

Asbestos-Related Diseases and Workers' Compensation

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Abstract

Although exposure to asbestos at work can give rise to incapacitating and often fatal diseases, there are significant obstacles for workers in claiming compensation for asbestos-related diseases. Such obstacles include the long latency of the disease, the need to establish causation many years after exposure, and the fact that individual workers may have been exposed to asbestos with multiple employers and/or in multiple jurisdictions. With the legacy of disease from past and present asbestos exposure expected to continue for some decades to come, there is a crucial need to address the obstacles to workers, and their families, receiving fair and adequate compensation. This article examines how asbestos-related diseases have been compensated in Australia, and how the Commonwealth, state and territory workers' compensation schemes might be reformed to facilitate compensation. The article clarifies the often conflicting interests of workers and employers (and their respective representatives), discusses alternative models for compensation in the United Kingdom and New Zealand, and explains options for national legislation, national uniformity or consistency in Australian schemes. The article evaluates alternative approaches with reference to the criteria of effectiveness, efficiency, equity and political acceptability, and proposes a strategy for reform based on uniform provisions specific to asbestos-related disease compensation.

I Introduction

Compensation with regard to dust diseases in general¹ and asbestos-related diseases in particular, presents major challenges to the legal system. The principal asbestos-related diseases (asbestosis, mesothelioma and lung cancer)

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¹ As to other toxic dusts, see, in particular Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into Workplace Exposure to Toxic Dust* (Final Report, 2006).

are caused by the inhalation of asbestos fibres.² Asbestos poses a risk to health whenever people are exposed to these fibres and even small exposures may cause some types of disease.³ Asbestos diseases have long latency periods (ranging from 15 up to 40 years, depending on the specific disease and the circumstances of exposure).⁴ Reconstructing the facts after such a long period in order to establish the work-related origin of the disease (as is necessary to obtain workers' compensation) is extremely difficult.⁵ Where the worker has been exposed to asbestos when working for multiple employers, perhaps in different jurisdictions, the challenges of establishing work-relatedness are even greater. The fact that not all exposure to asbestos is work related further exacerbates the problems, as does the genuine possibility that exposure to asbestos occurred prior to the current workers' compensation legislation in the respective jurisdictions, in which case the preceding (and usually far less adequate) legislation may apply. As if this were not enough, a history of cigarette smoking may also muddy diagnosis, particularly for lung cancer.⁶

In Australia, much asbestos disease has been caused by asbestos mining, particularly at Wittenoom in Western Australia, but it can equally be caused by working with a variety of asbestos materials and products, such as asbestos-cement sheeting, insulation containing asbestos, brake and clutch materials, and the handling and transport of asbestos as a raw material.⁷ Many of the multiple claims made against James Hardie Industries relate to some of the latter operations.⁸ It follows that the mining industry has been heavily implicated as a contributor to asbestos-related diseases, but it should also be borne in mind that high numbers of claims have been made by workers employed in the railways and construction industries where materials containing asbestos were in common use, and in the maritime industry where asbestos lagging was commonly used in ships as insulation. Australian data for mesothelioma indicate that both the number of new cases diagnosed annually, and deaths, have increased steadily over the last two decades and, taking into account the long latency for the disease, are expected to

² A R L Clark, 'Occupational Diseases' in John Ridley and John Channing (eds), *Safety at Work* (Butterworth-Heinemann, 1999) 344, 377–8; Paul Boyce et al, 'Respiratory Disorders' in Barry Levy and David Wegman (eds), *Occupational and Environmental Health: Recognizing and Preventing Disease and Injury* (Lippincott, Williams & Wilkins, 2006) 543, 562–3; National Occupational Health and Safety Commission, *Code of Practice for the Management and Control of Asbestos in Workplaces*, NOHSC: 2018, April, 2005, [15].

³ National OHS Commission, above n 2.

⁴ Ibid.

⁵ Harold Luntz and David Hambly, *Torts: Cases and Commentary* (Lexis Nexis, 5th ed 2002) 302, 311.

⁶ Thady Blundell, 'Asbestos-Related Disease Compensation 2006: at the Crossroads' (2006) 22 *Journal of Occupational Health and Safety: Australia and New Zealand* 427, 435.

⁷ For a comprehensive list of asbestos containing products and a summary of asbestos usage in Australia, see National OHS Commission, above n 2, 45–8, 49–50.

⁸ Edwina Dunn, 'James Hardie: No Soul to Be Damned and No Body to Be Kicked' (2005) 27 *Sydney Law Review* 339. See also Paul Von Nessen and Abraham Herberg 'James Hardie's Asbestos Liability Legacy in Australia: Disclosure, Corporate Social Responsibility and the Power of Persuasion' (2011) 26 *Australian Journal of Corporate Law* 55.

peak in the course of the next decade. The latest available data indicate there were 579 new cases in 2006 and 551 deaths in 2007.⁹

This article examines how asbestos-related diseases have been and should be compensated in Australia, with a focus on workers' compensation rather than common law. While much has been written about the latter, particularly in the context of the recent and ongoing litigation against the James Hardie Group,¹⁰ very little has been written concerning the multiple deficiencies of the workers' compensation system, as it relates to diseases with long latency periods, yet this may prove far more important to many asbestos-damaged workers than fault-related liability.

This article seeks to redress the balance. Part II provides a historical context and surveys current legal provisions with regard to compensation for asbestos-related diseases. Part III explores the main opportunities for reform, with a focus on asbestos-related disease. It begins by identifying criteria against which 'success' can be measured, before making international comparisons with the United Kingdom and New Zealand compensation schemes, exploring less ambitious reforms in terms of harmonisation of workers' compensation arrangements across Australia, and considering whether a narrower, asbestos-specific and highly targeted approach to reform would meet the criteria for success.

Desktop research and analysis was complemented by telephone interviews with representatives of jurisdictions and by face-to-face discussions at the Dust Diseases Board of NSW, which has played an influential role in developing alternative procedures for dealing with such diseases.

II Workers' Compensation for Asbestos-Related Disease

Workers' compensation legislation in Australia was adopted by each jurisdiction in the early years of the 20th century, based in very large part on what was then the British model. The distinctive feature of this approach was to provide no-fault compensation with regard to work-related injury (and subsequently disease). This approach served to mitigate the manifest limitations of common law liability, which was narrowly interpreted by the courts of that era, and extremely difficult to establish.¹¹

On the one hand, this approach had the considerable attraction that compensation was automatic (without the necessity for long, costly and uncertain

⁹ M Clements, G Berry and J Shi, 'Actuarial Projections for Mesothelioma: an Epidemiological Perspective' (Paper presented at the Actuaries of Australia XIth Accident Compensation Seminar, Sydney, 1–4 April 2007); Safe Work Australia, 'Mesothelioma in Australia: Incidence 1982–2006: Mortality 1997–2007' (Report, Safe Work Australia, May 2010) 6–8, 16.

¹⁰ See Dunn, above n 8; Peta Spender, 'Blue Asbestos and Golden Eggs: Evaluating Bankruptcy and Class Actions as Just Responses to Mass Tort Liability (2003) 25 *Sydney Law Review* 223.

¹¹ John Fleming, *The Law of Torts* (Lawbook, 7th ed 1987) 48; Terence Ison, *The Forensic Lottery: A Critique of Tort Liability as a System of Personal Injury Compensation* (Staple Press, 1967); Committee of Inquiry into Compensation and Rehabilitation in Australia, Parliament of Australia, *Compensation and Rehabilitation in Australia: Report of the National Committee of Inquiry* (1974) ('Woodhouse Report').

litigation) provided the injury was demonstrably work related and there was incapacity arising from the diagnosed work-related condition. On the other hand, the compensation provided (in contrast to common law negligence) was less adequate, generally covering loss of earning capacity and medical costs but not non-pecuniary loss (eg pain and suffering, loss of expectation of life). In most instances, workers compensation schemes in Australia also provided some form of maximum payment schedule, whereas the common law allows for an open-ended assessment at the discretion of the court. Finally, it should be noted that if injured workers elect to pursue common law damages, they may have to reimburse their employers or workers' compensation authorities for any statutory benefits paid out.

In its original form, workers' compensation addressed some of the worst excesses of the industrial revolution in the industries in which they were most visible. The original United Kingdom *Workmen's Compensation Act 1897*, 60 & 61 Vict, c 37 (*'Workmen's Compensation Act 1897'*) was limited in scope and only covered particular industries such as railways, mining and quarrying, factories and laundries. This template was later followed in Australia, with the early workers' compensation legislation in South Australia and Western Australia similarly focused on dangerous industries. The mining industry was particularly prominent and from relatively early on, special consideration was given to the kinds of diseases contracted in mining, such as silicosis and chronic bronchitis. Later, when the link between exposure to asbestos and a number of diseases became apparent, it was a natural extension of the approach to treat it as a compensable industrial disease.¹²

However, asbestos-related disease has some distinctive features that merited, not just its inclusion in workers' compensation schemes as a work-related disease, but also the inclusion of special conditions to address it. In particular, the outcome for a worker who contracts such a disease is frequently terminal, and almost invariably severely incapacitating. In the case of mesothelioma, the time between diagnosis and death is particularly short, making speedy processing of the claim and decision-making essential. Proving that such a condition was attributable to any particular employer is also exceptionally difficult for reasons described above, and this was especially the case in the mining industry, where workers were highly mobile and had frequently worked for a range of employers in asbestos-related work.

It was only belatedly, and in response to external pressure, that jurisdictions began to appreciate the inappropriateness and unfairness of applying provisions initially designed specifically for work related injury. Gradually, definitions were broadened to take account of work-related disease in general, and of asbestos-related diseases with their long latency periods, gradual onset and other distinctive characteristics.¹³ Provisions designed for work-related injury traditionally require

¹² See Kevin Purse, 'The Evolution of Workers' Compensation Policy in Australia' (2005) 14 *Health Sociology Review* 8.

¹³ Diseases present particular problems for compensation schemes, particularly with questions of work-relatedness and evidential issues for sustaining a claim. The response has sometimes been to enact separate statutory schemes or have special provisions for particular diseases within the primary workers' compensation statute. See Alan Clayton, Richard Johnstone and Sonya Sceats,

proof of specific identifiable trauma which is inappropriate for occupational disease.

When the jurisdictions finally came to make special provision for asbestos-related disease, each went about it largely in its own way, albeit often consistent with its own particular workers' compensation arrangements, but certainly not with those of other jurisdictions. The remainder of this section describes the main differences between the jurisdictions' provisions with regard to a number of issues important to workers seeking compensation for asbestos-related disease. From this account, the need for reform will become readily apparent.

In terms of work-relatedness and evidential issues for sustaining a claim, legislation in the majority of jurisdictions contains a general presumption that where a worker suffers from an asbestos-related disease and the worker's employment has involved exposure to and inhalation of asbestos fibres, this employment contributed to a substantial degree to the disease. The onus is on the employer to provide evidence to the contrary in order to rebut the presumption.¹⁴ In contrast, the legislation in Queensland contains no such presumption, simply requiring that the worker's employment was a 'significant contributing factor' to the worker's contraction of the disease.¹⁵ This puts the onus on the worker to show that the condition from which they suffer is work related. The result is that workers in Queensland are substantially disadvantaged in seeking compensation.

The legislation in New South Wales takes a different approach again. The schedule of dust diseases is comprehensive, including all asbestos-related diseases, and listing asbestosis, asbestos-induced carcinoma, asbestos-related pleural diseases and mesothelioma,¹⁶ and a person is entitled to compensation where he or she has a dust disease that is 'reasonably attributable to the person's exposure to the inhalation of dust in an occupation to the nature of which the disease was due'.¹⁷ The Dust Diseases Board of NSW's industrial history officers also help claimants to complete forms, and compile an industrial history of past employment and exposure to dust.¹⁸ Preparation of industrial histories and assessment of likely exposure in particular employment is also facilitated by the board's databases of industrial histories and dust exposure collected over many years.¹⁹

There is currently no uniformity between the jurisdictions with regard to who undertakes diagnosis. In Victoria, Queensland, Western Australia, South Australia and Tasmania, initial diagnosis is undertaken by a medical practitioner; secondary diagnosis is undertaken by an independent medical practitioner; and, if

'The Legal Concept of Work-Related Injury and Disease in Australian OHS and Workers' Compensation Systems' (2002) 15 *Australian Journal of Labour Law* 105, 120–1.

¹⁴ See, eg, *Workers' Rehabilitation and Compensation Act 1986* (SA) s 31(2), sch 3; *Dust Diseases Act 2005* (SA) s 8. See also Clayton, Johnstone and Sceats, above n 13, 120.

¹⁵ *Workers' Compensation and Rehabilitation Act 2003* (Qld) s 32.

¹⁶ *Workers' Compensation (Dust Diseases) Act 1942* (NSW) sch 1).

¹⁷ *Ibid* s 8(1).

¹⁸ Workers' Compensation Dust Diseases Board of NSW, *Making a Claim* <<http://www.ddb.nsw.gov.au/MakingaClaim>>

¹⁹ Workers' Compensation Dust Diseases Board of NSW, *Annual Report 2003–2004* (30 June 2004) 32–3.

required, final diagnosis is undertaken by a medical panel.²⁰ The ACT has a substantially similar process, while the Northern Territory and the Commonwealth prescribe the same two first steps but make no mention of the third.²¹ New South Wales technically only provides for diagnosis to be undertaken by a medical board consisting of three medical practitioners, although this is not actual practice.²² Again, the result is that workers in some jurisdictions are disadvantaged compared with those in others.

Nor is there any uniformity with regard to specifying how diagnosis is to be undertaken. In the majority of jurisdictions, guidance is provided to medical panels only.²³ Different approaches are taken in the Northern Territory where the legislation gives basic guidance about secondary diagnosis; in the ACT where general guidance is given to all doctors conducting medical assessments; and in the Commonwealth legislation, which is silent about diagnosis.²⁴ The New South Wales legislation provides no formal guidance about diagnosis but specific processes have been developed to guide the undertaking of final diagnosis.²⁵ The guidance provided also varies markedly between jurisdictions. The result is considerable uncertainty for workers seeking compensation, both in terms of the law, and in terms of the actual practices of boards and other decision-makers.

With regard to guidelines for certifying the nature and degree of the worker's impairment, again there is considerable variation, and such variation extends to the types of questions which medical panels are either required or empowered to address. This in itself is a delicate question since medical matters can often involve some issue of fact. For example, with work-relatedness matters, a medical panel may, in effect, be asked to accept certain facts upon which diagnosis

²⁰ See *Accident Compensation Act 1985* (Vic) ss 45, 63(2), 67(2), 103, 112; *Workers' Compensation and Rehabilitation Act 2003* (Qld) ss 132, 135, 179, 493, 500, 505, 510; *Workers' Compensation and Injury Management Act 1981* (WA) ss 36, 64; *Workers' Rehabilitation and Compensation Act 1986* (SA) ss 98, 98A, 98F, 98G, 108; *Workers' Rehabilitation and Compensation Act 1988* (Tas) ss 39(3)(b), 49, 50(5), 90A.

²¹ *Workers' Compensation Act 1951* (ACT) ss 72, 116, 201; *Workers' Compensation Regulations 2002* (ACT) reg 9, 10, 13, 14; *Workers' Rehabilitation and Compensation Act 2008* (NT) ss 12, 82, 90B, 91; *Safety, Rehabilitation and Compensation Act 1988* (Cth) s 54(2), 57(1)(b).

²² See *Workers' Compensation (Dust Diseases) Act 1942* (NSW) ss 7–8. Note that a two-stage process for diagnosis has developed that is not specifically prescribed by legislation. Initial diagnosis is undertaken by the worker's general practitioner, who then refers the worker to a medical specialist for further diagnosis. Testing is then undertaken by the Dusts Disease Board's in-house medical section, with final diagnosis by a medical panel.

²³ See Dust Diseases Board of NSW, *Respiratory Medical Examinations Fact Sheet (Nos 1 and 2)* < <http://www.ddb.nsw.gov.au/Publications/Pages/default.aspx> >; *Accident Compensation Act 1985* (Vic) ss 65, 68; *Workers' Compensation and Rehabilitation Act 2003* (Qld) s 510 (1) and (1A); *Workers' Rehabilitation and Compensation Act 1986* (SA) ss 98G(1)–(4), 98G(6), 98(3); *Workers' Rehabilitation and Compensation Act 1988* (Tas) s 54.

²⁴ *Workers' Rehabilitation and Compensation Act 2008* (NT) s 94(1), 96; *Workers' Compensation Regulations 2002* (ACT) rr 9, 15.

²⁵ When a claimant attends the Dust Disease Board's medical section, three forms of assessment may be performed: x-rays of lungs; a lung function test; and a medical consultation. If a claimant is unable to attend the Dust Diseases Board, arrangements are made for a designated local doctor to administer these tests.

is based.²⁶ Whether medical panels should have authority to address such issues or whether they should be within the sole jurisdiction of a court is a moot question. In jurisdictions where factual matters are in effect referred to medical panels then workers may effectively be denied a proper hearing — often resulting in appeals and prerogative writs to overturn the panels. To add to the confusion, a number of jurisdictions do not make any reference to the rules of evidence to be adopted in diagnosis. For example, the Victorian, South Australian, Western Australian and Tasmanian Acts state that their medical panels are not bound by the rules or practices as to evidence, and furthermore, that they may act informally, without regard to technicalities or legal forms.²⁷

The result is that there is considerable inconsistency between the way jurisdictions approach issues of diagnosis and in their processes and procedures. This is unfortunate and means workers in some jurisdictions are in a substantially worse situation than those in others. This inconsistency has particularly adverse implications for those who have engaged in asbestos-related work in multiple jurisdictions.

Mechanisms for providing administrative ease for claimants, thereby facilitating efficient and timely provision of compensation, have progressed substantially over the years, as it has become increasingly recognised that many of those seeking compensation for asbestos-related disease (especially mesothelioma victims) may have only a very short life expectancy. Nevertheless, jurisdictions report significant variation in terms of the timely and efficient provision of compensation with the result that once again, workers in some jurisdictions are unjustifiably disadvantaged.

There are three different approaches to the time in which an injured worker has to bring a claim for statutory compensation under the main workers' compensation schemes. Some jurisdictions set no time limit,²⁸ others set strict time limits but generally waive them for certain conditions or circumstances,²⁹ while a third group simply require workers to report their injury 'as soon as practicable' after they become aware of the injury.³⁰ Turning to common law, there are broadly two ways in which the civil liability and limitation Acts of the various jurisdictions deal with actions for damages regarding asbestos-related diseases. New South

²⁶ See, *Ansett Australia Ltd v Medical Assessment Panel* (1998) 19 WAR 395, 9, where the court noted that 'it would be a little surprising if the legislature had intended that issues such as causation could be decided by the [medical] Panel ...'.

²⁷ See *Accident Compensation Act 1985* (Vic) s 65(1)-(2); *Workers' Rehabilitation and Compensation Act 1986* (SA) s 98A(1)-(2); *Workers' Compensation and Injury Management Act 1981* (WA) s 145D; *Workers' Rehabilitation and Compensation Act 1988* (Tas) s 55. See also *Masters v McCubbery* [1996] 1 VR 635 which discusses this issue, and *Weearappah v Nisselle* [1999] VSC 249 (2 July 1999).

²⁸ *Workers' Compensation (Dust Diseases) Act 1942* (NSW); *Workers' Compensation and Rehabilitation Act 2003* (Qld); *Workers' Compensation and Injury Management Act 1981* (WA).

²⁹ *Accident Compensation Act 1985* (Vic) s 102; *Workers' Rehabilitation and Compensation Act 1986* (SA) ss 51(1)(a), 52(3)(b); *Workers' Rehabilitation and Compensation Act 1988* (Tas) ss 3(5), 32, 38; *Workers' Rehabilitation and Compensation Act 2008* (NT) s 182; *Workers' Rehabilitation and Compensation Act 2008* (ACT) ss 27, 120, 120A.

³⁰ *Safety, Rehabilitation and Compensation Act 1988* (Cth) s 53; *Seafarers Rehabilitation and Compensation Act 1992* (Cth) s 52.

Wales, Victoria and Queensland simply exclude such injuries from the operation of their respective civil liability or limitation Acts.³¹ The remaining jurisdictions, with the exception of South Australia and the Northern Territory,³² prescribe that the relevant limitation period does not begin to run until the injury comes to the person's knowledge, or when it ought to have come to their knowledge (the date of discoverability).³³ The result, both with regard to workers compensation and to common law, is disparities in time limits for bringing claims in different jurisdictions that cannot be justified on any rational grounds.

In terms of the availability of common law damages, the position has changed significantly in the last two decades with the enactment of provisions that have sought to roll back both the circumstances in which common law claims can be made³⁴ and damages awarded in each case.³⁵ Some jurisdictions have abolished the right to access common law, or introduced threshold tests,³⁶ and/or placed restrictions on types of damages that an injured worker can receive, and/or placed caps on the amount of damages that can be awarded.³⁷ However, in Queensland and the Australian Capital Territory access to common law actions is not limited for personal injury claims generally, and in New South Wales such actions are not limited for dust diseases.³⁸ As a consequence, workers in these jurisdictions are in a better position than workers elsewhere.³⁹

Turning to incapacity benefits, step downs and age limits, almost all jurisdictions provide for a period of near-full income replacement of pre-injury earnings for workers who cannot earn due to a work-related injury.⁴⁰ These weekly income replacements are 'stepped down' by a percentage or a set amount after a

³¹ *Civil Liability Act 2002* (NSW) s 3B (but see also *Dust Diseases Tribunal Act 1989* (NSW) s12A; *Limitation Act 1969* (NSW) s 8(2)); *Limitations of Actions Act 1936* (Vic) s 27B(2); *Limitation Act 1974* (Qld).

³² South Australia abolished access to common law claims by workers against employers in 1992, (*Workers Rehabilitation and Compensation Act 1986* (SA) s 54), as did the Northern Territory in 1987 (*Work Health Act 1986* (NT) s 54), and see Safe Work Australia, 'Comparison of Workers' Compensation Arrangements in Australia and New Zealand' (2010) Commonwealth of Australia: 14, 21.

³³ *Limitation Act 2005* (WA) ss 6(2), 13, 56; *Limitation Act 1974* (Tas) ss 2(1), 5, 5A 38; *Limitation Act 1985* s 16B(2).

³⁴ For example, a worker who has an asbestos-related condition arising from asbestos exposure in Victoria must satisfy a 'serious injury' threshold in order to claim damages: *Accident Compensation Act 1985* (Vic) ss 134 AB (38), 135A (19).

³⁵ Australian jurisdictions have implemented tort reform measures that have had the effect of limiting access to the tort system and capping various heads of damages. See, Alan Clayton, 'Some Reflections on the Woodhouse and ACC Legacy' (2003) 34 *Victoria University of Wellington Law Review* 449.

³⁶ Note that asbestos claims usually easily reach the common law threshold in the jurisdictions which have them, so they are rarely a constraint on claims.

³⁷ Safe Work Australia, 'Comparison of Workers' Compensation Arrangements in Australia and New Zealand' (Report, 2010) 181–6.

³⁸ *Civil Liability Act 2002* (NSW) s 3B.

³⁹ However, some statutes have been amended to make it easier for asbestos victims to make claims within the thresholds or limits for such claims. See, eg, the *Asbestos Disease Compensation Act 2008* (Vic), which contains provisions to facilitate lodgement of common law claims by workers with asbestos-related conditions, to enable individuals to pursue an initial claim and a further claim if they develop a subsequent asbestos-related condition, and to ensure that the 'serious injury' requirements are satisfied and that damages are recoverable from the deceased's estate.

⁴⁰ For a comparison of these benefits generally see Safe Work Australia, above n 37, 33–9.

determined period. Most jurisdictions also place an age limit on the receipt of such payments. As asbestos-related diseases typically have long latency periods and workers will often be beyond the age of retirement before they begin to show symptoms of an affliction, these age limitations are especially significant. Western Australia, however, exempts those workers who are suffering from mesothelioma or pneumoconiosis⁴¹ from the age limit.⁴² The New South Wales scheme also differs, setting no age limit and thereby allowing workers suffering from asbestos-related disease to receive weekly benefits until their death.⁴³ Once again, the result is significant variation between the provisions of different jurisdictions with no rational basis.

Finally, asbestos victims, like all other claimants, find that their entitlements and benefits are determined by sometimes arbitrary differences between the provisions of different jurisdictions. Here is not the place for a detailed exposition of such differences. Suffice to say, that although the 10 principal workers' compensation schemes in Australia have common objectives (adequate financial compensation, appropriate rehabilitation and return to work, affordable premiums and full funding by employers), workers making claims against employers in different jurisdictions confront variations in the degree of access to common law, work-related tests, rehabilitation and return-to-work requirements. In addition, employers operating across state and territory borders face significant compliance burdens and costs from dealing with multiple workers compensation schemes.⁴⁴

The overall result both with regard to workers compensation in general and to asbestos-related disease in particular, is that 11 different jurisdictions (three in the Commonwealth and one in each state and territory) have their own systems with only limited commonality. Very little of this variation can be justified in terms of any overall principle. These jurisdictional differences have a number of important implications and they are of profound significance to the substantial numbers of itinerant workers who may find that, because they have been exposed to asbestos in a number of jurisdictions, they must make a claim in more than one court.

III Towards Reform

A Identifying Goals

Since the mid 1970s (beginning with the 1974 *Woodhouse Report*)⁴⁵ there have been regular calls for radical changes to be made to Australia's approach to compensation for work-related injury and disease.⁴⁶ Notwithstanding significant

⁴¹ Asbestosis is a type of pneumoconiosis.

⁴² *Workers' Compensation and Injury Management Act 1981* (WA) sch 5.

⁴³ *Workers' Compensation (Dust Diseases) Act 1942* (NSW) s 8.

⁴⁴ Productivity Commission, *National Workers' Compensation and Occupational Health and Safety Frameworks*, Report No 27 (2004) xxii, xxv–vi.

⁴⁵ *Woodhouse Report*, above n 11.

⁴⁶ See, most recently and references within: Peter Hanks, *Accident Compensation Act Review: Final Report* (WorkSafe Victoria, 2008).

modifications to that system, no fundamental change has taken place. This part explores the main opportunities for reform, with a focus on asbestos-related disease, but recognises that reform may be intimately connected in some respects with reform of workers' compensation arrangements more generally.

Such a normative exercise can only be undertaken if the criteria against which 'success' is to be measured, are clearly identified. That is, unless we are able to identify what successful compensation reform would look like, it will be impossible to know whether, or to what extent, we have achieved it.

Developing criteria against which to evaluate social policy is a challenge that has increasingly occupied the minds of decision-makers and others. For example, the OECD has identified effectiveness, efficiency and cost-effectiveness as important indices of success, not only in its studies of economic mechanisms, but also more broadly.⁴⁷ Many other policy-making bodies, academic think tanks and individual writers have come up with other similar, but far from identical lists.⁴⁸ In the absence of any consensus on precisely what criteria a successful compensation strategy should satisfy, and with no value-free way of establishing any, it is necessary to state the criteria that will be used and why they have been chosen.

The first three criteria applied in this article are those that find their way into almost all lists. They are effectiveness with regard to social policy achieving its purported objectives, efficiency with regard to delivering benefits to workers at least cost to the state and to employers, and equity with regard to showing fairness in the burden-sharing among players. The fourth criterion, political acceptability, is also widely understood to be a necessary prerequisite to successful social policy. It may prove crucial in the context of workers' compensation arrangements given the strong and successful resistance of most jurisdictions in the past to external interventions in their activities, including national uniformity initiatives.

In attempting to translate and apply these criteria to the specific circumstances of asbestos-related disease the first difficulty that must be confronted is that workers and employers have only very limited common interests in this area. Even a cursory reading of the history of engagement between workers who had contracted asbestos-related disease and the companies who employed them, exposes fundamental conflicts between the two sides of industry. Not least, a series of damning reports and investigations have suggested that some employers have commonly put corporate profits ahead of workers' health, with devastating

⁴⁷ Organisation for Economic Co-Operation and Development ('OECD'), *Environmental Policy: How to Apply Economic Instruments* (1991); OECD, Group on Economic and Environment Policy Integration, Expert Group on Economic Aspects of Biodiversity, *Economic Incentive Measures for the Conservation and Sustainable Use of Biological Diversity: Conceptual Framework and Guidelines for Case Study Biological Diversity: Economic Incentive Measures for Conservation and Sustainable Use* (1995); OECD, *Making Markets Work for Biological Diversity: The Role of Economic Incentive Measures* (1995).

⁴⁸ See, eg, Ecologically Sustainable Development Working Group, *Intersectional Issues Report* (Australian Government Printing Service, 1992); Australian Manufacturing Council, *Best Practice Environmental Regulation* (1993).

consequences for the latter.⁴⁹ Accordingly, workers and employers are likely to have substantially different views as to what 'effectiveness' means, and some modest disagreement with regard to questions of equity and efficiency. These in turn translate, as we will see, into broader conflicts with regard to what is politically acceptable.

Turning first to the interests of workers, it is necessary to distinguish the issues that workers and their representatives might pursue with regard to asbestos-related provisions specifically, from concerns with workers' compensation schemes more generally. The latter have been comprehensively canvassed in previous reports by the Productivity Commission⁵⁰ and, more recently, in the 2008 Victorian *Accident Compensation Act Review*.⁵¹ Such issues need not be rehearsed in detail here but include workers' compensation systems which are effective in paying fair and adequate benefits and also extend to sufficient, no fault compensation for permanent impairment and death.

In terms of asbestos-related disease, workers and their representatives are likely to be most concerned about:⁵²

- questions of diagnosis. Asbestos-related cases involve complex issues of diagnosis and arguably require specialists to make the appropriate medical judgments. There have been moves to have decisions made by medical panels rather than judges, but this has been done in different ways and to varying extents across jurisdictions. Workers therefore encounter different approaches to diagnosis in different jurisdictions. Uniform criteria for expert diagnosis would advance effectiveness, through speedy decision-making about entitlement to compensation, as well as equity for workers in different jurisdictions and those who have worked with asbestos in multiple jurisdictions;
- questions of work-relatedness and evidence for sustaining a claim. Establishing work-relatedness is especially problematic given the long latency period of asbestos-related diseases, the fact that not all exposure to asbestos is work related, and because a worker may have worked for multiple employers and/or in different jurisdictions in asbestos-related work. Even if a worker has demonstrated work-relatedness in one jurisdiction, the worker may be unsuccessful in another jurisdiction where the onus of proof is more demanding. Workers' interests are best served by uniform criteria for establishing work-relatedness which would also support effectiveness and equity in payment of adequate compensation;
- administrative ease for claimants (compensation in an efficient and timely manner). Prompt and efficient decision-making is particularly important in many asbestos cases because life expectancy after diagnosis may be short. Expedited decision making is crucial in cases of mesothelioma where, if

⁴⁹ See, eg, Ben Hills, *Blue Murder: Two Thousand Doomed to Die — The Shocking Truth About Wittenoom's Deadly Dust* (Belinda Press, 1989); Gideon Haigh, *Asbestos House: The Secret History of James Hardie Industries* (Scribe, 2006); Matt Peacock, *Killer Company: James Hardie Exposed* (HarperCollins, 2009); Neil Gunningham and Joseph Rees, 'Industry Self Regulation' (1997) 19 *Law and Policy* 363; Dunn, above n 8.

⁵⁰ Productivity Commission, above n 44.

⁵¹ Hanks, above n 46.

⁵² See, eg, ACTU Congress, 'Future of Work: Rehabilitation and Compensation for Injured Workers Policy' (Policy Statement, ACTU, 2009) 33–4.

decision making is protracted, the victim is likely to die before the case is heard and compensation awarded;

- statute of limitations. Asbestos cases, as with other industrial diseases involving long latency periods, cannot be fairly and equitably dealt with under statute of limitations provisions that require a claim be made within a limited time after the cause of action arose;
- limitations on availability of common law damages. Over the last two decades a number of jurisdictions have sought to limit the circumstances or the extent to which workers can claim common law damages, or to abolish such entitlements altogether. This may be a concern for workers and their representatives, in view of the serious and fatal consequences of asbestos-related disease; and
- age limits. Although almost all jurisdictions place an age limit on the receipt of workers' compensation benefits, such a limit is inequitable as asbestos-related diseases typically have long latency periods and, as such, workers will often be beyond the age of retirement before they begin to show symptoms of an affliction.

Workers and their representatives are therefore likely to deplore the disparities between, and the difficulties posed by workers' compensation provisions across jurisdictions, and argue for consistent provisions capable of effectively, efficiently and equitably delivering compensation for asbestos-related diseases.⁵³ They are however likely to welcome asbestos- or dust diseases-based exclusions from general workers' compensation legislation which facilitate access to workers' compensation or common law damages for asbestos-related diseases.

On the other hand, employers and their representatives, who are generally concerned to reduce regulatory and administrative burdens, lower compliance costs, and the costs of workers' compensation insurance might welcome greater consistency for efficiency reasons, but not at the price of increasing the costs of compensating asbestos victims. They are also likely to take a very different view from workers with regard to exclusions provisions. For example, the exclusion of dust diseases from limitations relating to common law claims in New South Wales is a particular concern as, on one view, this may result in inflationary cost increases which are seen as a key driver of increased asbestos claim costs, while '[t]he absence of such reforms contributes significantly to the level of uncertainty.'⁵⁴ Employers and their representatives' concerns about the effectiveness of schemes with regard to achieving affordable premiums and full funding, and efficiency with regard to delivering benefits to workers at least cost to employers, are also likely to mean that they oppose other exclusions relating to asbestos diseases, largely because it is in their interests to limit the range of circumstances in which workers will be eligible for compensation.

Insurance companies are also unlikely to see eye to eye with workers and their representatives with regard to many of the above issues. They have benefited from the past failure of the legal system to deal with claims involving

⁵³ Ibid.

⁵⁴ Stevan Girvan and Alan Smee, 'Paying for Asbestos: Part 2' (2005) 28(3) *Australian and New Zealand Institute of Insurance and Finance Journal* 33, 33.

mesothelioma where the time between diagnosis and death is short, and where only expedited decision-making will ensure the claim is heard before death ensues. They might therefore have pragmatic reasons for regretting the provisions more recently introduced to address this injustice and inequity.

On the other hand, employers and workers and their representatives usually support mechanisms designed to reduce costs and speed up claims. These and other streamlining mechanisms serve to speed up the overall process (benefiting workers) while also reducing costs (benefiting employers). They support effectiveness and efficiency goals. The Dust Diseases Board of NSW is held up as an exemplar as it provides 'an extremely efficient and streamlined process for the determination of asbestos litigation'.⁵⁵

Yet even in terms of reducing costs and speeding up claims, workers' and employers' interests are not always in harmony. Perhaps the best way to short-cut many disputes is via the presumption of work-relatedness which, as indicated earlier, applies in most jurisdictions. Whether employers would support the extension of such a presumption (which operates in the worker's favour) in the other states (NSW and Qld) is doubtful given the additional cost burden to them (via their insurance premiums) of a greater number of successful compensation claims. Again, the two sides are likely to be at odds.

Overall then, as regards workers' compensation and common law claims for asbestos-related disease, the conflicts between workers and employers in terms of what they might regard as efficient, effective and equitable far exceed any common ground. Moreover there may be tensions between these criteria. For example, there is a trade off between efficiency on the one hand, and due process (a part of equity) on the other. While some commentators assert the importance of workers having their claims fully presented and independently determined with proper rights of representation, appeal or review,⁵⁶ others argue that efficiency and effectiveness are best served by a move away from legal determinations to medical panels from which there is limited or no rights of appeal.⁵⁷ Similarly, there are commonly fundamental tensions between what is efficient, effective or equitable and the fourth criterion of political acceptability. As discussed below, political acceptability trumps the other criteria in the sense that what is not politically acceptable will never get beyond the policy drawing board.

Against this backdrop, and mindful of the tensions between workers' and employers' interests and the sometimes competing claims of effectiveness, efficiency, equity and political acceptability, various reform options will now be examined. Part B examines two international examples which provided different approaches to compensation. Part C explores efforts to harmonise workers' compensation arrangements generally across the Australian jurisdictions. Part D

⁵⁵ S Herd, 'Dust Diseases: Recent Developments for Asbestos Claims' (2006) 26(2) *Proctor* 11.

⁵⁶ Blundell, above n 6, 429.

⁵⁷ At the heart of this problem is the referral of factual matters to medical panels which, in many cases, effectively denies a worker a proper hearing and results in appeals and prerogative writs to overturn the panels' decisions. (Personal communication with Rob Guthrie, Curtin Business School, Curtin University, WA, 2 October 2011).

considers whether a narrower, asbestos-specific and highly targeted approach to reform would better meet the criteria for 'success'.

B *International Comparisons*

Australia's workers' compensation schemes are not the only possible arrangements for compensating workers for asbestos-related diseases. Before going further, it is therefore helpful to refer briefly to the approaches of two other western democracies with sufficiently similar legal systems to make such comparison appropriate — the United Kingdom and New Zealand — and to ask whether or to what extent it might be desirable to apply one of these models in the Australian context.⁵⁸

The United Kingdom, having adopted a workers' compensation system based on the German model by virtue of the *Workmen's Compensation Act 1897* (UK), modified this approach following the publication of the *Beveridge Report* in 1942.⁵⁹ This report recommended that all people of working age pay a weekly national insurance contribution to fund the provision by the state of a broad range of integrated benefits. Today, the Beveridge legacy includes an industrial injuries scheme and an extremely complex system of disablement benefits under social security legislation. Under this legislation, industrial diseases such as those caused by work-related exposure to asbestos, are listed in a schedule to the relevant regulations.⁶⁰

Benefits paid under the arrangements in the United Kingdom are limited in scope and in the amounts that can be paid in any given circumstances. In the definitive work on this subject, Wikeley⁶¹ argues that the UK arrangements have largely failed victims of asbestos-related disease who experience considerable difficulties in having such disease recognised as work-related, and in securing compensation for their medically-diagnosed disease. He further demonstrates the arbitrary and incomplete coverage provided through the scheme, the delays in prescribing some asbestos-related diseases for benefit purposes, and the low success rates in benefit claims, suggesting that this is largely a consequence of differing legal and medical concepts of proof.

Accordingly, many of those suffering serious asbestos-related disease in the United Kingdom, and incurring substantial pain and suffering, look to common law

⁵⁸ Canada has problems of a similar nature to Australia with regard to compensation for asbestos-related disease. See Katherine Lippel, 'Workers' Compensation for asbestos related disease in five Canadian provinces' (Final Report, Occupational Health Clinics for Ontario Workers/Canadian Partnership Against Cancer, February 2010).

⁵⁹ William Beveridge, *Report of the Inter-Departmental Committee on Social Insurance and Allied Services* (1942) ('*Beveridge Report*').

⁶⁰ See *Social Security (Industrial Injuries) (Prescribed Diseases) Regulations 1985* (UK) SI 1985/967 with subsequent updates and amendments. The *Pneumoconiosis etc (Workers' Compensation) Act 1979* (UK) c 41 pays lump sum payments to asbestos victims who were exposed to asbestos at work and who are unable to secure civil compensation. The 2008 Mesothelioma Scheme, under the *Child Maintenance and Other Payments Act 2008* (UK) c 6, pays a lump sum payment to mesothelioma sufferers who do not qualify for a payment under the 1979 Act.

⁶¹ Nicholas Wikeley, *Compensation for Industrial Disease* (Ashgate, 1993).

remedies, either seeking damages on the basis of employer's (or another duty holder's) negligence or breach of statutory duty. This system has no shortage of problems. Employers need two types of insurance cover, rather than one, resulting in additional costs. Courts require representation of the plaintiff and defendant by lawyers and involve legal standards of proof. Such court actions are also unsuited to asbestos disease adjudication where many years have elapsed since the causative event(s) and processes, making reconstruction of the facts an enormously challenging, time consuming and expensive task. The adversarial litigation process also commonly involves long delays before liability is determined, because little effort is made to mediate and avoid the litigation process as plaintiffs' lawyers routinely take the view that 'the only effective way of obtaining proper levels of compensation for sufferers and their families is to pursue a policy of assertive litigation'.⁶²

The evidence also suggests that many workers in the United Kingdom who have contracted an asbestos-related disease are reluctant to take action against former employers, even when they have connected their health problems to past working conditions. Their reasons include: the long latency period of asbestos diseases and the fact that many employers have gone out of business between a worker's exposure to asbestos and disease diagnosis; a reluctance to risk paying both sides' legal costs if a case were lost; the prospect of paying a solicitor only to be told there is no case to answer; loyalty to a former employer, from whom a worker might be receiving a small pension; discouragement as a result of the relevant government agency rejecting a claim for industrial benefit; and the variable performance of trade unions.⁶³

Internationally, there has been considerable debate about the place of the common law in compensating injured workers. Critics assert that common law litigation is a 'forensic lottery' which fails to compensate large numbers of injured workers, entails high transaction costs (legal and administrative expenses) and long delays in the delivery of benefits.⁶⁴ Against this, proponents argue that for cases involving severe disablement and premature death (as with asbestos disease), common law actions provide larger payouts because they allow for assessment of damages commensurate with plaintiffs' circumstances,⁶⁵ and need not be protracted if they are settled with regard to precedents set in earlier cases.⁶⁶

⁶² Ian McFall, quoted in J Robins, 'Mesothelioma: Dust Cloud' (2007) 3 *Law Society Gazette* 42. However, it must also be said that most so-called plaintiff lawyers well appreciate the risks of going to trial and the costs of litigation. In many instances, their clients are risk-averse and do not have the resources to proceed with long-term litigation. See generally Marc Galanter, 'Why the "Haves" Come out Ahead: Speculations on the Limits of Legal Change' (1974) 9 *Law & Society Review* 95 and Rob Guthrie 'Negotiation, Power in Conciliation and Review of Compensation Claims' (2002) 24 *Law and Policy* 229.

⁶³ Laurie Kazan-Allen, *Asbestos Compensation in Europe* (7 July 2000) International Ban Asbestos Secretariat <http://ibasecretariat.org/lka_eu_comp.php>.

⁶⁴ See, eg, Clayton, above n 35, 461.

⁶⁵ See, eg, Girvan and Smee, above n 54.

⁶⁶ This has been the case in Australia, where many legal actions involving asbestos exposure at Wittenoom have been settled based on earlier cases. See, Tim Hammond, *Asbestos Litigation in Australia: Past Trends and Future Directions* Clyde Bank Asbestos Group <http://www.clydebankasbestos.org/gac2004/English/pl_5_05_e.pdf>.

In the UK, some of the weaknesses of the common law litigation with regard to asbestos disease have been addressed in the *Compensation Act 2006* (UK) c29.⁶⁷ For example, s 3 addresses the situation of persons who, as a result of their negligence or breach of statutory duty, have caused or permitted another person to be exposed to asbestos. The Act provides that irrespective of the fact that it is not possible to determine whether it was this or another exposure which caused mesothelioma, that person will be liable. The effect is that the claimant can recover full compensation from any negligent employer.⁶⁸

Overall, however, it is unlikely that the arrangements for compensation for asbestos disease in the United Kingdom remotely approximate best practice, based as they are on the much criticised and limited system of the industrial injuries and disablement benefits in conjunction with common law liability. The UK arrangements would not constitute an advance on the current Australian workers' compensation schemes and have therefore not been proposed as a reform option in the Australian context.

The second case for comparison is New Zealand, where a radically different approach to compensation was taken following the recommendations of the 1967 *Woodhouse Report*.⁶⁹ This involves a comprehensive, no-fault accident compensation scheme which provides 24-hour coverage for personal injury generally, and not merely for work-related injury or disease. That is, all personal injuries are compensated, regardless of their origin, under an approach seeking to incorporate community responsibility, comprehensive entitlement, complete rehabilitation, real compensation and administrative efficiency.⁷⁰ Common law actions for personal injury are also precluded. Details of the original *Accident Compensation Act 1972* (NZ), and subsequent legislative iterations and modifications, which include funding, experience rating and rehabilitation, are widely available and need not be repeated here.⁷¹

For present purposes, it should be emphasised that in terms of asbestos-related disease, the position is not as satisfactory as it is in other respects. The *Accident Compensation Act* and its successors are limited in application to 'personal injury'. As a consequence, the current legislation, the *Injury Prevention, Rehabilitation and Compensation Act 2001* (NZ), excludes 'personal injury caused wholly or substantially by a gradual process, disease or infection'.⁷² However, there is an exception whereby 'personal injury' extends to a gradual process,

⁶⁷ For the circumstances leading up to the introduction of the 2006 reforms, see *Fairchild v Glenhaven Funeral Services* [2003] 1 AC 32; *Barker v Corus* [2006] 2 AC 572.

⁶⁸ In November 2009, the Court of Appeal examined the impact of the *Compensation Act 2006* (UK) c 29 on the existing common law rules with regard to the work-relatedness of mesothelioma. In *Sienkiewicz v Greif* [2010] QB 370, the court held that the correct test for work-relatedness in such cases is whether the tortious act of the defendant materially increased the risk of the claimant contracting mesothelioma, in that the increase was more than minimal. See T Bennett, 'Material Increase in Risk of Mesothelioma under Section 3 of the *Compensation Act 2006*' (2009) 25 *Professional Negligence* 210, 213.

⁶⁹ New Zealand, Royal Commission to Inquire into and Report upon Workers' Compensation, *Compensation for Personal Injury in New Zealand: Report of the Royal Commission of Inquiry* (1967).

⁷⁰ See, generally, Clayton, above n 35.

⁷¹ Industry Commission, *Workers' Compensation in Australia*, Report No 36 (1994), app E, E23–E 26.

⁷² *Injury Prevention, Rehabilitation and Compensation Act 2001* (NZ) s 26.

disease or infection that is work-related, a treatment injury or consequential on personal injury...for which the person has cover.⁷³ Accordingly, asbestos-related diseases are covered to the extent that they fall within the above categories and definitions.

In the case of asbestosis, cover will apply provided that the manner in which it was contracted is work-related.⁷⁴ In contrast, mesothelioma, which can be caused by the penetration of a single asbestos fibre to the lung or pleura, as distinct from gradual accumulation of asbestos dust in the body, is treated as an 'accident' because it involves 'the inhalation...[or] the oral ingestion of any...foreign object on a specific occasion'.⁷⁵ The anomalous result is that mesothelioma sufferers can claim compensation irrespective of whether the disease is contracted at work or not, while asbestosis sufferers must prove the work-related nature of their disease.

International commentary on the New Zealand scheme is mixed. For example, Clayton refers approvingly to New Zealand's comprehensive no-fault scheme, compared to 'the chaotic, inconsistent, limited and expensive mishmash of measures for dealing with personal injury in Australia.'⁷⁶ Other commentators note that benefits have gradually been cut over the years, the scheme has become more costly to fund, and financial and political pressures have led to the scheme failing to achieve the social justice principles originally conceived.⁷⁷ While far from perfect, a strong case can be made that the New Zealand approach is superior to the available alternatives in terms of its coverage and level of benefits.

The current Australian workers' compensation schemes fall somewhere between the UK and New Zealand systems. The Australian schemes provide public, universal systems that employers must pay into, under which workers with occupational injuries and diseases are entitled to prompt, automatic benefits including rehabilitation and assistance with return to work. They also have the merits of being no fault systems, although they limit payment of compensation to injuries and disease arising out of or in the course of employment, and the sums awarded under workers' compensation are substantially less than at common law (even with legislative limitations on the circumstances in which common law claims can be made and caps on the amounts awarded). Nonetheless, Australian workers' compensation benefits are far better than benefits under the United Kingdom's industrial injuries scheme.

The Australian schemes, however, fall short of the New Zealand scheme in terms of just and equitable compensation of injuries and diseases, given their limited breadth of coverage and the benefits available. The New Zealand scheme is superior in terms of efficiency as transaction costs are minimised because compensation is not confined to work-related injury and disease. The scheme rates highly on effectiveness because almost all injured persons receive the

⁷³ Ibid s 20(2)(e)-(h).

⁷⁴ By virtue of *Injury Prevention, Rehabilitation and Compensation Act 2001* (NZ) s 20(2).

⁷⁵ Ibid s 25. See also Maria Hook, 'New Zealand's Accident Compensation Scheme and Man-Made Disease' (2008) 39 *Victoria University of Wellington Law Review* 289.

⁷⁶ Clayton, above n 35, 462.

⁷⁷ See, eg, Bronwen Lichtenstein, 'From Principle to Parsimony: a Critical Analysis of New Zealand's No-Fault Accident Compensation Scheme' (1999) 12 *Social Justice Research* 99.

compensation intended. The scheme also rates highly on equity because it is rare for individual claimants, or classes of claimants, to be treated differently from others (although there are some exceptions, as with asbestos cases).

Nevertheless, the New Zealand scheme scores poorly on political acceptability, at least from the stand point of Australia, and it is for this reason that there seems no possibility that any future reforms in this country will remotely approximate the New Zealand approach. Although an initiative to adopt the New Zealand model was contemplated by the Whitlam government in the 1970s,⁷⁸ the political will to take this direction has long since been lost. This is not only because of the considerable cost implications of such a move, but also because of the threat it would pose to those with powerful and embedded vested interests who benefit from the regulatory status quo. There are also few, if any, powerful and organised advocates in favour of a scheme based on the New Zealand model, and those who might be injured or contract disease outside of the workplace are not part of any pressure group, effective or otherwise.

Overall, whatever the benefits of the New Zealand approach, its low score on political acceptability mean that there seems no possibility of it being adopted in Australia at the present time. The remainder of this article will therefore be concerned with more modest reforms that might be achieved with regard to compensation for asbestos-related disease within the general framework of Australian workers' compensation legislation.

C *Harmonisation of Compensation Arrangements*

Within Australia, as discussed, each jurisdiction has its own arrangements for workers' compensation. In international terms, this is an unusual arrangement, and one which has had a number of undesirable consequences. Not least, it has resulted in numerous inter-jurisdictional inconsistencies for which there is no underlying rationale.⁷⁹ In the case of asbestos diseases, these concern such critical matters as how to establish work-relatedness and related evidentiary issues, limitation periods, how diagnosis is to be made, the role, powers and functions of medical panels, and mechanisms for providing administrative ease and expediting asbestos-related claims.

The result of these numerous inconsistencies is that workers in particular jurisdictions are seriously disadvantaged in seeking compensation for asbestos-related disease as compared to their peers elsewhere, generating inequities and incentives for forum shopping. In the past, the latter has resulted in large numbers of sufferers of asbestos-related disease seeking to lodge their claims before the Dust Diseases Board in New South Wales, rather than in jurisdictions with more onerous provisions. Only if issues such as the onus of proof, the role of medical panels and the appropriate limitations period are addressed uniformly and in ways

⁷⁸ *Woodhouse Report*, above n 11.

⁷⁹ See, generally, Richard Johnstone, *Occupational Health and Safety Law and Policy: Text and Materials* (Lawbook, 2nd ed, 2004) ch 10.

that meet the legitimate concerns of workers, as described at the beginning of this section, will effective and equitable outcomes be achieved.

Employers of course, will have concerns to reduce their costs and their focus is likely to be on those inconsistencies that generate inefficiencies and impact on effectiveness with regard to scheme funding and affordability objectives. Inconsistencies cause unnecessary complexity, administrative burdens and duplication of work effort, especially for companies with operations in multiple jurisdictions. Many of these inconsistencies relate to workers' compensation schemes generally, and disparities between asbestos-specific provisions are simply one manifestation of a much broader problem. That is, to the extent that employers drive the political debate, then it is harmonisation of the workers' compensation arrangements generally that is the main game, rather than asbestos claims.

Such system-wide concerns have driven the workers' compensation policy debate for many years. Recognising the manifest shortcomings of having 11 schemes, a number of reports have made recommendations for greater harmonisation, albeit not without considerable controversy. For example, an influential Industry Commission report in 1994 examined proposals that ranged from a national scheme established through a single, uniformly applied Commonwealth Act, to national uniformity based on all jurisdictions enacting uniform legislation, to achieving consistency by jurisdictions agreeing to adopt 'best practice' at their own pace.⁸⁰ Yet only three years later the Heads of Workers' Compensation issued their own report,⁸¹ effectively undermining the Industry Commission recommendations, which it was feared would add another layer of infrastructure and administration.

Other reports touching on the question of harmonisation of workers' compensation arrangements include the Productivity Commission's 2004 report on *National Workers' Compensation and Occupational Health and Safety Frameworks*⁸² and reports by the New South Wales,⁸³ South Australian⁸⁴ and Western Australian⁸⁵ governments, and the Commonwealth House of Representatives Standing Committee on Employment and Workplace Relations.⁸⁶ The first of these reports has been especially influential, particularly in terms of its

⁸⁰ Industry Commission, above n 71, 228.

⁸¹ Heads of Workers' Compensation Authorities, *Promoting Excellence: National Consistency in Australian Workers' Compensation* (1997).

⁸² Productivity Commission, above n 44.

⁸³ McKinsey and Company, 'Partnerships for Recovery: Caring for Injured Workers and Restoring Financial Stability to Workers' Compensation in NSW' (Report, McKinsaey and Company, 1 September 2003).

⁸⁴ Brian Stanley, Frances Meredith and Rod Bishop, *Review of Workers Compensation and Occupational Health, Safety and Welfare Systems in South Australia* (Department for Administrative and Information Services, Workplace Services, 2002).

⁸⁵ Rob Guthrie, *Report on the Implementation of the Labor Party Direction Statement in Relation to Workers' Compensation* (Government of Western Australia, 2001).

⁸⁶ House of Representatives Standing Committee on Employment and Workplace Relations, Parliament of Australia, *Back on the Job: Report into Aspects of Australian Workers' Compensation Schemes* (2003).

evaluation of possible models for establishing national frameworks for workers' compensation arrangements.⁸⁷

As Purse, Guthrie and Meredith⁸⁸ explain, the Productivity Commission's proposal was for a new system to be implemented in three discrete stages, utilising three different scheme design models that would progressively increase the availability of national workers' compensation coverage for corporate employers. In model A, multi-state firms that met a 'competition' test would be able to transfer from state and territory schemes to become national self-insurers, subject to meeting certain prudential and other criteria. In the next stage, model B, Commonwealth legislation would be enacted to create a new national workers' compensation scheme that would provide national self-insurance coverage for all interested multi-state firms. Under model C, a new national scheme would be made available for all corporations and would provide options for both premium based insurance and self-insurance. These developments could also be accompanied by the creation of a new national body, directly accountable to the Workplace Relations Ministers Council, to oversee these processes.

The Productivity Commission's proposed approach has been criticised as being overwhelmingly designed to benefit large companies, with the concerns and interests of injured workers and small business being subordinated to this overriding objective, and existing state and territory schemes being subjected to escalating funding pressures.⁸⁹ Notwithstanding such criticisms, important elements of the Productivity Commission's general approach have been adopted by the Commonwealth government and some 29 large companies with operations in a number of jurisdictions have successfully sought self-insurance licences with Comcare and now operate under the *Safety, Rehabilitation and Compensation Act 1988* (Cth) ('SRC Act') across all jurisdictions.⁹⁰

Harmonisation initiatives have also been taking place through agreement between jurisdictions. In August 2006, the Victorian and New South Wales Ministers with portfolio responsibility for workers' compensation announced reforms to their schemes in an effort to harmonise key administrative areas and cut red tape for employers operating across the country. A 10-point harmonisation plan was released as a part of that announcement, and this plan has since been adopted by eight jurisdictions.⁹¹ Although the plan involved a commitment to common approaches to administering premiums, compensation, OHS prevention issues and self insurance, while protecting the level of benefits and support provided to injured workers, the plan falls far short of a comprehensive approach and does little to rectify the many anomalies that exist with regard to specific issues such as asbestos-related disease.

⁸⁷ Productivity Commission, above n 44, viii.

⁸⁸ Kevin Purse, Rob Guthrie and Frances Meredith, 'Faulty Frameworks: The Productivity Commission and Workers' Compensation' (2004) 17*Australian Journal of Labour Law* 306.

⁸⁹ Ibid.

⁹⁰ See Safety Rehabilitation and Compensation Commission, — Current Licensees <http://www.srcc.gov.au/self_insurance/current_licensees>. See also Rob Guthrie, (2012) *Insurance Law Journal*, forthcoming.

⁹¹ Australian Capital Territory, New South Wales, Northern Territory, Queensland, South Australia, Tasmania, Victoria and Western Australia.

More recently, the Heads of Workers' Compensation Authorities has developed *The Australian and New Zealand Workers' Compensation Strategy 2009-2012*, which identifies a common set of objectives, principles and priority areas to improve workers' compensation and injury management arrangements across jurisdictions. There is also a commitment to maintain fair, affordable and financially viable workers' compensation schemes. Safe Work Australia has responsibility to guide and provide advice on the overall strategic planning and policy development for harmonisation of workers' compensation arrangements.

Given these various developments, is a national scheme for workers' compensation generally, and including asbestos-related cases necessary or practicable? The answer would seem to be 'no'. The principal driver for a national scheme is the concerns of major employers operating in different jurisdictions to reduce complexity and inconsistency and thereby reduce their costs. That is, pressure for a national scheme is largely driven by efficiency concerns. Yet these concerns have been met through the elegant mechanism of providing for companies operating interstate to obtain self-insurance licences with Comcare and operate under the *SRC Act*⁹² across all jurisdictions.⁹³ Accordingly, unless the present government chooses to preclude such companies from obtaining licences, the main impediment to efficiency has already been substantively addressed in the absence of a national scheme.⁹⁴

A national scheme is also, in all probability, not practicable, as it is likely to be politically unacceptable to states and territories with different political agendas and vested interests, which vary with the political complexion and circumstances confronted by the governments of the day. Moreover, because the funding arrangements for the states are different, the financial situation varies substantially between jurisdictions. It is likely that political acceptability (or the lack of it) would trump concerns about efficiency, effectiveness or equity. In any case, these criteria for success can be addressed by mechanisms other than a national scheme. A national scheme is not essential to rectify the various deficiencies in current workers' compensation legislation generally, and for asbestos-related diseases in particular.⁹⁵

D *Towards an Asbestos-Specific Solution*

In considering any additional harmonisation arrangements that might be desirable with regard to compensation for asbestos-related disease (or dust diseases generally) a distinction must be made between: (i) matters for which the principles governing compensation for such diseases do not depart materially from those relating to workers compensation more generally (for example, the

⁹² Note that Comcare also manages claims under the *Asbestos-Related Claims (Management of Commonwealth Liabilities) Act (No 122) 2005* (Cth).

⁹³ This solution did, however, leave other questions unanswered. See, Purse Guthrie and Meredith, above n 88.

⁹⁴ However the *SRC Act* would only cover employees of licensees for asbestos-related diseases if exposure occurred since the employer joined the Comcare scheme. (Personal communication, Alex O'Shea, Comcare, 30 May 2010).

⁹⁵ I am indebted to Rob Guthrie for discussions that facilitated the following approach.

definition of 'worker' for the purposes of making a claim); and (ii) matters for which the principles governing compensation for such diseases do or may so depart (for example, the onus and standard of proof with regard to diagnosis and work-relatedness). The former will be addressed within the context of any broader harmonisation process described above. The latter would need to be dealt with independently of that process. Key questions then are: what might that involve?; and, how might efficiency, effectiveness, equity and political acceptability, or at least some approximation to them be achieved, recognising that there are inevitable tensions between these criteria, and between the interests of workers and employers?

To address this question, it is necessary to return to the concerns of workers and employers, and their respective representatives, as described at Part IIIA above. In terms of equity, it is manifestly unfair that workers in some jurisdictions should have entitlements and benefit from asbestos-specific provisions for determining eligibility, while those in others are greatly disadvantaged by their absence. It is manifestly unfair, for example, that workers in some jurisdictions should benefit from compensation while those in others will die in an impecunious state, simply because the key provisions in the respective legislation of these jurisdictions vary. It is in the interests of effectiveness that any changes to achieve greater consistency and equity, should involve a levelling up, so that all workers in all jurisdictions benefit from more generous entitlements and eligibility criteria, in order to meet the legitimate concerns of workers and their representatives outlined above.

In particular, there are sound policy reasons for:

- uniformity in terms of the onus of proof, with the presumption being that employment was the cause of the development of an asbestos-related condition, at least for the asbestos-related diseases of asbestosis and mesothelioma. This is required given the long latency period and difficulty establishing work-relatedness for exposure years before. This would require changes to the law in any jurisdiction where it is necessary for a worker to prove that work was a significant contributing factor to disease (as in Queensland), and with regard to scheduling asbestosis and mesothelioma. Consistency in these areas would facilitate compensation and avoid the considerable inequity of existing disparities between jurisdictions;
- all jurisdictions to adopt similar mechanisms to facilitate speedy resolution of claims. Most asbestos victims become severely incapacitated, some have terminal conditions, and mesothelioma sufferers in particular die within one or two years of diagnosis. Mechanisms to speed up claims resolution might include fast-track hearings, mediation at the earliest possible time and certainly prior to a main hearing, and medical panels which the evidence suggests are both efficient and effective in terms of diagnosis, as distinct from dealing with factual issues.⁹⁶ For example, the Dust Diseases Board of NSW's streamlined process takes into account the rapid progression of some asbestos-

⁹⁶ The referral of factual matters to medical panels effectively denies a worker a proper hearing in many cases, and often results in appeals and prerogative writs to overturn the panels. (Personal communication Rob Guthrie, Curtin Business School, Curtin University, WA. 18 June 2010).

related diseases and their painful and incapacitating nature, and is regarded as the best model to follow on this, as on a number of other issues;⁹⁷

- facilitating the claims of workers who have engaged in asbestos-related work in more than one jurisdiction (usually also for multiple employers). This issue has a number of dimensions. It would involve consistent standards with regard to the onus of proof and the means by which proof is established to overcome the difficulties experienced by workers even when they have already established their claim in another jurisdiction. There are sound reasons to include a provision in each jurisdiction allowing for proof obtained in one jurisdiction to be accepted and adopted in another, to prevent a worker from having to undergo multiple medical procedures. There is also a need for mechanisms across jurisdictions to establish that the last employer is responsible for paying compensation to the worker and must then sort out with other past employers the relative proportion of compensation for which they are responsible, thereby ensuring that the worker gets compensation at a relatively early time. Such mechanisms currently exist within jurisdictions but not across jurisdictions;
- uniform processes and procedures for medical panels, including the range of questions that panels are asked to address. A composite list, drawing from the best provisions of different states, could sensibly be developed and applied across the jurisdictions. Medical panels should also be required to give reasons for their decisions, to avoid unnecessary litigation,⁹⁸ and to follow due process to the same extent in all jurisdictions.⁹⁹ The manner in which medical panels provide their certificates and reasons for decisions should be the subject of regulations, to reduce the potential for unsubstantiated or poorly considered opinions, and associated litigation;
- uniform provisions relating to limitations periods in asbestos disease cases (both workers' compensation and common law). While most jurisdictions allow for an extension of time in respect of latent conditions and in most instances workers have access to common law rights even if the diagnosis of their medical conditions arises many years after their exposure, such provisions should be consistent across all jurisdictions, and drafted so as to take account of the special circumstances of asbestos-related disease; and
- modifying the age restriction. Asbestos-related diseases are exceptional because they typically have long latency periods and, as such, workers will often be beyond the age of retirement before they show symptoms of disease. Accordingly there is an argument for exempting asbestos claims from the age limit that applies to incapacity benefits in workers' compensation generally, as has been done for dust diseases in New South Wales.

So far, this discussion has made a series of proposals that would largely achieve equity and effectiveness. Efficiency, in terms of workers' compensation generally, was addressed earlier, the argument being that the opportunity that

⁹⁷ Herd, above n 55.

⁹⁸ In Victoria, Western Australia and New South Wales there has been significant litigation involving the question of whether or not medical panels have adequately given reasons for their opinions in the medical certificates that they provide.

⁹⁹ There is a trade-off between efficiency and due process, with concern expressed within the legal community as to the problems of taking decision-making away from independent judges and giving it to medical panels from which there is limited or no appeal. See Blundell, above n 6, 428–9).

multi-state employers have to be licensed under the Commonwealth scheme largely addresses this issue even in the absence of broader harmonisation. However, the *SRC Act* would only cover employees of licensees for asbestos-related diseases if exposure occurred since the employer had joined the Comcare scheme.¹⁰⁰ Since this will be very recent in the case of non-Commonwealth entities, coverage under Comcare will be of little use to asbestos victims, almost all of whose exposure will have been before this time. Short of changes to the *SRC Act* to take account of this situation, which seems unlikely, given that the employers licensed under Comcare (as self-insurers) would be buying into substantial liabilities, the most obvious and desirable solution would be for the jurisdictions to agree on uniform (or at least consistent) provisions with regard to liability and the related issues identified above.

A central issue, then, is whether these proposals for ‘contained harmonisation’ of asbestos-specific provisions could be successful or whether they might flounder on the same criterion as other proposals discussed earlier; that is, of political acceptability. There are strong reasons to suggest they would not, as they do not involve ‘big-ticket’ financial considerations. One reason why harmonisation has not taken place with regard to workers’ compensation schemes generally is that issues such as the level of weekly payments, constraints on common law liability and medical expenses involve major financial considerations, and amendments made with regard to one of these issues usually affects other issues, thereby threatening to unravel the whole financial spectrum of workers compensation.¹⁰¹

While the proposals made above with regard to asbestos-related diseases have some financial consequences insofar as workers may be able to prove their case more easily in some jurisdictions, this is unlikely to be seen by employers, insurers or the jurisdictions themselves as a major financial impact, as asbestos disease claims are not numerous. Nor would asbestos-specific provisions, which are essentially ‘stand alone’, entail the risk of unravelling other provisions. There is also widespread public sympathy for asbestos victims. Accordingly, harmonisation proceeding along onus of proof, evidentiary and procedural issues is unlikely to run into any major obstacle in terms of political acceptability.

This still leaves open the question of how contained harmonisation of asbestos-specific provisions should best be achieved. The least interventionist approach would be to build on existing arrangements. Since multi-jurisdiction employers can elect to apply for a licence under Comcare (subject to continuation of this approach following a review of self-insurance under Comcare)¹⁰² then one solution is for asbestos-specific provisions to be enacted under the *SRC Act* as a model for other jurisdictions (addressing the issues and adopting the solutions proposed above). This would bind all Commonwealth entities and the large companies choosing to participate in this scheme although, as indicated earlier, the *SRC Act* would only cover employees of licensees for asbestos-related diseases if exposure occurred since the employer joined the Comcare scheme. Accordingly,

¹⁰⁰ Personal communication with Alex O’Shea, Comcare, 30 May 2010.

¹⁰¹ I am indebted to Rob Guthrie for alerting me to the implications identified in this paragraph.

¹⁰² Department of Education, Employment and Workplace Relations, *Report of the Review of Self-Insurance Arrangements under the Comcare Scheme* (2009).

the 'Commonwealth as model' approach would only work effectively to the extent that other jurisdictions reform their asbestos-specific provisions on the Comcare model so that substantive consistency is achieved. However, change under this approach may be slow, proceeding in all likelihood at the rate of the most laggard jurisdiction, and involving piecemeal change.

An alternative, more interventionist, model that might achieve faster change would be the 'template model'. Here, the mechanism for achieving contained harmonisation would be agreement by Heads of Government through the Council of Australian Governments ('COAG'), to adopt certain measures identified above with regard to claims for asbestos-related disease by uniform legislation, while allowing jurisdictions to retain autonomy on other elements of workers' compensation legislation. Such an approach would provide access to compensation for workers, regardless of when their exposure to asbestos occurred. It also has the attraction of being consistent with the Commonwealth's approach to harmonisation of OHS legislation,¹⁰³ and may be more politically attractive (that is to say it might engender more support from jurisdictions) than the first approach, as all governments would participate equally in defining the asbestos-specific provisions through the COAG process.

IV Conclusion

Dust diseases in general, and asbestos-related diseases in particular, have caused difficulties for workers' compensation schemes. Their long latency period, related challenges in establishing work-relatedness and attributing responsibility to particular employer(s), and the sometimes short time between diagnosis and death, suggest that exceptional compensation arrangements are needed.

Yet when the Australian jurisdictions have made special provision for asbestos-related diseases, they have gone about it in their own ways, consistent with their own particular workers' compensation arrangements, but not with those of others.

In broad terms, compensation for asbestos-related disease should be efficient, effective, equitable and politically acceptable. Manifestly, it is not. There are substantial disparities between the provisions of different jurisdictions with regard to such critical matters as: how to establish work-relatedness and related evidentiary issues; limitation periods; how diagnosis is to be made; the role, powers and functions of medical panels; mechanisms concerned to expedite asbestos-related claims; and mechanisms enabling benefits to be claimed beyond the age of retirement.

The result is that workers in some jurisdictions are substantially disadvantaged in seeking compensation as compared to those in others. Those who

¹⁰³ The Council of Australian Governments formally committed to the harmonisation of work health and safety laws by signing an inter-governmental agreement. See, Council of Australian Governments, *Inter-Governmental Agreement (the IGA) for Regulatory and Operational Reform in Occupational Health and Safety* (2008). Subsequently a model *Work Health and Safety Act* was developed which all jurisdictions except Western Australia have agreed to adopt.

have worked in asbestos-related work in multiple jurisdictions are particularly disadvantaged. On some matters there is also considerable uncertainty both in terms of law and actual practices of decision-making bodies. This too, puts workers in some jurisdictions in a worse situation than those in others.

International comparisons are of limited value in addressing how the current arrangements might be reshaped. The UK's arrangements would not represent an advance on current Australian schemes, and there seems no possibility of New Zealand's radically different approach of 24-hour coverage being adopted as it is unlikely to have political traction in Australia at the present time.¹⁰⁴ In contrast, a reshaping of asbestos-related provisions *within* the general framework of Australian workers' compensation legislation seems much more plausible.

Such reshaping need not be dependent upon any national harmonisation initiative across workers' compensation systems generally as there is no impediment to reforms targeted specifically at compensation for asbestos-related disease under the current schemes. The changes needed to rectify the injustices of current arrangements for compensating asbestos-related disease could be made independent of any broader harmonisation process.

As has been argued, there are compelling policy reasons for each of the Australian jurisdictions to adopt consistent provisions ensuring: uniformity in terms of the onus of proof; speedy resolution of claims; ready establishment of liability where the worker may have worked for multiple employers in asbestos-related work; proof obtained in one jurisdiction is accepted in another jurisdiction; the claims of workers who have engaged in asbestos-related work in more than one jurisdiction are processed expeditiously; uniformity of the processes and procedures of medical panels, including the range of questions they are asked to address; consistency in the manner in which medical panels provide their certificates and reasons for decisions; and exemptions from limitations periods and from provisions relating to cessation of benefits at retirement age, in asbestos-related disease cases.

Finally, it is important to recognise that many of the issues raised in this article concerning compensation for asbestos-related disease pertain to the area of occupational disease more generally, albeit that the current compensation arrangements with regard to asbestos may be seen as a particularly egregious example of more general failings.

¹⁰⁴ But see, Productivity Commission, *Disability Care and Support: Public Inquiry* (27 March 2012), <<http://www.pc.gov.au/projects/inquiry/disability-support>> where suggestions were made to move in the direction of the New Zealand approach.

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