

**Brief to the Workers Compensation Act Review Committee**

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I would like to thank the members of the Committee for giving me an opportunity to speak today. I graduated from the University of Manitoba Medical School in 1980 and interned at the Wellesley Hospital in Toronto. Following this, I worked for two years at the Misericordia General Hospital in Winnipeg. I then entered the internal medicine residency program at the University of Manitoba in 1983. I received my fellowship from the Royal College of Physicians and Surgeons of Canada in Internal Medicine in 1987. I completed a two year occupational medicine residency program at the Mount Sinai Medical Center in New York City in 1988. I then worked at the Irving J. Selikoff Mount Sinai Occupational Medicine Clinic until June 1989. I returned to Manitoba where I accepted a position at the University of Manitoba. In November 1990, I obtained my second fellowship from the Royal College, this being in Occupational Medicine. I am currently an Associate Professor in the Departments of Community Health Sciences and Internal Medicine at the University of Manitoba. I am the Medical Director of the Department of Occupational and Environmental Medicine at the Health Sciences Center. I am also an attending physician on the clinical teaching units in internal medicine at the Health Sciences Center and a physician at the MFL Occupational Health Center. I am a consultant in Occupational Medicine to a number of large employers in the province. I have also served as a consultant to the WCB on a number of projects and functioned in a variety of capacities on medical review

panels. I would like to comment on some aspects of the Workers Compensation Act as they have affected my patients based on my 15 years of experience working in the field in Manitoba.

Over the past few years I have seen a number of individuals who requested assistance in appealing WCB decisions regarding their permanent partial disability awards. These individuals felt that their awards were too low and thought that the reason for their low reward was their low impairment rating. This is quite understandable as the impairment rating is the only component in the formula used to calculate the reward that has variability, given that the rates per percentage impairment are fixed by the Workers Compensation Act. Workers who have low impairment rating wind up with low awards. For example a 41 year old man who had a major disfiguring burn to his face, eye lids, ears, hands, back, buttocks and legs and fortunately minimal functional impairment was given an impairment rating of 20 %. This translated into an award in 2002 of \$12,760.00. I feel that the 20% impairment rating may not be unreasonable assessment in this case if one considers a scale of impairment ranging from no impairment (0%) to complete impairment where one can not do anything of 100%. The problem is translating this impairment into a monetary reward. As quoted in a WCB letter to this patient in 2002, he received \$1,160 for the first 10% of his impairment and \$11,600 for the next 10%. Given the nature of this man's injuries, this award is too low. Most individuals in our society, if given the option, would want a higher level of insurance than what the Workers Compensation Act provides. As workers have given up the option to sue their employers for the workers' compensation system, one would expect that they should have a reasonable level of coverage. The Workers Compensation Act must readdress the conversion of impairment ratings into

monetary awards to bring the awards up to appropriate levels. This problem is particularly severe for levels of impairment less than 5%. This level of award would not pay for a year of monthly Winnipeg bus passes at the current price \$67.40/month.

Occupational diseases are frequently multifactorial. The Workers Compensation Act currently accepts a disease as occupational when occupational factors are deemed the dominant cause of the disease. This translates into a system where a condition is either accepted as work related with full compensation benefits or rejected with no benefits. Although on the surface this may seem reasonable, this approach to occupational diseases has a number of major limitations.

For many occupational diseases there are no specific markers or tests that can separate out occupational from non-occupational causation. Epidemiologic studies are commonly used to identify occupational risk factors for disease. Using the Workers Compensation Act's current definition, a condition is accepted as work related when epidemiologic studies show a doubling of the risk because at this point, it could be stated that there is an over 50% chance that the work place factors lead to the development of the disease. Epidemiologic studies commonly identify the number of cases of a disease in a population and compare this to the number of cases that would be expected in a reference population. The ratio of the observed to expected number of cases is a measure of the risk. Levels above 1.0 suggest an elevated risk, while levels below 1.0, suggest a decreased risk. A rate ratio of 2.0 suggests a doubling of risk. Thus a

rate ratio of greater than 2.0 is used in some definitions of "dominant cause" in occupational disease claims.

It is easier to identify a doubling of risk when the disease in question is rare or when occupational exposures are associated with very elevated risks of development of disease. Stated another way, it is harder to show a doubling of risk for more common diseases or when the occupational exposure is associated with a significant, but lower level of risk. This creates a difficult level of proof for common multifactorial diseases where workplace and non-workplace factors interact in the development of disease.

To illustrate this point, I would like to give the following example. Let us assume that there are two workforces, A and B, each with 20,000 workers. In each of these workforces there is an occupational exposure that leads to an increase in disease. In workforce A the exposure leads to a 20 fold increase in a rare disease. Given the size of the workforce one would only expect 0.1 cases of this rare disease. As the exposure leads to a 20 fold increase in the level of disease, two cases of the disease would be observed. At this work site the exposure would cause, two cases minus the 0.1 cases that were expected, or about two extra cases of disease. These two individuals would have their WCB claims accepted as they would meet the "dominant cause" criteria since the exposure in question caused a 20 fold increase in the disease. Let us contrast this with workplace B where an exposure causes a 1.5 fold increase in a more common disease. Assuming a baseline rate of about 20 cases one would observe 30 cases ( $20 \times 1.5$ ). At this work site the exposure lead to the development of 10 extra cases of disease. Unfortunately under the current stipulations of the Workers Compensation Act, as it could be argued that the workplace exposure

was not the "dominant cause" of the disease, none of the cases at work site B would be classified as work related. Although none of the extra cases of disease are seen as work related, site B has a worse problem because it has 10 extra cases of occupational disease versus only 2 in site A. Following the "dominant cause" logic to its extreme, work sites would only have to lower exposures to a level where there was no longer a doubling of the risk of disease prior to being at risk for compensation claims. This clearly is not the intent of the Workers Compensation Act or the Workplace Safety and Health Act.

A proportionate system would help address this issue in a fairer fashion. Threshold percentages of attribution should be set below which a case would be deemed non-occupational and above which the case would be determined of occupational origin. Between these two thresholds a proportionate system could be put in place to decide the level of compensation paid. A number of political and practical issues would have to be addressed to make this system work. Such a system however, would give adjudicators and medical review panels more latitude in deciding the importance of occupational contribution in an individual disease case.

The assessment of impairment in Occupational Asthma in Manitoba needs to be updated. The system used in this province for asthma is the same as for other occupational lung diseases. The system uses a combination of symptoms and a variety of physical findings and lung function tests. In total 19 different criteria are measured. Of these, only five are important in evaluating asthma. Further, how these criteria are translated in to an impairment rating has not been validated. Other provinces, such as Ontario and Quebec, are using a better system. These provinces base their impairment ratings on the degree of airflow limitation, airway hyper responsiveness and the need for medications, criteria which are important in the assessment of asthma. These criteria are based of

those recommended by the American Thoracic Society. I recommend that we in Manitoba follow suit. I would also recommend that a procedure be put in place to periodically review the methods by which all medical impairment ratings are calculated to ensure that they reflect the current state of knowledge in the field.

Thank you for giving me the opportunity to present to you today. I would be happy to answer any questions you may have on my presentation.