The Forum of Asbestos Victims Support Groups

Response

The Industrial Injuries Disablement Consultation Paper

Introduction

Victims of Asbestos-related disease

1. The Forum of Asbestos Victims Support Groups represents workers disabled by asbestos disease. Over half of all Industrial Injuries Disablement Benefit (IIDB) prescribed disease payments are paid to asbestos victims.[1]

2. Most asbestos victims are eligible for State Pension Credit, and the majority are over State Pension Age.[2] Almost all asbestos victims will never work again or are already retired. Forty percent of all payments for prescribed diseases were made to mesothelioma sufferers in 2004/05.[3] Mesothelioma sufferers have a life expectancy of between 8-13 months, and they will die as a result of their employment.

3. **The government intends to dovetail the IIDB Scheme with its welfare reform programme which aims to significantly increase the employment rate for disabled people. In seeking to achieve this aim it would be wrong to ignore the needs of those, such as asbestos victims, who are rendered incapable of work, or who are affected late in life due to long-latent disease, or to reduce existing scheme provision in any way whatsoever.**

The IIDB Scheme: The Key Question

4. The Industrial Injuries Scheme (IIS), introduced in 1948, has been renamed 'the IIDB Scheme' because the scheme was so badly degraded by government cuts that it now consists of just one benefit, IIDB, and two associated allowances. The IIS (or now IIDB) has never 'served us well for over 50 years', as the Consultation Paper suggests.[4] The scheme has never incorporated rehabilitation or prevention since its inception and provides poor no-fault compensation.

5. One consequence of the degradation of the IIS was the increased reliance on common law claims (tort) to secure compensation. In 1978, the aggregate value of the IIS was three times that paid in tort, and the scheme paid seven times the number of beneficiaries compared with tort.[5] The IIS was the main provider of compensation for work injury.

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[1] DWP Consultation Paper Fig. 8

[2] DWP Consultation Paper, 3.2 ' Some 60% of new prescribed disease claims are from people over State Pension Age'.

[3] DWP figures for Dec 2004 to Sept 2005 – 1,350 mesothelioma payments of 4,000 payments for PDs

[4] DWP Consultation 1.15

[5] Royal Commission on Civil Liability for Personal Injury 1973-1978, (Pearson Commission), Cmd.7054, Vol. 1, Chp. 17, para. 772

Today, more is paid in compensation through tort than through the IIDB Scheme.[6] Much of the annual IIDB cost is for high numbers of past claims still in payment. Current, annual IIDB payable assessments are falling and represent just 20% total personal injury awards: now tort pays five times the number of beneficiaries compared with the IIDB Scheme. It is argued that injured workers are little better off today than under the discredited Workmens' Compensation Act 1897.[7]

6. Today, most employers have hardly even heard of the IIDB Scheme[8] and others, including employee representatives (TUC), see tort *'as the core for compensating occupational illness and injury'*, and, *'using no-fault compensation to plug gaps in the fault-based system'*.[9]

7. **The key question for stakeholders is whether the no-fault IIDB Scheme should be a comprehensive no-fault scheme, incorporating substantial compensation and rehabilitation and prevention, or continue as a second-rate provider of minimal compensation. We argue in favour of significant improvements to the IIDB Scheme which will reduce reliance on tort, but leave tort as an option, especially for those seriously disabled.**

8. Our proposed scheme falls far short of the fully-fledged no-fault schemes found in most European countries and in the US, Canada, Australia and New Zealand. This is because in those schemes access to tort compensation is either restricted or not permitted. However, our proposals should mean less reliance on tort by providing a better no-fault scheme which will satisfy the needs of many injured workers. This can only be done by incorporating elements of typical no-fault schemes which have always been absent from the UK scheme.

** The term 'work injury' includes occupational disease.

SUMMARY OF PROPOSALS

Compensation

1. Pay full wages for 26 weeks for total incapacity for work
2. Reduce threshold for IIDB from 14% to 5%
3. Provide enhanced IIDB payment to mesothelioma sufferers

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[6] Parsons C, (2002) "Liability Rules, Compensation Systems and Safety at Work in Europe", The Geneva papers on Risk and Insurance, Vol.27 No.3, July , p366

[7] *'The withdrawal, since October 1990, of all industrial injuries cover for nine-tenths of potential claimants – and all compensation for a fall in earning capacity for the remaining one-tenth who continue to receive disablement benefit – appears to return us to a situation which applied almost 100 years ago when private litigation was the main method by which workers obtained compensation for employer negligence. Once again workers will need legal representation to prove, in a civil court, that the accident arose out of employer negligence and not their own actions (as against the existing tribunal system where no proof of negligence is needed), and workers who do not have the resources to take their case to court will not have a chance of being compensated'* Walker, A., Walker, L.(1990) "Disability and Financial Need – the Failure of the Social Security System", p28

[8] Wright, M. and Marsden, S. (2002) "Changing business behaviour- would the true cost of poor health and safety performance make a difference?", HSE commissioned Contract Research Report.

[9] TUC (2003) "Radical solutions are all we can afford", submission to the DWP, pp2-3

4. Use half median wage for IIDB scale payments
5. Re-instate a form of reduced earnings allowance
6. Pay CAA and ESDA automatically to mesothelioma sufferers
7. Equalise in-life and posthumous 1979 Act payments

Rehabilitation

1. Legal requirement to provide a rehabilitation programme
2. Incorporation of a coordinator/case management system for rehabilitation
3. Legal requirement on employers to retain workers for a specified period of time
4. Requirement to set out rehabilitation programme in the Health and Safety Policy
5. Legal requirement on employers to provide an occupational health service
6. Introduction of a form of reduced earnings allowance (see above)
7. Scheme administrators to monitor rehabilitation and provide statistics on rehabilitation

Decision Making

1. Appoint properly trained, specialist medical advisers
2. Appeal tribunal should be inquisitorial
3. Appeal tribunal should accept the appellants case where balance is 50:50

Occupational Disease

1. Independent body to determine prescription of disease
2. Incorporate EU schedule of occupational diseases
3. Budget for independent research into occupational disease
4. Reform criterion for prescription of occupational disease
5. Allow ‘individual proof’.
6. Allow ‘injury by process’.

Coverage

1. Include self-employed
2. Include environmental and work clothes asbestos claims
3. Include travel between home and work

Funding

1. Employers to pay full cost of a new scheme
2. Differential levy on employers according to industry injury profile

Relationship with other forms of compensation/benefits

1. IIDB should be paid in addition to means-tested benefits and tax credits
2. Proportionate benefit recovery where damages are reduced due to apportionment and contributory negligence.
3. Proportionate 1979 Act recovery where damages are reduced due to apportionment and contributory negligence.
4. Disregard personal injury payments for spouses on death of personal injury recipient

Administration

1. Administration by a board overseen by the DWP

Response to Key Questions in the Consultation Paper

Purpose

Q1. What is the case for a no-fault scheme?

1.1 The case for a no-fault scheme has been made, on many occasions, by the Industrial Injuries Advisory Council (IIAC), for example[10]:

- Work is necessary for society and individuals have no free choice to work only where it is safe. Occupational injury and disease still occur, despite regulations, and the individual has little control over employer compliance. Society has a duty to provide for the consequences of occupational injury.

- Neither common law arrangements nor general benefits can provide adequate compensation for actual injury or for reduced earnings for all those injured at work.

- A no-fault scheme promotes prevention of injury by recording occupational injury and heightening awareness of the human consequences of unsafe working conditions, and by its role in identifying occupational diseases.

- Prevention is also enhanced by providing sufficient resources, e.g. the now defunct Reduced Earnings Allowance, to enable a worker not to continue in work that would worsen health condition.

1.2 Additionally, it is accepted that no-fault schemes in other countries are best placed to provide vocational rehabilitation, and in most cases, act as an important incentive for prevention of work injury because they are exclusively financed by employers.

Q2. What should be the purpose of a no-fault scheme?

2.1 The purpose of the IIDB Scheme should be to provide substantial compensation, assist in rehabilitation and contribute to prevention of industrial injury and disease. To date, the scheme has never incorporated rehabilitation or any meaningful prevention and provides poor compensation.

2.2 The role and purpose of the IIDB Scheme has been unclear from its inception. It has been described as:

> *'a jumble of benefit and allowances, some parts directed towards need, others toward income replacement. Yet the system as a whole is consistent with neither objective and seems to have no overall structure….It is much regretted that so little heed seems to have been paid to foreign systems, some of which adopt a more rational, and less cumbersome approach to these questions.'*[11]

2.3 In general, no-fault compensation schemes provide substantial earnings replacement for a period of time for total incapacity for work. Thereafter, they pay a benefit or pension for loss of faculty and reduced earnings capacity.

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[10] IIAC, 1990, 'The Industrial Injuries Scheme and the reform of Disability Income', Position Paper 5

[11] Ogus, A. and Barendt, E. (1982) *The Law of Social Security*, 2nd. Ed. London: Butterworths, p297

2.4 In the UK until 1982, injury benefit was paid at a higher rate than sick pay, without having to satisfy NI contributions requirements. Injured workers now receive no scheme entitlement for total incapacity for work at all. There is no scheme entitlement to compensation for reduced earnings: Reduced Earnings Allowance was abolished in 1990. IIDB is paid after 15 weeks from the date of injury which results in at least 14% disablement.[12]

Q3. Should a scheme be a compensation scheme, a benefit scheme, or both?

3.1 The DWP hasn't got a clue what the purpose of the scheme is, and nor did its predecessors.[13] IIDB is paid for 'loss of faculty resulting in disablement'. It is paid on top of earnings and is tax–free. It is, therefore, **compensation** for disablement due to a work injury, and paid as a benefit - IIDB. Yet, IIDB is taken into account where means-tested benefits are paid, such as Income Support. As a result, some injured workers may be worse off claiming IIDB because they could lose all means-tested benefits and also 'passport benefits', such as free eye tests and dental care. Even a mesothelioma sufferer, who has months to live, can be worse off, or hardly any better off after claiming IIDB. (*Case Studies 1&2)*

3.2 The failure of the DWP to reconcile the concept of no-fault compensation and benefit or pension for loss of faculty stems from the breach in 1948 with the principle of earnings related compensation payments, funded by employers for work related injury. The government now has to shoulder the full cost of the no-fault compensation scheme instead of employers, as is the case elsewhere, and will simply not countenance payment of means-tested benefits and IIDB from the public purse. Consequently, and quite irrationally, the government treats IIDB as compensation for disablement where the employer pays wages, but treats IIDB as a 'benefit', i.e. income, when government pays means-tested benefits.

3.3 This confusion is compounded where some injured workers are paid occupational sick pay, often at their full wage rate plus IIDB, while others fall back on Statutory Sick Pay and reduced Income Support because they receive IIDB.

3.4 Unlike the UK, in typical workers compensation schemes elsewhere, earnings, either at the full rate or near to the full rate, are paid by the employer for a period of time for total incapacity for work. Where a worker suffers a permanent incapacity, a proportion of previous earnings is calculated, usually on the basis of disablement, and is paid by the employer. A qualifying threshold is sometimes applied. Commonly, state benefits are paid on top of the disablement pension sometimes to a specified maximum related to

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[12] Exceptions include asbestosis and mesothelioma and asbestos-related lung cancer

[13] This confusion was shared by earlier government department's which was highlighted with reference to the DHSS Discussion Document on the IIS in 1980. Brown, J. (1982) Disability Income: Part 1 Industrial Injuries, Policy Studies Institute, p226

'….the DHSS Discussion Document sometimes treats disablement benefit as compensation and at other times as income replacement, and there is a tendency in other circles to argue that 'over compensation' occurs when the incapacitated worker receives more than his previous income when disablement benefit is added to other benefits – though no similar argument is put forward when he receives disablement benefit (and possibly mobility allowance also) in addition to normal wages.' Brown, J. (1982) Disability Income: Part 1 Industrial Injuries, Policy Studies Institute, p226

previous earnings. And the important concept here is the relationship between disablement benefit and wage rates rather than means-tested minimum living levels.

3.5 As a matter of policy, employers should pay the full social costs of work injury. Wages should be paid to injured workers for total incapacity for work for a period of time, and thereafter, IIDB paid on top of wages if return to work, or on top of benefits if return to work is not achieved.

Proposals for Compensation

1. Total Incapacity for Work

Injured workers should be paid full wages for a period of time where totally incapacitated for work. Some European no-fault schemes pay near to full wages for a maximum of 52 weeks, others pay near to full wages until the injured worker recovers or the injury is permanent. [14]

In the UK, the employer should pay full wages to injured workers for a minimum of 26 weeks[15], the time when IIDB should be assessed and put into payment. Thereafter, IIDB should be paid by the employer on top of wages if return to work is achieved, or on top of benefits if return to work is not achieved. In many cases this will not incur any extra wage payment by employers where occupational sick pay is already paid.

Lump Sum Payments: We are totally opposed to any suggestion that IIDB should, generally, be paid as a lump sum payment. Weekly payments allow for periodic review of disablement and adjustment of payments. It is accepted that common law lump sum payments under compensate serious injury. Administrative efficiency afforded by lump sum payments would be achieved by seriously disadvantaging claimants, especially those with serious injuries or diseases.[16]

The DWP has expressed concerns that the IIDB 90 day qualifying period can be a barrier to intervention at a critical early stage of rehabilitation.[17] Rehabilitation of injured workers will be enhanced by providing full wages until IIDB is assessed and paid.

There will be a strong disincentive to pursue thousands of low value common law personal injury claims where wages are paid during injury absence and return to work is achieved very quickly.

2. Permanent Incapacity for Work

IIDB should be assessed for loss of faculty causing disablement and paid by employers to injured workers on top of wages and on top of benefits, if return to work is not achieved.

3. Reduced Earnings Allowance

An earnings related allowance should be re-introduced to compensate workers for a reduction in earnings capacity caused by a work injury. Even a relatively minor injury

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[14] **MISSOC** Social protection in the Member States of the European Union, of the European Economic Area and in Switzerland Situation on 1 January 2004

[15] This would be much less than fully-fledged no-fault schemes where 52 weeks is the norm, e.g. Spain, Iceland, Norway

[16] An exception might be mesothelioma where life expectancy is so short.

[17] DWP Review of Employers Liability Insurance, 1st stage report, 3 June 2003, p77

may, in some instances, have a catastrophic effect on earning capacity and allowance should be made for this eventuality. This allowance should therefore be paid from 1% disablement.

4. IIDB

a. The IIDB threshold should be reduced from 14% to 5%.

b. The IIDB scale of payments should reflect the disproportionate effect of fatal occupational disease such as mesothelioma. We support the IIAC proposal that an appropriate payment should be made to mesothelioma sufferers who have a limited life expectancy.[18]

c. The IIDB scale was arbitrarily based on the Personal Injuries (Civilians) Scheme, established under the Personal Injuries (Emergencies Provisions) Act 1939, and was used as a device to avoid relating payments to earnings.[19] The maximum payment (£127.10) is less than one third of the median wage (approx. £447). The IIDB scale should be revised using one half of the median wage as the maximum payment (approx. £225). Relating payment for permanent disability to wages will bring the UK in line with the approach taken in other countries, but does not involve using individual wage rates to calculate a pension for permanent injury.

5. IIDB associated allowances CAA and ESDA

Mesothelioma sufferers make up the vast majority of those entitled to CAA/ESDA, yet few receive these benefits. This is simply because at diagnosis mesothelioma sufferers may not be sufficiently disabled to qualify for the higher rates which are in excess of DLA/AA. Unfortunately, within a short period of time they are likely to be bed ridden, but by then neither the sufferer nor the sufferer's family is in a position to think about benefits. CAA/ESDA should be paid automatically to mesotheliomna sufferers.

6. Pneumoconiosis etc. (Workers Compensation) Act 1979 (1979 Act)

1979 Act dependency claims are paid at about one third of living claims. The reason given for this by the DWP is that this mirrors common law arrangements. This is quite wrong. In fact, for asbestos claims, a dependency claim is worth more than as an in life claim.[20] A mesothelioma sufferer aged 62 would receive £24,176 in life. However, his

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[18] IIAC submission to the DWP consultation on improving mesothelioma claims handling

[19] Bartrip, P.W.J. (1987) 'Workmen's Compensation in Twentieth Century Britain', Aldershot: Gower Publishing Co. Ltd. p134: Quote by Caldwell , secretary to the Compensation Advisory Committee *'(it) seemed to be working; according to Parker's account, seemed to be working perfectly, no problems at all for people injured in air raids, civilians injured in air raids. Why don't we just apply this to chaps in industry? Parkers's view was that this was what we should do and because he told the working party that the scheme was working, it was not throwing up any difficulties or problems, it was a way of escaping from the earnings problem. It was based on the loss of faculty in accordance with the scale which was borrowed from the war pensions scheme paid in accordance with the medical board's findings. It was as simple as that. So we were rather persuaded by Parker that this was the answer to the problems.'*

[20] Presentation by Alan Gore QC to the Merseyside Asbestos Victims Support Group Conference "Asbestos & the Law", 3 June 2005.
"….it is often the case that in claims on behalf of the terminally ill, the claim is more valuable pursued after death [my emphasis] *than pursued during lifetime on a lost years basis because in the later case, the following claims are not (yet) available, namely:-*

- *the statutory claim for bereavement;*
- *funeral expenses;*

widow would receive £5,088 if a claim was made after death. Often mesothelioma sufferers die very shortly after diagnosis and it is extremely difficult for a sufferer to complete an application before death. We propose that 1979 Act payment are the same for dependency and in life claims.

Proposals for Rehabilitation

Q4. What support should a scheme offer and how should any support be provided?

4.1 The new Scheme administrators should monitor the rehabilitation arrangements proposed below and provide advice to government on the outcomes of rehabilitation of injured workers and make recommendations for improvements. It is unacceptable that currently nothing is known about the rehabilitation of injured workers.

Q5. How should a new scheme be integrated with measures for the prevention of work-related accidents and illness, rehabilitation, retention, retraining and return to work?

5.1 There should be a formal coordinator/case management system for work injury. Rehabilitation provision for injured workers is highly fragmented and uncoordinated. There are government initiatives, including: Pathways to Work and the proposed Condition Management Programmes as part of the Employment Support Allowance provisions. Beneficial as these programmes may be, they do not provide a framework for workers who are injured at work, or ensure the earliest possible intervention for vocational rehabilitation, especially for post-acute care. They are aimed principally at people who are no longer employed. There should be rehabilitation arrangements specifically provided by the employer while the injured worker is still employed while absent from work or on return to work, and the employer should fund government access to work provision for injured workers.
Ideally, employers should adopt a case management approach in order to provide timely, post-acute care, e.g physiotherapy, at the earliest possible opportunity and provide a planned and structured return to work. Employers should be required to inform the administrators of the scheme of the case management strategy and report to the administrators on the outcome of the strategy so that statistics may be kept about rehabilitation. There should be legislative requirement to incorporate a case management system.

5.2 There should be a legal liability on employers to:
(a) provide a rehabilitation programme, and;
(b) to retain injured workers in employment for a specified period of time, and;
(c) to set out their approach to rehabilitation in their health and safety policy.
For example, in Australia, employers are obliged to establish a work rehabilitation programme and cannot lawfully dismiss an injured worker for a period of 26 weeks. In

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- *damages for the value of services that will be lost during the lost years; and,*
- *there is usually a disadvantageous differential between the percentage of income that would be treated as dependency in a claim under the Fatal Accidents Act 1976 (often at least two-thirds) and the percentage that would be treated as an available surplus in calculating the lost years claim (often only 50%).”*[20]

Germany, the insurance institutions, Berufsgenossenschaften, prioritise rehabilitation and it is unlawful for an employer to dismiss an injured worker who is 50 per cent or more disabled without permission from a public welfare authority.[21]

5.3 There should be a legal duty on employers to provide an occupational health service. In the UK, there is no legal requirement for employers to provide OH services nor is there a specific legal duty for employers to provide qualified medical or nursing staff, and there is as yet no legal requirement that the occupational health physician should hold any other qualification than ordinary registration.[22] This is in stark contrast to provisions in other European countries. Unlike some European countries, the UK has not signed up to the International Labour Organisation (ILO) Convention 161 or Recommendation 171on OH services.

5.4 The new Scheme should provide full loss of earnings for 26 weeks in order to encourage rehabilitation and prevent untimely return to work.

5.5 The new Scheme should provide a reduced earnings allowance to prevent workers returning to occupations where their injury/illness may be made worse.

Proposals for Decision Making – Occupational Diseases

Q6. How can we be sure that the principles of equity, transparency and simplicity are met?

6.1 The new scheme administrators should appoint specialist medical advisers to assess claims and should monitor the performance of medical advisers more effectively. The Medical Services' Advisers (doctors) are insufficiently trained in their role and in our opinion their assessments are inconsistent and, in some cases, based on inadequate evidence. Success at appeals is high and suggests a high rate of poor assessments.

Q7. How should inclusion of injuries and diseases in the scheme be decided?

7.3 An independent board, such as IIAC, should continue to decide on inclusion of injuries and disease within the scheme.

7.2 The board should receive an adequate budget to commission or carry out independent research into occupational disease. Currently, IIAC relies on the availability of existing research which is often inadequate.

7.3 There is no statutory requirement for the criteria used by IIAC for there to be a doubling of risk for a disease to be prescribed where the condition is prevalent outside the occupation in question. This is, in effect, simply a means to restrict the number of prescribed diseases and as such militates against prevention of occupational disease. In other countries, it is sufficient that occupation materially or significantly contributed to a disease for it to be prescribed as an occupational disease. The statutory requirement that a

[21] James, P. and Walters, D. (1999) *Regulating Health and Safety at Work: The Way Forward*, The Institute of Employment Rights, p 19

[22] D Kloss, *Occupational Health Law*, chp. 1 p 21, 3rd ed. Oxford Blackwell. 1998

disease can only be prescribed if there is a recognised risk to workers in a certain occupation and the link between the disease and occupation can be reasonably presumed or established in an individual case does not and should not be interpreted as requiring a doubling of risk.

7.4 The European Commission has issued a Recommendation that Member States adopt the European schedule of occupational diseases (EC/90/326). IIAC have not supported that recommendation.[23] The fact that EC countries have variation in the level of proof required to prescribe a disease should not deter the UK from adopting the schedule.

7.5 IIAC has commented on situations where in individual cases, there is a clear occupational cause, but it is not possible to show a doubling of risk in the workplace as a whole to prescribe a disease. IIAC concede that "large numbers of people have work-related conditions which are common but for which there is no strong evidence to support prescription."[24] Sometimes, it is possible for such a condition to be defined as an accident, but where a 'process' causes such a condition this route is closed off, as a claim may only be made for a prescribed disease or an injury.

In other countries, Individual Proof is allowed, usually in addition to a list of 'prescribed' diseases, so that a claim may be made for an injury by process. Both the European Commission and the International Labour Organisation have recommended the introduction of an individual proof system. IIAC have failed to recommend an Individual Proof system and it is unacceptable that such a system is not accepted in the UK.

Q8. How should the decision on entitlement be decided?

8.1 Some Decision Makers (DMs) do not scrutinise medical advisers' decisions sufficiently and accept decisions which are clearly wrong. DMs are not bound by medical advisers' assessments but act as though they are.

8.2 Medical Appeal Tribunals should be inquisitorial rather than adversarial. The appellant should not be obliged to prove a case, rather the tribunal should seek to determine through enquiry whether the decision that an injury or disease was work-related was correct.

8.3 Medical Appeal Tribunals should determine in favour of an appellant where the evidence is 50:50 in respect of the work-related cause of a disease.

Coverage

Q9 How could the scheme best meet the needs of individuals affected by injury or disease caused through work?

9.1 By adopting an Individual Proof system and reducing the excessively high standard of doubling of risk many more injured workers, especially women, who are often affected by musculoskeletal injuries, would be covered by the scheme.

[23] IIAC Position Paper No. 8
[24] IIAC Position Paper No 9

9.2 The scheme must take into account the prevalence of current conditions which result in the majority of absence from work due to occupational causes, especially musculoskeletal disorders and stress. As the decline in injury and disease due to the era of heavy industry continues, and existing claimants from that era die, the scheme will be virtually redundant if it does not adapt to include modern work injury and disease. It is, therefore, essential that the rules for prescription of occupational disease is revised.

Q10 Who should be covered by a new scheme?

10.1 The self-employed should be covered, especially in construction where most forms of self-employment are a device whereby employers avoid paying holiday pay, national insurance stamps and other benefits. Most self-employed construction workers are not self-employed in any meaningful sense, and this fact has been long recognised in law.

10.2 Those suffering from asbestos disease caused by environmental and work clothes exposure should also be covered by the scheme.

10.3 Travel between home and work should be covered by the scheme. 15 out of 17 European countries surveyed cover travel between home and work. The UK is exceptional in not providing such cover.[25]

Funding

Q11. How should the new scheme be funded?

11.1 A new scheme should be funded exclusively by employers in order to enhance prevention of work injury and disease. Research has shown that the IIDB Scheme is not a motivator for employers to improve safety performance, and comments that *"This is unsurprising given that IIDB is just one of a number of state benefits covered by general taxation and has no tangible link to employer costs or health and safety performance."*[26] The same can be said for rehabilitation. There is little incentive to offer rehabilitation if the full social costs of work injury are not met by employers. The same research shows that in other countries the cost of workers compensation ranges from 1.5% to 3% in contrast to the UK where the cost is approximately 0.23%.

11.2 A levy on employers in specified industries should be used to finance the scheme and payments should be adjusted to reflect the injury profile of the industry.

Q12 Who should administer a new scheme?

12.1 Employers should not administer a new scheme. A board, overseen by the DWP, should administer a new scheme and do so in close liaison with the HSE.

Q13. How can any new scheme be made simpler, and more cost effective, to administer?

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[25] See n14
[26] HSE CRR, 436/2002

13.1 The consultation document cites the administrative cost of the IIDB Scheme as £16.6 million per year. i.e. about 2% of total costs of £776 million. In 1992-3 the administrative cost was estimated at £56 million per year out of a total cost of £633 million, i.e. about 9%.[27] If the current scheme is made more cost effective it will cost nothing at all! At 2% the cost of the IIDB Scheme is incredibly low. The pertinent question is not 'how can the scheme be more cost effective?', but rather, 'how can the scheme be made more effective in providing fair and substantial compensation to as many injured workers as possible?'

13.2 In order to achieve this, our proposals include the adoption of 'individual proof' which would increase the cost of adjudication, and also add administrative functions in respect of rehabilitation and prevention. However, if a new scheme is to have any relevance to the world of work today and incorporate rehabilitation and prevention the cost of the scheme must reflect this.

Q14. How should any future scheme relate to other forms of compensation or benefit and ensure that any benefits in the scheme do not conflict with existing benefit?

14.1 We have already argued that payment for permanent work injury for loss of faculty should be paid by the employer and be paid on top of all benefits, including tax credits. IIDB does not conflict with other benefits because its function is not to enhance income, but to compensate for disablement. It should be considered in the same way as Disability Living Allowance and Attendance Allowance.

14.2 Tort payments for 'divisible' diseases such as asbestos diseases, pleural thickening and asbestosis are subject in law to apportionment. Thus, where four negligent employers all equally exposed someone to asbestos they are all responsible for an equal portion of damages. Where two of the employers are no longer trading and the insurers cannot be traced the claimant receives only 50% of the damages. However, a 100% recovery of benefits is made. We propose that the proportion of benefit recovery should be equal to the proportion of damages paid.

14.3 The same principle should apply to the Pneumoconiosis etc. (Workers Compensation) Act 1979 (1979 Act). The proportion of recovery of 1979 Act payments should be equal to the proportion of damages paid.

14.4 The same principle should apply where damages are reduced because of 'contributory negligence'.

14.5 Personal injury payments, including 979 Act payments, are disregarded for means tested benefits for 52 weeks where the recipients are in receipt of Income Support, and disregarded without a time limit where recipients are paid Pension Credit. However, on the death of the injured person, personal injury payment inherited by a surviving spouse is no longer disregarded.

[27] See n20

Mesothelioma sufferers have a very short life expectancy: in many cases personal injury payments are made after their death. Even where payments are made before death, there is usually only a short time between payment and death. The main advantage of personal injury payments for mesothelioma sufferers is the solace they bring in the knowledge that their surviving spouse may have some financial security after their death. To reduce a widow's income in such circumstances is not right. Personal injury payments should be disregarded when inherited by the recipient's spouse.

International Comparisons

Q15. What can be learned from international comparisons?

15.1 Scheme Funding. International comparisons show us that almost all no-fault schemes are funded by employers.

15.2 Prevention. Employers' liability for the full cost of work injury provides a stimulus to improve health and safety in the work place, and differential scheme payments reflecting the claim incidence sheets home responsibility to improve health and safety performance in higher risk industries. However, research has shown that experience rating systems can result in employers 'forcing' injured workers back to work too early.[28]

15.3 Rehabilitation. Similarly, employers' liability for the full cost of work injury is a stimulus to rehabilitation. No-fault schemes in other countries provide loss of earnings payments for total incapacity for work and payment for reduced earnings capacity, both a stimulus to rehabilitation.

15.4 Coverage. Other countries' schemes invariably cover travel between home and work. Many schemes cover categories of self-employed, e.g. fishing and farming.

15.5 Compensation. No-fault schemes provide loss of earnings for total incapacity and payments for permanent incapacity are related to earnings.

15.6 Occupational Disease. Most countries' schemes incorporate a list of recognised occupational diseases and also allow for individual proof and for 'injury by process.' Most countries' schemes have a lower threshold for listing a disease as occupationally related.

[28] Kralj, B. (2000) *Occupational Health and Safety: Effectiveness of Economic and Regulatory Mechanisms*, pp209-210 in Gunderson, M. Hyatt, D. (Eds.) "Workers' Compensation: Foundations for Reform", University of Toronto Press

This submission has been agreed, after discussion, by the following asbestos victims support groups:

Barrow Asbestos Related Disease Support;
Bradford Asbestos Victim Support Group,
Cheshire Asbestos Victims Support Group,
Derbyshire Asbestos Support Team;
Greater Manchester Asbestos Victims Support Group,
Merseyside Asbestos Victims Support Group,
North East Asbestos Support & Awareness Group,
Ridings Asbestos Support & Awareness Group,
Sheffield and Rotherham Asbestos Group

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The case studies are based on actual cases

Weekly Income Before and After Payment of IIDB

Case Study 1: (Greater Manchester Asbestos Victims Support Group)

Mr F. aged 62, has been diagnosed with mesothelioma. He lived on his own before his diagnosis, but now his son and daughter in law have moved in with him to look after him.

Diagnosis: Mesothelioma

Before Payment of IIDB	After Payment of IIDB
Mr. F aged 62 was in receipt of Incapacity Benefit of £89.10 and Pension Credit of £24.95.	Mr. F now receives Incapacity Benefit of £89.10 and Industrial Injuries Disablement Benefit of £127.10, which gives him an income of £216.20.
Mr F receives full Housing Benefit of £70.00 pw and full Council Tax Benefit of £20.00 pw.	Mr F now receives £3.61 Housing Benefit and 0.09 Council Tax Benefit.
Mr F's income after his rent and Council Tax has been paid: **£114.05**	Mr F's income after paying his rent and Council Tax: **£129.90**

Mr. F is £15.85 better off after he has been paid IIDB because IIDB is taken into account for means tested benefits. The real value of Mr. F's IIDB is 12% of the amount he was awarded for his fatal disease mesothelioma.

Case Study 2: (Sheffield & Rotherham Asbestos Victims Support Group)

Mr G aged 66, has been diagnosed with mesothelioma and lives with his disabled wife. Mr & Mrs G are getting pension credit, full housing benefit and council tax benefit. Because they are getting pension credit guarantee credit they also get full health benefits, including vouchers for glasses, free dentures and dental treatment.

Current Income

130.13 Retirement pension Mr G
14.59 Work Pension Mr G
50.84 Reduced Earnings Allowance
25.00 Work Pension Mrs G
58.20 Retirement pension Mrs G
62.07 Pension Credit

340.83 Weekly income

Income after claiming IIDB for PDD3

130.13 Retirement pension Mr G
14.59 Work Pension Mr G
50.84 Industrial Injuries Reduced Earnings Allowance
127.10 Industrial Injuries Disablement Benefit (IIDB)
25.00 Work Pension Mrs G
58.20 Retirement pension Mrs G

405.86 Weekly income

Current Expenditure

0.00 Rent (full housing benefit 49.53)
0.00 Council Tax (full council tax benefit 15.08)

Total

340.83 income – 0.00 rent and council tax

= **340.83** + DLA

Expenditure

42.23 Rent (housing benefit 7.30)
13.00 Council Tax (council tax benefit 2.08)

Total

405.86 income – 42.23 rent and 13.00 council tax

Industrial Injuries Disablement Benefit is paid at the weekly rate of £127.10 but because it counts in full as income for pension credit Mr G's income would be too high to be paid any pension credit but he would still qualify for some help towards his rent and council tax.

Overall, Mr G is only £9.80 better off but, as he no longer qualifies for pension credit guarantee credit and full health benefits, he also has to pay towards dentures, dental treatment and glasses out of this meagre increase.

Mr. G refused to apply for Industrial Injuries Disablement Benefit because he might actually lose income