude that such worker was employed in such process or industry "immediately before the date of disablement" by virtue of the long latency period which is known to exist with respect to such cancer. [24]

This policy was reviewed in a recent Appeal Division decision[25] involving a claim for bladder cancer. The panel found it was not a viable interpretation of the phrase "immediately before" to include a gap of 19 years between employment and manifestation of the disease. The Appeal Division panel reviewed the statute and concluded that "immediate" or "immediately" are intended to refer to a short period of time. The panel suggested that the definition found in the policy may require a legislative amendment.

DISCUSSION

The occupational disease provisions have, at times, generated considerable controversy. Stakeholders have challenged the appropriateness of having separate legislative provisions for occupational disease; questioned the principle of scheduled coverage; alleged a lack of leadership by the Board in recognizing occupational diseases and a lack of diligence in keeping the schedule current. The following fundamental questions, identified in 1983,[26]continue to be posed today:

- How should "occupational disease" be defined?
- Should occupational diseases be treated legislatively in a different manner than personal injuries? (i.e., Should there be different requirements for compensability, different time limits for applying, different compensation provided?)
- Should the Board be required to adjudicate all occupational disease claims on a case by case basis under an open-ended

[24] Rehabilitation Services and Claims Manual, Item #26.21.
[25] Appeal Division Decision #96-0727.
[26] These questions are based on those posed in the report, Trends in Workers' Compensation: Task Force Report to the Board, Vol. II, November 1983.

statutory provision or should there be schedules which establish presumptive causal connections between certain occupational diseases and certain industrial processes?

- If presumptive schedules are to be used, should Schedule B be expanded, and if so, what criteria should be used for inclusion or amendment?
- If Schedule B is to be maintained, who should have responsibility for conducting reviews and deciding on changes?

How should "occupational disease" be defined?

At the root of this issue is the challenge of establishing disease causation. Unlike injuries, which often result from a single definable, observable incident where the effects are immediately apparent, disease causation is often multifactoral, involving elements which may be occupational, non-occupational, or both. Cancer, for example, may be caused by prolonged occupational exposure to carcinogens; by exposure in the general environment; by the worker's own dietary or smoking habits; or by the combined and possibly synergistic impact of these factors. In addition, the difficulties of establishing causation are exacerbated by the fact that many diseases have a long latency period. This may explain why so few claims are made or paid for disease.[27]

Difficulties in establishing causation have led to pressure from employers to limit the scope of occupational disease compensation.[28] Indeed, Meredith noted in 1913 that the Canadian Manufacturers Association had expressed concern that the system would soon expand into a general plan of sickness insurance if diseases were covered at all.[29] As a result, the legislation in some Canadian jurisdictions excludes certain conditions from recognition as occupational diseases. The Manitoba, New Brunswick, Nova Scotia and Prince Edward Island Acts all exclude chronic stress. In Prince Edward Island "an ordinary disease of life" is also excluded under the Act.

Although the British Columbia Act does not preclude any condition from possible recognition as an occupational disease, Board policy may. For example, according to policy, a state of emotional and physical exhaustion due to the stress of work over time (sometimes called "chronic stress") is neither

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[27] Terence G. Ison, Compensation Systems for Injury and disease: The Policy Choices, Butterworths, 1994, p.7. See also Compensating for Occupational Disease in Canada 1995/1996, Association of Workers' Compensation Boards of Canada, p. 13. The results of this survey show that in Canada, the ratio of accepted time loss occupational disease claims to total number of accepted time loss claims was 6.9% in 1994. In B.C. the ratio was 6.7%. These ratios have remained virtually unchanged since 1991.

[28] For example, in 1952 Chief Justice Sloan noted that the Consolidated Mining and Smelting Association had opposed adding occupational deafness to the schedule and that the Canadian Pulp and Paper Association had submitted that the Board was improperly granting pensions for heart conditions (Supra Note 6 at pp R47 and R90).

[29] Supra note 1.

compensable as an injury nor as an occupational disease. It is not compensable as an injury because it is not traumatically- induced[30] and it is not compensable as an occupational disease because the Board does not recognize any psychological or emotional conditions as occupational diseases.[31]However, in a paper on psychological stress,[32] the former Chief Appeal Commissioner reiterated that policy cannot restrict legislation and concluded that the Act, as presently drafted, may be sufficiently broad to encompass chronic stress.

Some provinces have limited the scope of coverage for occupational disease by setting a higher standard of proof of employment causation. In B.C., for a disability due to disease to be compensable, there must be “something in the nature of the employment that has causative significance”.[33] This means that “it is not necessary that the worker’s employment be the most significant factor in his continuing condition; it is sufficient that the employment was a significant contributing factor".[34]

In contrast, the Acts in Manitoba and Prince Edward Island have provisions specifying that where a disease is partly due to employment and partly due to other causes, it is compensable only when the evidence establishes that employment was the “dominant cause”. The Saskatchewan Board, by practice, requires the evidence to be “significantly or predominantly” in support of work relatedness.[35] For example, that Board’s policy in respect to chronic stress requires that there be “clear and convincing evidence” that the work was the “dominant cause” of the disablement. Whether the legislation uses the term "significant", "dominant" or "predominant" to describe the standard, its meaning is still subject to interpretation in each case.

In the future, the list of medical conditions that could potentially be covered under the legislation will continue to grow and contemporary trends indicate that establishing causation will become even more problematic. For example, the increasing incidence of cancers in the general population, an ever expanding array of chemicals used in commerce and in the home, a growing number of home based workers, an aging workforce and the development of new technologies for use in the workplace will all add to the complexity of policy development and adjudication. Calls from some employers to restrict occupational disease compensation are likely to increase on the basis that it is too hard to determine work-relatedness. At the same time, there will be increased demands from other stakeholders to extend the scope of disease

[30] Rehabilitation Services and Claims Manual, Item #13.20.
[31] Rehabilitation Services and Claims Manual, Item #32.10.
[32] 10 WCR 257.
[33] Decision # 101, published at 2 WCR 23.
[34] Terence G. Ison, Workers' Compensation in Canada, 2nd ed., Butterworths, 1989 p.58.
[35] Compensating for Occupational Disease in Canada 1995/1996, Association of Workers’ Compensation Boards of Canada, p.40.

coverage on the grounds that, if a disease is work-related, it should be compensable.

Should there be separate occupational disease provisions in the legislation?

In his second report on the workers' compensation system in Ontario, Paul Weiler expressed the view that "[occupational] disease has historically been treated as the legal stepchild of the workers' compensation regime."[36] In a similar vein, Ison writes that "The acts generally read as if they had been drafted to deal with injury cases, and the coverage of disease was engrafted as an afterthought."[37] The reason for these perceptions was that, typically, the statute was structured so that the basic condition entitling a person to benefits was a personal injury by accident arising out of and in the course of employment. Occupational diseases frequently had a provision of their own "tucked away in the back of the statute, under which, ironically, a person disabled as a result of the disease [was] 'entitled to compensation as if the disease was a personal injury by accident'. The reason for this roundabout statutory route [was] that [occupational] diseases [had] always been subject to special definitions and limitations." [38]

Although equal treatment of injuries and diseases had clearly been intended by Meredith and Pineo, the Ontario and B.C. Acts continue to be structured in such a way as to afford disease an apparently subsidiary status. However, the trend in the rest of Canada is towards equal treatment. For example, Quebec and the Yukon have adopted a generic term for both occupational disease and injury. Quebec uses the term "employment injury" while the Yukon uses "work-related impairment" or "work-related disability". Newfoundland and Saskatchewan have taken a different approach by including occupational disease in the definition of "injury". In Manitoba, Alberta, New Brunswick, P.E.I., the Northwest Territories and Nova Scotia the definition of "accident" includes an occupational disease.

However, equality of treatment does not necessarily mean that diseases and injuries are treated identically. For example, Quebec continues to have separate time limits for occupational disease claims in recognition of the fact that many diseases have long latency periods. Such provisions are unnecessary in the Yukon because time limits run from the date of disability, whatever the cause.

In B.C., occupational disease claims are subject to different time limits than injury claims, and there are different prerequisites for entitlement to compensation.

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[36] Paul C. Weiler, Protecting the Worker from Disability: Challenges for the Eighties, a report submitted to the Minister of Labour (Ontario) April 1983, p.25.
[37] Terence G. Ison, Dilemmas in Adjudication- a paper presented to the Occupational Disease: Risk, Prevention and Compensation Conference, May 20-21 1986, Toronto, p.5.
[38] Supra note 36, p.26.

The "disablement" requirements

Section 6 requires that a worker suffering from an occupational disease be "thereby disabled from earning full wages at the work at which he was employed" before he or she is entitled to compensation (other than health care benefits). However, this is not a requirement where the death of a worker is caused by an occupational disease. The Board's policy interpretation is that there must be a loss of earnings from regular employment at the time of disablement (unless the worker's death is caused by an occupational disease). As a result, where an occupational disease does not become manifest until after retirement, arguably, no compensation (other than health care benefits) is payable to the worker.[39] However, if a worker dies from an occupational disease, manifesting after retirement, his or her spouse would be entitled to benefits.

While the language in section 6 was found in the original statute and was common in other Canadian Acts, British Columbia is the only jurisdiction that retains an economic test for occupational disease claims.[40] The worker community has advocated for removal of this language so that retirees suffering from an occupational disease can be compensated for impairment of function. However, as such awards must be calculated with reference to average earnings, a method for determining average earnings of retirees would need to be formulated.

The Board's interpretation of the "disabled from earning full wages" requirement is reflected in its policies dealing with the payment of compensation for allergies and sensitivities. According to these policies, allergic reactions that may appear as dermatitis[41]or asthma[42]are compensable as occupational diseases. However, the underlying sensitivities that cause these conditions do not, in themselves produce entitlement to some benefits. The policies state that, when the worker's symptoms have resolved, he or she is no longer suffering from an occupational

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[39] See Appeal Division Decisions #92-1313 (published at 9 WCR 269), #96-0727 and #96-0727 as examples. However, see also Appeal Division Decision # 92-0658, 92-0659, 96-0660 (published at 8 WCR 145) where it was found that a worker who had received temporary disability benefits for his occupational disease prior to retirement did not have to meet the test in section 6(1) again to be considered for permanent disability benefits.

[40] This is different from injury cases. See Rehabilitation Services and Claims Manual, Item #12.00 which states: "The basic provision governing a worker's right to compensation for personal injury is Section 5(1. This provides that where, in an industry within the scope of the Act, personal injury or death, arising out of and in the course of employment is caused to a worker, compensation as provided by the Act shall be paid by the Board." Section 5(2) provides that, where an injury disables a worker from earning full wages at the work at which he was employed, compensation as payable...from the first working day following the day of his injury; but health care only is payable...in respect of the day of his injury. The Board interprets this section as dealing with commencement of wage loss benefits rather than entitlement to compensation. (See Rehabilitation Services and Claims Manual, Item #34.30).

[41] Rehabilitation Services and Claims Manual, Item #30.50.

[42] Rehabilitation Services and Claims Manual, Item #29.20.

disease. Neither is the worker considered to be disabled from working at his or her regular employment.

However, the fact is that a worker who suffers from asthma, caused by occupational exposure to red cedar dust, is incapable of working at his or her regular employment. As a result, this policy has been contentious. Application of the policy means that such a worker will not receive consideration for a permanent disability pension unless his or her symptoms do not entirely resolve or the worker is left with a permanent impairment of the respiratory system. However, the worker will receive wage loss benefits during the period of his or her recovery from an asthma attack and may be provided with rehabilitation benefits to enable him or her to return to other employment.

In contrast, under the Ontario legislation, a worker is entitled to compensation if he or she has "a medical condition that in the opinion of the Board requires the worker to be removed either temporarily or permanently from exposure to a substance because the condition may be a precursor to an industrial disease".[43]

The Board's policy on preventive measures and exposures also involves the issue of disablement. This policy deals with the definition of "occupational disease" in section 1, specifically the clarification that "disease" includes "disablement resulting from exposure to contamination". Because "disablement" is required, the Board takes the position that:

> An exposure which does not result in a personal injury or occupational disease does not meet the requirements of the Act in terms of compensability.[44]

Based on this rationale, the Board's published policy states that:

> No matter how appropriate it may be for a worker to be provided with prophylactic health care, particularly following an exposure to an infectious agent, the Board does not have the statutory authority to pay for such health care where the worker has not sustained a personal injury or is suffering from an occupational disease, even if the exposure places the worker at risk of developing an occupational disease... In the event of such exposure, any medical or other expenses that the worker may incur to prevent the onset of injury or disease must remain the responsibility of the worker or the employer.[45]

The Board will pay for a gamma globulin injection if a nurse pricks his or her finger with a contaminated hypodermic needle, just used for injecting a patient suspected of having infectious hepatitis; it will not pay if an ambulance attendant

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[43] See definition of "industrial disease", R.S.O. 1990, C.- W.11, s.1.
[44] Rehabilitation Services and Claims Manual, Item #32.60.
[45] Ibid.

has the blood of a suspected Hepatitis B carrier splashed onto his hand, which has pre-existing cuts from gardening at home, unless the attendant contracts the disease.

Time limits

Some inequities in respect to time limits for occupational disease claims were remedied in 1994 with amendments to section 55. However, the time limit specified in section 6(3), providing that the statutory presumption for scheduled diseases is to be available only to workers employed in the specified process or industry "at or immediately before the date of disablement", remains an issue. At least since 1983, there have been calls for this section to be amended to recognize that some diseases, such as cancers, have a long latency period.[46]

The Appeal Division has also identified problems with the Board's policy interpretation of this section and has suggested that a legislative amendment may be required to take into account those situations where there is an extended period of time between occupational exposures and manifestation of the disease.[47] A review of Canadian legislation reveals that, of the five other provinces that have a statutory presumption, only Ontario and Quebec specify no time limit for its application. Alberta specifies a 12 month time limit, while Newfoundland and Nova Scotia use the same time limit as B.C.

Should there be a schedule?

As noted in Chapter 4 of the Rehabilitation Services and Claims Manual:

> The fundamental purpose of Schedule B is to avoid the repeated effort of producing and analyzing medical and other evidence of work-relatedness for a disease where research has caused the Board to conclude that such disease is specific to a particular process, agent or condition of employment.[48]

In the past, proponents of a presumptive Schedule have argued that its elimination would simply add another significant barrier to numerous existing barriers to acceptance of occupational disease claims. Advantages of a Schedule which are frequently cited are:

- administrative efficiency, by permitting fast-tracking of disease claims if there is sufficient evidence to meet the conditions of Columns 1 and 2, as no further, detailed investigation should be required;

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[46] Trends in Workers' Compensation: Task Force Report to the Board, Vol. II, p. 1 under Tab 18.
[47] Supra note 25.
[48] Supra, note 24.

- consistency in decision making, by providing guidance to adjudicators and a common tool for them to use in determining associations between diseases and processes or occupations; and
- educational value to workers and employers, by indicating which diseases and processes are associated and, therefore, potentially compensable.

Others have taken the position that each claim should be decided on its own merits, without the benefit of any presumption in favour of causation. The advantages of this approach are felt to include:

- reduced opportunity for error which might occur through the application of a presumption; and
- better adjudication as a result of thorough investigation of all claims.

The merits of a presumptive Schedule were debated before the Sloan[49] and Tysoe[50] commissions as well as before Weiler[51]during his review of the Ontario workers' compensation system. All concluded that a Schedule should be retained, primarily on the grounds of administrative efficiency and fairness to workers.

Mr. Justice Tysoe assessed the situation as follows:

> One or two individuals raised the question as to the necessity of a schedule. I have some doubts about it myself. However, I cannot ignore the presumption in favour of the workman that is created by subsection (2) of section 8 [now section 6(3)]. That presumption has been in the Act since it was first enacted in 1916, and it is in the Acts in some of the other Provinces. It is of definite benefit to workmen. Compensation payments for deaths of several firemen who died from heart disease would not have been permissible had it not been for the presumption, and there may be other instances of a like nature. I do not think the assistance of the presumption should be taken away from workmen. This is not to say that it should be given in respect of every disease. In my opinion it should not be.[52]

Mr. Justice Sloan expressed this view:

> It would appear that the International Association of Industrial Boards and Commissions favours blanket coverage rather than scheduled coverage of occupational diseases, but it seems to me, when kept in harmony with

[49] Supra note 5, p.128; Supra note 6, p.R35.
[50] Supra note 10, p.230.
[51] Supra note 36, p.32.
[52] Supra note 10, p.230.

> industrial development, the schedule system is simple to understand and easy to administer. Certainly I fail to see any superiority in the general coverage method which would justify a complete departure from the present policy of our Act.[53]

The value of a Schedule has been summarized by Dorsey et al. as follows:

> Its administrative value has been to produce efficiencies and consistency, although its existence has and can overshadow its role as only one avenue to establishing causation and entitlement to compensation for occupational disease. Its social value has been to establish an institutional memory in a highly specialized area of scientific knowledge. Its political value has been to draw attention to certain work processes and their consequences for the health of workers and society. This should bring attention to and create responsibilities and action for prevention by employers, workers, the Board and government.[54]

A different point of view was expressed in an Ontario Task Force report prepared in 1983 for Paul Weiler.[55] It concluded that while presumptive Schedules made it easier for some workers to establish their claims, their overall utility was questionable. The Task Force stated that this is because there were very few diseases listed in the Schedules and most of the diseases bore little resemblance to diseases then found in the workplace. Consequently the Schedules could rarely be used. However, this is clearly not the case in B.C., where nearly 30% of occupational disease claims are accepted through application of the presumption in Schedule B.[56]

Half of all Canadian jurisdictions do not use a Schedule.[57] On the other hand, Ontario now has two Schedules: one listing diseases for which there is a rebuttable presumption of causation and the other listing diseases for which the presumption is conclusive.[58] B.C.'s legislation also has a provision in section 6(11) which provides for a conclusive presumption of causation. However, the section applies only in the case of a worker dying under specified conditions.

Should Schedule B be expanded and, if so, what should be the criteria for inclusion or amendment?

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[53] Supra note 6, p.R35.
[54] Dennis L. Campbell and James E. Dorsey, Workers' Compensation 1993- Occupational Disease, Continuing Legal Education, June 1993.
[55] Supra note 35, p.14.
[56] Data provided by Occupational Disease Services for period January 1, 1995 to August 31, 1995.
[57] Schedules of occupational diseases were included in the original Workers Compensation Acts in all provinces, except New Brunswick. Currently, Manitoba, P.E.I., Saskatchewan, the Yukon and the Northwest Territories do not use a schedule. In the Northwest Territories this is under review.
[58] This latter schedule contains only 3 diseases: asbestosis, mesothelioma and cancer of the nasal cavities.

There is no simple, objective means of assessing whether Schedule B should be expanded.[59] The Act provides no guidance as to criteria for amending Schedule B. It gives the W.C.B. discretion to amend the Schedule on the "terms and conditions and with the limitations the board deems adequate and proper."[60]

The original six diseases in the B.C. Schedule were listed in the Schedule to the British Act. These diseases were related to "dangerous trades". The risks of carrying out such trades were self-evident and included acute poisoning by lead, mercury or arsenic.

Between 1916 and 1954, the process for adding diseases to the B.C. Schedule was described as follows:

> The Board at times followed the lead of Britain or Ontario. At times, amendments were made at the request of Board medical staff based on the accumulation of scientific or medical evidence. On occasion, amendments were initiated outside the Board, usually as a result of submissions to the Commissioners of the day.[61]

In 1966, Mr. Justice Tysoe described the principle operating then:

> The Board makes an addition to the schedule with the approval of the Lieutenant Governor in Council whenever it is satisfied from the advice it receives from the Board's Medical and Industrial Hygiene Departments that there is a substantially greater incidence of a particular disease in a particular employment than there is in the general population. Mr. Eades [Chairman] said:-
>
> > I think the test generally is: Is it common in that particular industry, and not common amongst the general public? Is it something specific to the industry?[62]

In 1975, the Board's Commissioners described the test for recognizing an occupational disease by inclusion in Schedule B and distinguished it from the test for recognizing an occupational disease by regulation (under what was then section 2).

> Where it appears to the Board that a disease is more likely to occur in a particular process or industry than elsewhere, it may be added to Schedule B.

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[59] Comparing schedules for other Canadian jurisdictions is not particularly instructive. Although there are differences amongst the schedules, there is also a substantial degree of similarity. At least some of the differences in the schedules can be explained by differences in each province's industrial base.
[60] Section 6(4)(a).
[61] Supra note 13, p.5.
[62] Supra note 10, p.228.

> ...Where it appears to the Board that a disease is sometimes due to the nature of an employment covered by the Act, but it does not appear that the disease is more likely to occur in a particular industry or process than elsewhere, the Board may designate or recognize the disease under Section 2.[63]

In 1990, the Board's Commissioners clarified that recognition of an occupational disease is restricted to a particular claim when, though the evidence in that claim supports a work relationship, the evidence is insufficient to support a more general recognition by regulation.[64]

The Board continues to use this three tiered model for recognizing occupational diseases and the test for inclusion in Schedule B, remains essentially the same as that described by Tysoe. In Chapter 4 of the Rehabilitation Services and Claims Manual, the following policy statement is made:

> The Board lists a disease in Schedule B in connection with a described process or industry whenever it is satisfied from the expert medical and scientific advice it receives that there is a substantially greater incidence of the particular disease in a particular employment than there is in the general population. The questions to be addressed include: is the disease common in that particular employment, and not common amongst the general public? Is it something specific to the employment?[65]

To ensure that the Board was provided with "expert medical and scientific advice" the Bylaws of the Industrial Diseases Standing Committee (as it then was) provided that "the Committee may establish minimum acceptable methodological standards for any research that the Committee may rely upon in making recommendations to the Board of Governors."[66] After extensive consultation with experts in the medical/scientific community as well as stakeholders, the Committee adopted a Protocol for the Assessment of Medical/Scientific Information.[67] As noted in its Executive Summary, "This protocol attempts to describe in a reasonably concise manner the sort of medical/scientific information that is useful in deciding questions about occupational causation of disease." It explains the "Criteria of Causality" first introduced by Sir Bradford Hill in 1965, provides a glossary of terms encountered in scientific literature and gives examples to illustrate the concepts which are described. The Protocol was the first document of its kind adopted for use by a Workers' Compensation Board in Canada.[68]

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[63] Decision #93, published at 2 WCR 4.
[64] Decision #326, published at 5 WCR 78.
[65] Rehabilitation Services and Claims Manual, Item #26.01.
[66] Bylaw No.1 of the Industrial Diseases Standing Committee, published at 8 WCR 613 (August 10,1992), Section 12.12.
[67] Protocol for the Assessment of Medical/Scientific Information, published at 9 WCR 429 (March 1, 1993).
[68] Summary of Public Hearing on Occupational Disease Policy, IDSC Secretariat, February 1994, p.6.

Who should be responsible for reviewing and amending the Schedule?

The Board's authority to add or delete scheduled items is unique in Canada. In other provinces with Schedules, changes must be made by Cabinet[69] or the Legislature[70] or the Board's authority to amend the Schedule is subject to Cabinet approval.[71] Keeping the Schedule current through the exercise of delegated authority has been a centerpiece of the scheme of scheduled recognition in B.C.

Prior to 1954, the Board took the initiative to add diseases to the Schedule, even though its power to do so was dubious.[72] The Board was subsequently given authority to amend the Schedule "subject to the approval of the Lieutenant Governor in Council". However, in 1966, Mr. Justice Tysoe questioned the need for Cabinet approval:

> With the greatest respect, I question the necessity of making its exercise subject to the approval of the Lieutenant Governor in Council. I have trouble understanding how laymen can have the knowledge required to judge whether or not a particular disease in a particular industry qualifies for the presumption in subsection(2) of section 8 of the Act that attaches to a scheduled disease.[73]

Two years later this requirement was removed from the Act.

The principle that appears to have guided each of these decisions was recognition of the Board's expertise in workers' compensation and industrial health and safety matters. The Board's ability to identify emerging disease issues, conduct ongoing research, review the scientific literature, as well as involve medical specialists and experts from other disciplines, may also have been factors.

In contrast, the Ontario legislation provides for the formation of an external advisory body to conduct disease research and make recommendations to the Board on new occupational diseases, eligibility rules, and criteria for entitlement. The Industrial Disease Standards Panel was created in 1985 on Weiler's recommendation and was renamed the Occupational Disease Panel in 1994. However, the Ontario W.C.B. has also maintained an internal Medical and Occupational Disease Policy Branch. A recent government review noted that there has been a confusion of roles between the Panel and the W.C.B. and duplication of effort. The review concluded that an advisory Panel at arms length

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[69] Alberta and New Brunswick.
[70] Quebec.
[71] Ontario, Nova Scotia and Newfoundland.
[72] Supra note 4.
[73] Supra note 10, p.232.

from the W.C.B. was “not the optimal means to assure effective adjudication of occupational disease.”[74] As a result, the review recommended that the Occupational Disease Panel be disbanded and its functions integrated into the W.C.B. A Bill[75] has been introduced in the Ontario Legislature incorporating this change.

OCCUPATIONAL DISEASE CLAIM COSTS

Although the issues involved in occupational disease claims are complex, the number of these claims, accepted annually by the W.C.B., is small in comparison to the number of claims accepted for injuries.[76] However, the cost of occupational disease claims is significant.

During the period 1991-1995, the Board accepted nearly 21,000 short term disability, long term disability and fatal claims for occupational disease. This figure does not include claims for health care benefits only. During the same period, benefits paid for occupational disease claims from all years totalled almost $222 million. This total includes the cost of short term, long term and survivor benefits but does not include the cost of health care and rehabilitation benefits.[77]

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[74] New Directions For Workers’ Compensation Reform, Report of the Honourable Cam Jackson, Ontario, June 1996, p.42.
[75] Bill 99, introduced November 26, 1996.
[76] See statistical supplements to WCB Annual Reports
[77] Statistics provided by the Statistical Services Department.

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