

**Submission
No 4**

FIRST REVIEW OF THE DUST DISEASES SCHEME

Organisation: The Thoracic Society of Australia and New Zealand

Date received: 21 April 2017

Submission to the NSW Legislative Council's Standing Committee Regarding the First Review of the Dust Diseases and Lifetime Care and Support Schemes

About the Thoracic Society of Australia and New Zealand (TSANZ)

The TSANZ mission is to lead, support and enable all health workers and researchers who aim to prevent, cure and relieve disability caused by lung disease. TSANZ is the only Peak Body in Australia that represents all health professionals working in all fields of respiratory health.

TSANZ has a membership base of approximately 1500 individual members from a wide range of health and research disciplines. TSANZ is a leading provider of evidence based guidelines for the treatment of respiratory disease in Australia and New Zealand, undertakes a large amount of professional education and training, is responsible for significant research administration and coordinates an accredited respiratory laboratory program.

The NSW branch of the Occupational and Environmental Lung Disease Special Interest Group (OELD SIG) of the Thoracic Society of Australia and New Zealand (TSANZ) welcomes the opportunity to make a submission regarding the Dust Diseases and Lifetime Care and Support Schemes.

Introduction

The TSANZ SIG notes with concern the re-emergence of coal workers' pneumoconiosis in Queensland and the recent identification of several potentially fatal cases of silicosis in NSW related to exposure to manufactured stone products.

We believe that occupational lung disease is significantly under-recognised in NSW. Resources need to be directed towards early diagnosis of these disorders and also towards optimal management, which will reduce long term costs including those of disablement and healthcare utilisation. The SIG aims to prevent all cases of occupational lung disorders as far as is reasonably practicable and promote collaboration between respiratory healthcare professionals and industry so that a co-ordinated approach can be implemented.

The term 'pneumoconiosis' refers to a group of lung diseases caused by the inhalation and retention of dust in the lungs. The Dust Diseases Authority, also known as icare Dust Disease Care, currently has a list of 13 compensable dust diseases, which are listed below.¹

- Aluminosis
- Asbestosis
- Asbestos-induced carcinoma
- Asbestos related pleural disease (ARPD)
- Bagassosis
- Berylliosis
- Byssinosis
- Farmers' Lung
- Hard Metal Pneumoconiosis
- Mesothelioma
- Silicosis
- Silico-tuberculosis
- Talcosis

These lung diseases are caused by inhalation of aluminium, asbestos, moulds, beryllium, cotton, hay and other organic dusts, hard metal alloys, crystalline silica, mycobacterium tuberculosis and talc. They cause progressive scarring of the lungs known as interstitial lung disease. Asbestos also causes benign and malignant lesions of the lining of the lung. These diseases cause troubling symptoms such as cough, breathlessness and chest pain and in some cases respiratory failure and death.

Although other diseases may be compensated under the current legislation, it does not appear that any are actually compensated in practice.² There are no data regarding the prevalence or incidence of occupational lung disease in Australia and it is therefore impossible to know how many cases are left undiagnosed. The TSANZ SIG notes with concern the re-emergence of coal workers' pneumoconiosis in Queensland, which clearly demonstrates that lack of documented cases is poor identification rather than lack of occurrence.

The TSANZ SIG notes that the Dust Diseases Authority list is now somewhat dated and that 95% of the claims processed by the DDA are related to asbestos exposure. Thus, a large component of dust-related diseases which occur in the modern workplace are not currently specified as being compensable.

The TSANZ SIG also points out that the current legislation limits compensation to several diseases well established to be associated with dust inhalation. Good medical evidence has confirmed that it is not only dusts which produce these diseases. In addition to dust inhalation, fumes, chemicals or gases and vapours may also produce occupational lung diseases.

These include:

- Occupational asthma including reactive airway dysfunction (RADS) and occupationally exacerbated asthma
- Occupational lung cancers including those related to causes other than asbestos (e.g. silica, arsenic)
- Dust-induced pulmonary fibrosis
- Chronic obstructive pulmonary disease (COPD) related to dust, fume and mist exposure
- Pneumonia related to occupational exposures

These disorders are successfully identified and compensated in other countries, particularly in Europe and Canada.

Occupational asthma

In most developed countries, occupational asthma is the most common work-related lung disease. Occupational factors account for up to 15% of new cases of asthma in adults.³ More than 450 sensitising causes have been identified, and in most cases removal from exposure ameliorates symptoms.⁴ Available evidence suggests that occupational asthma is under-diagnosed and underreported in NSW. This was demonstrated in low rates of reported occupational asthma in the Surveillance of Australian Workplace Based Respiratory Events (SABRE) study.⁵

There is an urgent need for improvement in recognition and in compensation of these cases. Occupational asthma (OA) is a preventable disease and improves with removal from exposure to the causative agent. Compensation for OA allows prevention of long term disease and is associated with a reduction in health care costs.

Occupational lung cancer

The WHO's International Agency for Research on Cancer (IARC) has classified 107 agents, mixtures, and exposure situations as carcinogenic to humans. These include all forms of asbestos and a number of agents found in the environment such as benzene, arsenic in water, cadmium, ethylene oxide, benzo(a)pyrene, silica, ionising radiation including radon, ultraviolet radiation including tanning devices, aluminium and coke production, iron and steel founding, or the rubber manufacturing industry.⁶

Currently, compensation for occupationally related lung cancer in NSW is overwhelmingly for asbestos-related lung cancer (DDB report).² When compared with the proportion of cases estimated to be related to occupational causes, this represents a small number (Cancer council report on occupational lung cancer). While recognising the important contribution of tobacco inhalation to the genesis of lung cancer, the TSANZ SIG nonetheless recommends that the broad spectrum of occupational carcinogens should be recognised, and compensation for occupational lung cancer should be improved.

Dust-induced pulmonary fibrosis

In addition to the classical pneumoconioses which are already compensated by the DDA scheme, other dust and fume inhalation is associated with the development of pulmonary fibrosis e.g. metals, wood dust. Several recent reports highlight the fact that a proportion of patients with so-called idiopathic pulmonary fibrosis (IPF) in fact have occupational lung fibrosis. Currently, these cases are not compensated but there are good scientific data suggesting they should be included in the scheme.

Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease is characterised by progressive airflow obstruction and, similar to lung cancer, is highly linked to inhalation of tobacco smoke. However, other environmental risk factors for COPD have been identified, including coal, cadmium, silica and biomass fuel as well as inhaled exposures in the workplace vapours, gases, and fumes. It is likely that approximately 15% of cases of COPD are work-related. For some exposures (e.g. coal dust), the loss of lung function produced by dust exposure is the same as that produced by cigarette smoking, and this is a major cause of disability.

Again, occupationally related COPD is under-recognised in NSW and most cases are likely to remain undiagnosed. The TSANZ SIG recommends that compensation should be extended to include occupationally related chronic obstructive pulmonary disease (which comprises both chronic bronchitis and emphysema).

Pneumonia related to occupational exposures

It is well documented that pneumonia can arise from exposure to occupational agents such as brucellosis from exposure to cattle, psittacosis from bird exposure and chlamydia from exposure to ducks. Also, there are other agents which are now recognised as also causing pneumonia (e.g. exposure to metal fumes and the development of pneumococcal pneumonia), and it is recommended that these should be recognised and appropriately compensated.

Coal dust-related lung diseases

The coal dust related lung diseases such as coal workers' pneumoconiosis are dealt with by a separate organisation, which is appropriate at this time. It is currently undergoing review. However, consideration should be given to the fact that these disorders are best diagnosed by respiratory physicians with special expertise in this area and that expertise is difficult to acquire and to keep up to date. Collaboration between agencies in diagnosing these diseases would be optimal.

Systemic diseases related to occupational dust exposures

There are several diseases which are related to dust exposure or interact with such exposures but which do not primarily affect the lung. One example is scleroderma, which has been related to occupational silica exposure, and Caplan's syndrome (rheumatoid pneumoconiosis).

No other compensation agency is equipped with the specialised expertise to deal with such diseases and the TSANZ SIG recommends that consideration be given to expanding the terms of reference of the DDA to include these disorders.

Administrative issues

Diagnosis and assessment of disablement

The medical process for the award of disablement as well as the assessment of disablement is not always accessible either to applicants or to their caring doctors.

The TSANZ SIG calls for greater transparency regarding the exact criteria used for diagnosis and for assessment of disablement. We recommend that the DDA openly conforms to current international guidelines both for

diagnosis and for assessment of disablement. Currently, several guidelines and position papers are available (e.g. ATS statement on non-malignant asbestos-induced diseases) and the TSANZ is actively engaged in developing local position papers (e.g. occupational asthma). The American Medical Association Guidelines on Permanent Impairment Edition 5 (AMA 5) are the most authoritative and widely used international guidelines for the evaluation of permanent impairment.⁷ The NSW Workers Compensation Guidelines Edition 4, April 2016 are based on AMA5. However, the pneumoconioses are excluded from these guidelines as they are subject to Dust Diseases Legislation.⁸

We also note that there is no formal medical appeal process for decision making. This can result in legal action with associated long delays and entailing considerable cost, producing significant distress for applicants. Where a difference of opinion has arisen on a medical matter, this would be best resolved by a medical appeal process involving independent medical experts.

The TSANZ SIG recommends that the DDA should review the current standards for diagnosis of occupationally related lung diseases in NSW as well as disablement assessment, and develop a process whereby these standards are publicly available. It also suggests that the DDA should give consideration to the establishment of a Medical Appeal Tribunal, where medical decisions can be resolved rapidly and without an adversarial process, and according to up to date established medical evidence.

Prevention of occupational lung disease

The Dust Diseases Authority deals with compensation. It does not contribute to the prevention of dust diseases, nor feedback its findings into existing prevention processes. The TSANZ SIG is concerned that this results in a missed opportunity for prevention. The TSANZ SIG recommends that the scope of operations of the Dust Diseases Authority be expanded to include improving efforts to prevent dust related diseases.

Recently, there have been several cases of severe silicosis described in NSW from the engineered stone products industry, which have arisen despite existing legislation and which are severe enough to be fatal. This sort of case, as well as many cases of occupational asthma, are examples of how new occupational exposures can cause disease. These cases may apply to the DDA, especially if its scope is improved. When new exposures cause disease, the DDA should notify Work Safe early, to allow a workplace assessment with appropriate improvement of toxic exposures where applicable.

Accurate data

There is an urgent need for accurate data on numbers of cases of occupational lung disease in NSW and in Australia as a whole. There is no centralised system for collection of information on occupational lung disease in NSW, unlike many other countries. Although the SABRE scheme was supported by the DDA for some years, working in collaboration with SABRE Victoria, it is no longer in operation. We recommend that data collection of this type should be a responsibility of the DDA and that the DDA should give consideration to re-establishment of the SABRE scheme or to an alternative similar scheme, with appropriate long term funding. A mandatory notification process (such as is used for infectious diseases such as tuberculosis) is an effective measure and is one option which could be considered.

Summary

The NSW TSANZ OELD SIG believes reform of the policies and practices of the NSW Dust Diseases Authority is needed to bring it in line with the current epidemiology and practice of occupational lung disease.

Recommendations include:

- Expanding the compensated occupational lung disorders to include occupational asthma, occupational COPD, occupational lung cancers, dust-induced occupational pulmonary fibroses and the occupational pneumonias.
- Greater transparency in the diagnosis and assessment of disablement for the occupational lung diseases to include conformity with international guidelines on diagnosis and disablement assessment.
- Consideration of the establishment of a Medical Appeal Tribunal.
- Expansion of the scope of operations to include early feedback to relevant agencies involved in the prevention of cases of occupational lung disease
- Improved data on cases of occupational lung diseases, possibly by re-establishment of the SABRE NSW scheme, or similar reporting process. Mandatory reporting of cases to the DDA should be considered.

The NSW branch of the Occupational and Environmental Lung Disease Special Interest Group of the Thoracic Society of Australia and New Zealand

References

1. Workers Compensation Dust Diseases Board. NSW Government. <https://www.ddc.nsw.gov.au>
2. Annual Report of the Dust Diseases Board 2014-2015 <https://www.ddc.nsw.gov.au>
3. Johnson A, Toelle B, Yates D, Belousova E, Ng K, Corbett S, Marks G. Occupational Medicine (Lond) (2006)56(4):258-262
4. Occupational Asthma in Australia. Australian Institute of Health and Welfare, Bulletin 59, April 2008
5. Hannaford-Turner K, Elder D, Abrahamson MJ, Johnson AR, Yates DH. Occupational Medicine (Lond) 2010 Aug; 60 (5):376-82
6. International Agency for Research on Cancer (IARC);2017 April 3. <http://monographs.iarc.fr/ENG/Classification/index.php>
7. A Medical-legal Comparison to the AMA Guides Fifth. Guides to the Evaluation of Permanent Impairment. Kingdon K. American Medical Association, 2011
8. State Insurance Regulatory Authority. NSW Government <https://www.sira.nsw.gov.au>