S. C. M. P. 24 July, 1978

Acting before issues vanish in the dust

THE RECENT addition of pneumoconiosis to the schedule of occupational diseases under the Workmen's Compensation Ordinance is a major effort by the Government to tackle the problem of compensation to people suffering from occupational diseases. But while the action is to be applauded, the Government did not act with the sense of urgency that the situation required.

The Commissioner for Labour, Mr J.N. Henderson, made clear in a speech in the Legislative Council on May 10 that the term pneumoconiosis – while covering a group of dust diseases of the lung – is defined in the bill as silicosis and asbestosis, the only two of known concern in Hongkong. The disease is caused by the inhalation of a variety of industrial dusts, such as free silica and asbestos dusts.

Silicosis has been reported as an occupational disease under official statistics as far back as 1960-1961, and accounted for 83 per cent of all occupational diseases in Hongkong during the past 17 years. The seriousness of the problem is reflected in the fact that, in 1976-77, out of 280 cases of occupational diseases, 267 were attributed to silicosis. Yet, until the recent Government action, victims suffering from the disease were not covered by the Workmen's Compensation Ordinance.

The disease poses a particularly serious problem because it may not be apparent until there is an irreversible pathological change in the lung tissue known as fibrosis, that is, the laying of fibrous tissues in the lungs caused by dust. Mr Henderson explained that, once this occurs, 'the condition is irreversible and removal from exposure may only slow down progression of the disease in some cases."

Mr Henderson . . . labour hazards

Because pneumoconiosis has a long latent period and is difficult to diagnose, especially in the early stages, and because many sufferers may, over the years, have changed jobs and even industries, the Government has devised a way of dealing with three categories of people: the backlog of several hundred silicotic cases, existing cases not yet discovered, and future cases.

To tackle the first category, the Government has allocated the sum of $25 million in payment of compensation to about 700 odd cases.

Moreover, the Government will initiate an X-ray programme to facilitate early detection. It has also agreed initially to accept responsibility on behalf of employers collectively for cases discovered at the inauguration of the scheme during the initial X-ray period, provided that the Government will recover the compensation plus interest through the pool by a levy on the employers in the affected dusty trades.

Most significantly, the Government has made it compulsory for all employers with employees working in the relevant trades to carry insurance in this field.

The scheme involves the establishment of an insurance pool financed by premia from employers in specified industries to meet compensation claims.

The introduction of collective insurance is a step forward in the field of workmen's compensation in Hongkong. Present legislation makes it the liability of the employer to pay workers incapacitated by industrial accidents or diseases. But the requirement that employers carry insurance has not been enforced.

Thus, employers are generally reluctant to assume liability. Moreover, small employers who have not taken out insurance for their injured workers may default. This system was scrapped in the UK in 1946, in favour of a national insurance scheme. It is about time that mandatory collective insurance covering pneumoconiosis be extended to other diseases in other industries.

Besides implementing compulsory insurance, there is additional room for improvement in the present Workmen's Compensation Ordinance. Under the system, the amount of compensation payable to the injured worker is a percentage of the compensation payable for permanent total incapacity proportionate to the loss of earning capacity caused by the injury. But the whole burden of this assessment rests on physicians on the medical assessment board convened in a hospital.

The assessment made by medical doctors is in effect just an estimate of the degree of physical disability of the injured worker. Under the present system, the percentage of physical disability is considered to be a percentage of the loss of earning capacity.

Thus, a worker who loses an arm at shoulder is considered to have suffered 65 per cent loss of earning capacity. His compensation would be a lump sum, equal to 65 per cent of the compensation he would have received if he had been totally and permanently incapacitated, such as in the case of total paralysis. No consideration is given to the nature and requirement of his occupation and alternative employment he is able to take up after the injury.

Under this method of assessment, those who suffer the same disability are compensated equally. But, in fact, the loss of a finger by a skilled handicraft worker is more acute a loss than for a casual labourer on a construction site. For this reason, we urge that the existing basis of assessment and compensation be replaced by a more realistic one which can take into account the foregoing factors, and be more closely related to the needs of the victim.

To achieve this goal, the present board of assessment should be expanded. Perhaps representatives from workers and management should be invited to sit on the board. Social workers who investigate workers' family backgrounds and rehabilitation opportunities and labour officers should also be included.

While the Government is now paying major attention to pneumoconiosis, it is doubtful if Hongkong now faces few other occupational diseases. The exclusion until recently of silicosis, and the continued exclusion of gas attack, tend to encourage scepticism of the Government's sincerity in recognising the seriousness of the problem of occupational diseases, and coping with it.

The last time the schedule of occupational diseases was reviewed was in 1969. It took nine years for another review, nine years during which hundreds of silicosis sufferers obtained no relief from the Government. This leisurely pace is clearly inappropriate in view of the rapid tempo of changes in technology, occupational structure and work environment.

In the 1950s and early 1960s, dermatitis was the major occupational disease, and now it is silicosis. What will be next? As industry develops, new hazards will open up, and we may be plagued by an array of as yet unknown diseases which are occupationally caused, but which don't come within the schedule of occupational diseases and hence won't be liable for compensation.

What is needed is a more dynamic and responsive system of identification of diseases that may be occupation-related. Worth exploring is the idea of a standing board, which will review at regular intervals the definition and scope of occupational diseases, taking into account the changes in technology.

Such a board could also have, as part of its task, the devising of methods of detection of new disease forms, followed by recommendations of health and hygienic controls. Ideally, this committee should include environmental specialists, doctors with experience in dealing with occupational diseases, labour officers and representatives of both labour and management.

Hongkong Observers Forum

THIS is another in a series of articles by the Hongkong Observers, which appears fortnightly on this page. Comments from readers are welcome, and should be addressed to Hongkong Observers' Forum, c/o S.C.M. Post, Tong Chong Street, Quarry Bay, Hongkong.