

# Compensation for occupational lung disease in non-mining industry

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**Abstract** The course from claim submission (by the National Centre for Occupational Health (NCOH)) to compensation (by the Workmen's Compensation Commissioner (WCC)) in 56 cases of occupational disease (OD) was traced. Success rates were determined and the procedural factors which affect claim outcomes isolated. Of note are the 22% of claims which remained unresolved 3 years after submission. The long latent period of ODs causes difficulty in obtaining the employer's corroborating documentation; this was found to be a major factor in the non-resolution of claims. Active intervention by the NCOH resulted in claim resolution for an additional 9%. These findings support the proposal that the WCC establish a network of access points for workers where assistance from trained staff is available. It is further recommended that the WCC accept substitutes for the employer's documentary proof in cases where this is unobtainable.

*S Afr Med J* 1994; **84**: 160-164.

Compensation for occupational diseases (ODs) in non-mining industry in South Africa is covered by the Workmen's Compensation Act (WCA) (Act 30 of 1941) and administered by the Workmen's Compensation Commissioner (WCC) of the Department of Manpower. The legislation was originally established for accidents.<sup>1</sup> ODs are dealt with in Section X and the second schedule, which contains 18 disease categories.

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It is widely recognised that compensation for occupational diseases is more complex than for accidents.<sup>2</sup> The relative paucity of OD submissions exacerbates this complexity. Every year approximately 21 000 South African workers are compensated for death and permanent disability. Of these, only about 90 (0,4%) are cases of OD.<sup>3-5</sup> Occupational lung diseases (OLDs) are responsible for approximately 60% of these claims, and dermatitis for most of the remainder.

A claim is formally initiated via completion of the relevant documentation by a medical practitioner, an employer or a worker. Diagnosis of the OLD is a prerequisite for this procedure. The WCC or one of the mutual associations collects any outstanding information and evaluates the claim. The mutual associations are private insurance carriers who administer claims under the WCA. Decisions on claim outcome are made by the WCC.

The amount of money awarded to a successful OLD claimant is based on physical impairment and his/her earnings at the time of last exposure to the causative agent. Impairment is assessed primarily on lung function testing. A single lump-sum payment is made to workers with 20% impairment; the amount is a proportion of 15 times the monthly salary. Workers with 30% or more impairment, receive a monthly pension equal to 75% times the percentage impairment (e.g. 40%), multiplied by their monthly salary. Notable exclusions from the WCA are workers earning more than a stipulated ceiling wage at time of exposure.

A function of the National Centre for Occupational Health (NCOH) clinic<sup>6</sup> is the submission and follow-up of compensation claims for OLD. Before submission to the WCC, a panel of experienced doctors confirms the diagnosis, identifies the attributable employer (in whose employ exposure was most likely to have occurred) and grades the impairment. The panel's assessment of patients examined by NCOH staff is recognised by the WCC. This recognition is procedural rather than statutory since the arrangement exists because the panel is chaired by the WCC's medical advisor (the Director of the Medical Bureau for Occupational Disease

(MBOD)). Other panel members are the Director of the NCOH and experienced medical staff from both organisations. The practical implications are that cases seen by the panel are not reassessed by the WCC's medical advisor and the panel's judgement is usually accepted as final. Despite this stringent pre-submission process and the clinic's experience with submissions, problems associated with claim resolution are not uncommon.

Although these problems have been discussed in general by Bachmann,<sup>7</sup> and specifically for byssinosis by White,<sup>8</sup> no South African study has documented the compensation process from submission to outcome of a series of pneumoconiosis claims. The pneumoconioses are the best-described and most common OLDs for which claims are made. The compensation standards established for these diseases should be the best that the system has to offer. For this reason we describe the process for 56 OLD cases (largely of pneumoconioses).

White *et al.*<sup>8</sup> reviewed the legal and administrative provisions for byssinosis compensation by examining 32 cases of presumed byssinosis. Extensive follow-up investigation was performed on each patient to ascertain, among other variables, the success rate, the length of time from submission to outcome and the reasons for claim refusal. Appeals were lodged in all appropriate instances of refusal. Their case series was obtained from a unionised workforce who, at the time of diagnosis, were all employed at the workplace where the OLD was contracted.

The objectives of this study were to determine success rates, identify factors associated with claim resolution and to make recommendations for the improvement of compensation procedures. Implicit in the publication of the findings of this study is the wish to remind doctors of compensation for ODs in the non-mining industry and so begin, in particular, to redress disease underreporting.

### Patients and methods

The subjects were all of the 59 compensable OLD patients certified by the panel during 1986 and whose cases were submitted by the NCOH to the WCC.

Fig. 1 shows the time sequence of data collection. NCOH tracing information was available for 56 of the 59 patients certified by the panel; a self-administered postal questionnaire was sent to these 56 patients. The questionnaire was in English but was adapted for individuals with low literacy levels after consultation with Learn and Teach, an adult literacy organisation.

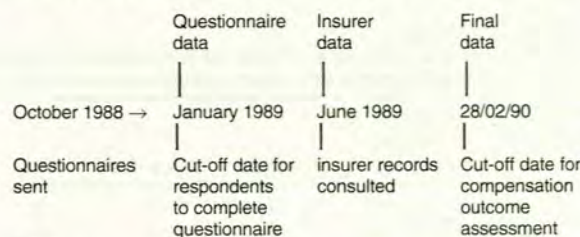


FIG. 1. Time sequence for data collection.

Insurer records of the WCC and mutual associations were consulted to validate the questionnaire data and to provide missing information about: (i) exact date and amount of compensation; and (ii) reasons for rejection or non-resolution of claims.

Final compensation outcomes were assessed on 28 February 1990. It was felt that 3 years from submission (end of 1986 to February 1990) were sufficient for all cases to be resolved.

Consultation of insurer records in 1989 led to the re-examination of unresolved claims. Thereafter, the NCOH actively assisted by obtaining additional information and making regular enquiries to the insurers on behalf of workers.

### Results

Forty-six (82%) of the study subjects were black and 10 (18%) white. Most (79%) were under 65 years old (Fig. 2) and therefore still potentially of working age. Four (7%) were aged between 31 years and 40 years. Thirty-one (55%) were assessed by the NCOH/MBOD panel as being more than 20% impaired (Fig. 3).

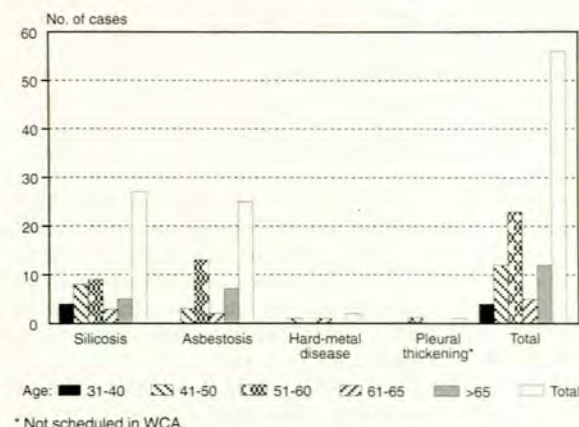


FIG. 2. Fifty-six cases in terms of age and disease.

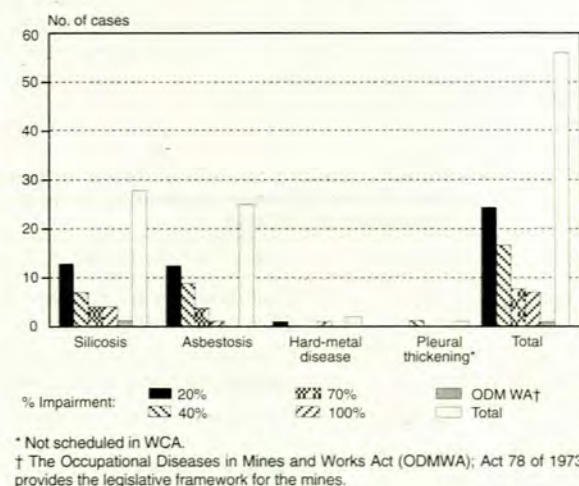


FIG. 3. Fifty-six cases in terms of impairment and disease.

Forty-six (82%) of the 56 subjects completed a questionnaire; this left 10 non-responders (18%). Insurer data on the overall status of the claim only, were collected on 9 non-responders.

### Compensation outcomes

Table I shows that 29 respondents (63%) reported receiving compensation. Of these, 28 were confirmed by insurer data; 1 respondent had confused a non-WCA pension with compensation. In addition, 2 respondents incorrectly denied receipt of compensation payouts. Therefore, 30 (65%) had been compensated by June 1989. Eight months later, after NCOH intervention, 34 (74%) had been compensated according to final data.

None of the 5 patients for whom insurer data were lacking had been compensated, according to questionnaire data. In 3 of these cases the workers were unable to recall the exact name of the employer in question. This could account for the unavailability of insurer records.

**TABLE I.**  
**Compensation outcomes for respondents — questionnaire data, insurer data and final data**

Claim status	Questionnaire data (15/1/89)		Insurer data (6/89)		Final data (28/2/90)	
	No.	%	No.	%	No.	%
Received	29	63	30	65	34	74
Rejected	2	4	2	4	2	4
Pending	15	33	9	20	5	11
No insurer information	N/A*		5	11	5	11
Total	46		46		46	

\* Not applicable.

Two workers were rejected. One (No. 24) earned more than the ceiling wage and was, therefore, not classified as a workman or covered by the act. The other (No. 44) was diagnosed as having asbestos-related pleural thickening, which is not included on the second schedule. Interestingly, no additional cases were rejected during the study period.

Two workers with hard-metal disease caused by tungsten carbide were submitted under the second schedule disease description, 'other fibrosis of the lung due to mineral dust', and were compensated.

Ten respondents had not received compensation by 28 February 1990 (5 cases were pending and 5 respondents had no insurer information); reasons are given in Table II. These were extrapolated from NCOH files and insurer records but are not necessarily the official grounds for non-resolution.

**TABLE II.**  
**Probable reasons for non-resolution of claims in the 10 respondents regarded as pending or having no insurer information at 28/02/90**

Case no.	Reason for non-resolution of claim
4, 11	Confusion whether workplace covered by WCA or ODMWA*
13, 18, 36	Employer no longer exists or insufficient tracing information from worker
6, 28, 37	Employer exists but no records of date of exposure, therefore refused to complete ERA; no worker-kept documentary proof
1	Occupational exposure disputed (as a truck driver, regularly slept on the ground next to an asbestos mine)
25	Medical complication; worker had pulmonary tuberculosis at time of submission resulting in an inconclusive degree of impairment/disability

\* The Occupational Diseases in Mines & Works Act (ODMWA, Act 78 of 1973) provides the legislative framework for OD on the mines.

Insurer data showed that of the 10 non-responders, 8 (80%) had been compensated; 1 claim was unresolved and no information was available on the other. If these 10 non-responders are included in the calculation of rates of failure to receive compensation, the maximum and minimum possible failure rates are 25% and 14% respectively at the study's cut-off date.

## Payments

Payments were often small: 1 individual was awarded a lump sum of R368 and another a pension of only R10,64 per month for a 70% disability (Table III). Questionnaire and insurer data did not always agree on payouts as back payments of pensions were confused with lump sums, and small amounts paid directly into bank accounts were not noted (e.g. in case No. 34, a pension of R14,41 was paid into a bank account).

**TABLE III.**  
**Compensation amounts awarded to 46 respondents (according to insurer data)**

Nature of payment	No.	%	Amount (rands)	
			Mean	Range
Lump sum	21	46	4 405	368 - 9 200
Pension	13	28	250	11 - 600
No payment	12	26	-	-
Total	46			

In 3 cases, the WCC reduced the panel's impairment rating so that workers received a lump sum rather than a pension. Reasons for this were not provided.

## Delays

Information about delays was obtained from the questionnaires only. Resolution of claims generally took many months; the mean number of months from submission to first payment was 15,6 (range 2 - 37 months). The average delay is probably even longer than that reported here, as there was active intervention by the NCOH when problems were identified. In addition, cases pending at 28 February 1990 were not included in the calculation of delays. This would substantially increase the mean delay insofar as each case remained unresolved after 38 months.

## Factors influencing claim resolution

We attempted to identify factors associated with claim resolution. Insurer data for all subjects were used to compare the 11 pending claims with those of the other 44 claimants (Table IV). A more recent date of last exposure to the causative agent was significantly associated with claim resolution. No relationship was found between type of OLD, race, company size, presence of a workplace-based health service and claim conclusion.

**TABLE IV.**  
**The influence of date of termination of employment by attributable employer on claim resolution for 55\* cases**

Last year at attributable employer	Resolved	Unresolved	Total	% resolved
1941 - 50	0	2	2	0
1951 - 60	2	3	5	40
1961 - 70	6	1	7	86
1971 - 80	4	3	7	57
1981 - 86	32	2	34	94
Total	44	11	55	

\* One case excluded because of insufficient data.  
 $\chi^2 = 12,53; P = 0,0004.$

Most workers were unaware of the reason for an unsuccessful claim. Exceptions to this were 4 white workers who were able to offer an explanation for their failure to receive compensation.

## Discussion

Compensation is a legal right which the working class has won. In essence, it is the product of a trade-off between workers and employers whereby the former have foregone the chance to litigate for damages against the latter. In exchange, they have become beneficiaries of a no-fault insurance system which promises protection against income loss as a result of injury or disease sustained at work.<sup>9</sup> The findings of this study should be considered with this trade-off in mind.

## Limitations

A major limitation of this study is the single referral source (NCOH); this could place constraints on generalisability. Except with regard to proximity to the employer (see below), however, the findings accord closely with those of White *et al.*,<sup>8</sup> as well as the unpublished experience of the Industrial Health Research Group (IHRG), Department of Sociology, University of Cape Town (personal communications — D. Edwards, 1989 - 1992).

Claims from a specialist referral clinic such as the NCOH are jeopardised by lack of proximity to the employer. This exacerbates the difficulties in obtaining the employer's documentary proof of 'accident' (the Employer's Report of Accident (ERA) — form Wcl.2). It can be argued, however, that these difficulties are inherent in the system of compensation for OLD. Given the long latent period of these diseases, workers are frequently no longer employed by the attributable employer when the disease is diagnosed. Therefore, it is likely that the problems faced by workers in this series are common to the majority of claimants.

It is probable that these claims represent the best submission scenario available in South Africa for OLD. Before submission to the insurer, each claim was scrutinised by a panel of experts. If the claim seemed inconclusive, it was deferred. In addition, the diseases which comprise this case series are among the best-described OLDs — the pneumoconioses. To establish work-relatedness is usually straightforward if exposure exists alongside the concomitant clinical findings. The course to resolution should, then, have been relatively uncomplicated.

## Unresolved cases — the elusive ERA

In 6 of the 10 unresolved cases, the ERA was unavailable. Given the long latent period of OLDs, it is often impossible to trace the employer (he may no longer be trading or the worker may be unable to provide sufficient tracing information). Alternatively, if the employer can be traced, he may be unwilling to complete the ERA because the records from the stipulated period have been destroyed. Despite affidavits by workers/colleagues and UIF cards that provide proof of employment, claims usually remain unresolved. This is borne out by experience at the NCOH.<sup>10</sup> All of White *et al.*'s<sup>8</sup> patients were in active employment at the time of diagnosis, the ERA was submitted for all and none of the cases remained unresolved. Under the WCA (sec. 51(4)) employers are required to submit the ERA within 30 days of receiving notice of a claim. It is recommended that prosecutions under this section<sup>11</sup> be substantially increased.

Included in the WCA conditions for claim resolution are the ERA and the form Wcl.3, in which the worker states his/her version of the 'accident'. The principle of bilateralism is encouraged because it gives credence to

both the worker's and the employer's views, but the stalemate that arises in the absence of employer substantiation must be circumvented. What is practical for trauma submissions is often not so for OLDs because of their long latent periods.<sup>1</sup> The *de facto* differences between compensation for diseases and for accidents must be acknowledged.

The objection<sup>12</sup> procedure provides the only forum for a worker's version to be heard in a manner that recognises the complexity of OLD compensation. The objection procedure was not used in any of these cases since the retrospective nature of the study meant that the 60-day limit on appeal had lapsed long before. White *et al.*<sup>8</sup> used the process successfully, and 4 out of 4 appeals were upheld.

This study, however, suggests reluctance on the part of the WCC to reject claims outright, thereby denying workers this option unless claims are scrupulously monitored as in White *et al.*'s study. The expense and time-consuming nature of objection must also be considered. White *et al.*<sup>8</sup> report that an additional 29,8 months need to be allowed for the appeal procedure. An alternative is for workers to have access to a national network of trained WCC staff and field workers. They could assist in the establishment of employer attributability, in obtaining the ERA where feasible, and in applying criteria for case acceptance/rejection where not. In the latter instance, the wage on which the compensation will be based might need to be an estimated figure. The impact of the NCOH's time-consuming intervention is manifest in the 4 (9%) additional cases that were compensated. Very few potential claimants have access to the NCOH and the insurer bodies could shoulder this responsibility.

This would concur with practice in the UK where specially trained adjudicating officers attempt to answer the question: 'Is the disease due to the claimant's employment by a specific employer?'<sup>13</sup> In Washington state, much weight is given to the health care provider's opinion as to work-relatedness of disease, and claims are assessed by an adjudicator with a university degree and 3 months' training.<sup>14</sup> In Canada, there are numerous options for worker assistance with compensation claims (personal communication — T. G. Ison, March 1992).

The new Compensation for Occupational Injuries and Diseases (COID) Act<sup>15</sup> provides for collateral evidence in support of claims. The legislative framework exists and it remains for the relevant sections to be used.

Additionally, employment records must be available for a period long enough to account for the disease's latent period. Worker-kept proof of employment is encouraged but the onus is on employers in hazardous industries to keep records. The COID Act<sup>15</sup> requires record-keeping for 4 years after the final entry is made in an individual worker's register. This is patently inadequate.

## Factors predicting claim outcome

Blessman<sup>14</sup> found a rejection rate of 18% for OD claims in Washington state. The factors most predictive of rejection of OD claims were the specific disease category and experience/frequency of claim filing. In the USA, OD claims are frequently submitted for diseases with an indeterminate aetiology, e.g. the occupational cancers; the pneumoconioses occur rarely. White *et al.*'s<sup>8</sup> rejection rate was 15/32 with 4/4 subsequently upheld on appeal. In that paper it was argued: 'Analysis of the medical basis of decision-making indicated that 7 claims were refused and at least 4 had their awards reduced as a consequence of inconsistent decisions. Arguable decisions resulted in 5 claims being refused and 1 award being reduced.'

Our case series, however, was dominated overwhelmingly by pneumoconioses claims that were not rejected as a result of misdiagnosis. The rejection rate was extremely low (4%) but the 22% of cases still unresolved after 3 years is of concern. The only factor significantly associated with claim resolution was duration since last exposure. The more recently the worker was exposed, the better the chance of obtaining the ERA, and therefore a decision on the claim.

### Claim rejection

The low rejection rate is not necessarily favourable. Rejection implies that the system is running smoothly enough for claims to be resolved. Secondly, it gives workers a hearing. To prevent rejection as a result of inappropriate submission, the WCC should publicise standards both for claim submission and medical diagnosis. It would then be fulfilling its role proactively as both guide and advisor. As Bachmann<sup>7</sup> and White *et al.*<sup>8</sup> state, clearly defined criteria for diagnosis would eventually reduce the number of ineligible claims. In addition, clear guidelines would create positive inducement to the medical profession to initiate the compensation process for ODs capably.

### Other problems

There are many disincentives to submit claims for OLDs. The length of time from when the claim is filed until its resolution is at least 16 months, compared with 7 months in Ontario.<sup>10</sup> White *et al.*<sup>8</sup> reported delays of only 13,8 months. This could conceivably be attributed to the availability of the ERA since all his patients were employed by the attributable employer at the time of claim submission. It is possible that delays were caused by poor claim submission in some cases, but this is unavoidable until the WCC stipulates conditions of submission. Compensation payment is only one aspect of the response to a disabled worker. Another is removal from exposure to prevent further disability. This can often mean a reduction in wages, or unemployment, rendering the supplementary income provided by compensation an essential prerequisite.

The amounts paid out are often abysmally low. This is due to the generally low wage-base of South African workers. Compensation is based on the wage earned at the time of exposure to the hazard, which often predates the diagnosis by many years. It is then based directly on employer contributions to the accident fund for that particular worker. The new Act<sup>15</sup> proposes that compensation for ODs be based on the wage earned at the time of diagnosis, equivalent to the 'date of accident'; this is a long-awaited improvement.

### Conclusion

The new Act<sup>15</sup> introduces important changes with regard to OD compensation. Most notable are the changes to the definition of compensable OD, the expansion of the

second schedule and the establishment of a new basis for calculating compensation for OD. Only the last-mentioned is discussed here. Nonetheless, these changes will remain academic unless attention is directed firstly at increasing awareness of ODs among workers, medical practitioners and employers in order to increase reporting. An environment conducive to claim submission, with the appropriate guidelines, must be created. Attention must also be paid to the procedural aspects of OD compensation. This study isolates problems which undermine the efficacy of the legislative provisions. These are: long delays from submission to claim conclusion, inadequate payouts and a high proportion of unresolved claims. The long latency of ODs is elucidated as contributory. The NCOH's intervention improved claim resolution. An important remedy is for workers to have access to experts within the WCC to assist the expedition of OD claims. Where the responsible employer can be traced, prosecutions for failure to complete the ERA must increase. Diversion of resources to OD compensation implies recognition of the special circumstances pertaining to ODs. This should lead to improved claim outcome. The matter is urgent. If South Africa's compensation system cannot process pneumoconiosis claims efficiently, then the system cannot bring to manage the pool of multi-organ diseases brought about by increasingly sophisticated technology.

We would like to thank the WCC and his staff and those of Federated Employer's Mutual Association, for their co-operation and concern. Learn and Teach is due special thanks for help with the questionnaire.

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