
COMPENSATION FOR OCCUPATIONAL DISEASE: HIDDEN AGENDAS

by Sherry I. Brandt-Rauf and Paul W. Brandt-Rauf

***Prologue:** Occupational medicine, like all subsectors of medical care, involves economic trade-offs between equality and efficiency. In the specific case of occupational medicine, these questions are usually caught up in the sometimes conflicting interests of corporations and their employees. In this paper, Sherry and Paul Brandt-Rauf shed light on one of the fascinating dimensions of occupational medicine. Sherry Brandt-Rauf holds a master of philosophy degree in sociology and a law degree, both of which were obtained at Columbia University. She is an assistant professor of social medicine at Columbia, where her research priorities have included the legal, social, and ethical issues surrounding organ transplantation, occupational health policy, medical malpractice, and acquired immunodeficiency syndrome (AIDS). Paul Brandt-Rauf holds three doctorates in applied chemistry, medicine, and public health (with an emphasis in environmental sciences), all of which were obtained from Columbia. He is board certified in internal medicine and occupational medicine. His principal research interests revolve around occupational cancer, and he is currently at work on a book on the management of occupational medicine. In the years that the Brandt-Raufs have been engaged in occupational medicine, this specialty has begun to gain more attention in the medical sphere. More medical school graduates have been attracted to residences in occupational medicine in the past decade. Also, corporations have become more interested as health costs have risen, and workers' sensitivity to the potential of subjecting themselves to harmful chemical exposures has increased. Finally, the National Academy of Sciences' Institute of Medicine (IOM) recently completed a study entitled "The Role of the Primary Care Physician in Occupational and Environmental Medicine." The IOM now plans a three-year program of follow-up actions including workshops on critical issues, discussions between professional organizations and government agencies, and dissemination to practicing physicians.*

Courts and legislatures have struggled for decades with the problem of compensating workers for occupational disease. They have used a variety of approaches including tort litigation, state and federally created funds, and no compensatory remedy at all. Commentators have frequently succumbed to the strong temptation to label these different approaches with such epithets as pro-labor and pro-management. The implication is that simple self-interest predicts who will favor which approach. What is less frequently recognized, however, is that values are an important dimension in evaluating compensation mechanisms. In the area of occupational health, the two values most commonly advanced have been fairness and economic efficiency.

This article explores the values implicit in the long-standing debate over the mechanisms for compensating victims of occupational disease. We begin by reviewing the: treatment of workers' health and safety at common law, the background for modern remedies. We then turn to workers' compensation, which today provides the basis for most of the payments to victims of workplace injury. Finally, we look at possible future solutions to the problems of disease compensation.

History Of Common Law Treatment

Prior to workers' compensation, injured employees sought their remedy against employers in court in tort actions. Even when employees' injuries were caused by an accident, they seldom won their suit.¹ Most lawsuits of this kind were resolved in favor of the employer either because of problems of proof or because of powerful defenses open to the employer.²

Proving that the employer had been negligent was difficult in such actions. Witnesses were hard to come by because fellow employees were loath to testify.³ And even if workers could meet the burden of proving negligence, they could be defeated by the "unholy trinity of defenses:" the "fellow servant" rule, assumption of risk, and contributory negligence.⁴ The fellow servant rule provided that the employer could not be held liable in tort to one employee for the actions of another employee.⁵ The doctrine of assumption of risk barred recovery for employees who had consented to confronting the risk, either explicitly, in the employment contract, or implicitly, by continuing to work after becoming aware of a hazard.⁶ Finally, if the employer could prove that the injured employee had been negligent in some way, perhaps in unreasonably exposing himself or herself to risk, no recovery was possible.⁷

Courts took two basic approaches when confronted with cases in which the injury involved was caused by disease rather than by accident.

Some saw no reason to distinguish between the two causes of injury and merely treated the disease victim like the already familiar victim of accident. For example, in *Wiserman v. Carter White Lead Company*, a worker claimed that he had sustained lead poisoning from working in a dusty, dirty blow room. His employer rested his defense on the claim that the worker must have known about the hazard and that in continuing to expose himself by working in the room, he assumed the risk of disease.⁸ The court rejected the employer's defense by reference to ordinary tort principles:

It must be conceded that plaintiff knew that the conditions existing in the blow room were unusual. The fact that the men were wearing respirators, and that he also wore one, was sufficient to advise him of that fact, but, if his testimony is to be believed, he did not thereby know or realize that the inhalation of the lead fumes or dust would render him liable to contract the serious disease with which the evidence shows he was liable to contract if he did not make proper use of the appliances furnished.⁹

When courts followed this line of reasoning but rejected an employee's illness-based claim, they did so for the same reasons for which they would have rejected an accident claim: the common law defenses or inadequate proof.¹⁰

Other courts simply rejected the notion that there might be a common law right of action for occupational disease. These courts generally rested their conclusion on two rationales: (1) that, at common law, there had never been any cause of action for occupational disease and (2) that such disease was inevitable and expected and could not consequently be said to flow from the employer's negligence.¹¹

Taking what is perhaps a more sophisticated perspective, one court recognized that, even if one conceded the inevitability of occupational disease, some disease, like some accidental injury, might be compensable. The court in *Jones v. Rinehard & Dennis Co.* stated that:

such right of action does not exist in the employee merely because he has contracted disease as an incident of his employment, in the absence of a showing of negligence on the part of the employer, because such disease may arise in spite of due care of the employer to prevent its being contracted by the employee. In such circumstances, it becomes a risk to the employment which an employee. . . must be presumed to have taken upon himself. But that an employee has a right of action at common law for disease arising from his employment through the negligence of the employer seems clear.¹²

Although conceding the inevitability of disease, then, this court would still treat it like accidental injury, providing a remedy when negligence was present and the defenses absent.

This brief review of the tort system reveals that, in its application to

occupational disease and injury, it reflects a primary concern with economic goals. At the time of much of this litigation, the industrial revolution of the late nineteenth century was beginning. Policymakers were interested in supporting industry even while recognizing that it would bring new risks to workers' lives and health. The tort remedy was left in place to provide some remedy to victims of the workplace, but defenses were created and applied in a way that guarded the nascent industry.¹³ The language of the courts also reflected economic considerations, but often it revealed a concern for equitable treatment as well. For example, in *Jones v. Rinehard & Dennis Co.*, discussed above, the court manifested a desire to treat disease victims with fairness by regarding them as no different from those accidentally injured.

The disparity of judicial approaches to occupational disease suggests that the area was ripe for legislative action. Change was, in fact, supported both by those whose primary goal was economic progress and by those most concerned with creating a fair remedy for the injured. Self-interest no doubt provided some incentive for both groups: it has been suggested that the former were propelled by the increasing number of successful tort suits by workers, while the latter were motivated by the unpredictability of victory in court.¹⁴ Despite differences in goals between the two groups, the identity of their conclusions led to widespread change in the compensation system. The result was workers' compensation.

Workers' Compensation

Today, all states have workers' compensation plans. All of these plans compensate occupational disease victims, many compensating for any disease suffered.¹⁵ This was not always the case.¹⁶ Many courts construed early workers' compensation statutes to deny recovery for disease, reasoning that the statutes were intended only to codify common law remedies while eliminating defenses and fixing recovery. By this logic, they did not compensate for disease because the common law did not. Other courts held that disease was not "accidental"—the threshold requirement for compensation under a number of state statutes.¹⁷ In some instances, there was such hostility to compensation for disease that even when the statute provided for it, courts denied recovery on technical grounds.¹⁸ In fact, there is some basis in legislative history for this outcome. Some state workers' compensation commissions considered disease to be beyond their purview. Their reluctance to confront it may have been due to its magnitude, reflecting very real, and perhaps well-founded, economic concerns.¹⁹

Unfortunately, the ultimate decision to incorporate occupational dis-

ease into the compensation framework, which had been designed primarily for injury, has disappointed both those seeking an economically efficient way to deal with disease and those seeking a fair one. Twenty-one states limit coverage to diseases peculiar to the workplace, thereby excluding ordinary diseases of life and eliminating coverage for a significant amount of occupationally related disease.²⁰ In addition, 60 percent of disease claims are initially denied, as compared with 10 percent for accidents, placing a heavy burden on the ill worker who must establish the connection between workplace exposure and disease.²¹ This burden of proof is compounded by long latency periods, multiple causes, effects of synergism, and statutory minimum-exposure requirements, all of which combine to keep the rate of compensation for disease low. It is estimated that only 5 percent of occupational disease may be covered by workers' compensation, thus providing a possible disincentive to employers to internalize the costs of occupational disease with preventive measures.²²

Asbestos-related disease has provided a focus for much of the dissatisfaction with disease compensation. Thousands of workers were exposed to asbestos in shipyards during World War II, and many others were exposed in civilian insulation and other factory work.²³ Scientists have now learned that even moderate amounts of asbestos exposure are associated with increased rates of disease including asbestosis, mesothelioma, and possibly other forms of cancer for which the association is not so clear.²⁴ Unfortunately, despite clear associations and serious disability, many victims of these toxic exposures have been unable to attain recompense through the usual state mechanisms and have made their way into the courts. At least one manufacturer has declared bankruptcy based on estimated future liability in these cases.²⁵

As a result, interest in a federal remedy for victims of asbestos and other toxic substances has surfaced, both by those concerned with economic implications and by those most interested in achieving fair treatment for the ill. One recent bill, H.R. 3090, would have created a federal fund, much like those currently administered by the states, into which manufacturers would pay and from which payments would be made to the disabled and surviving families of the deceased.²⁶ Like state statutes, the proposed bill would have created exposure requirements and established presumptions, conclusive and rebuttable, for compensation.

Both H.R. 3090 and its companion, H.R. 1626, proved extremely controversial.²⁷ Supporters claimed that the bills would make the costs of disease compensation more foreseeable and manageable for the corporations and for the federal government and, therefore, for taxpayers.²⁸ Others suggested that under the new legislation, obtaining compensation

would become a faster, easier, and more equitable process.²⁹ Opponents argued that corporations rather than federal taxpayers should bear the costs of compensation, and that the federal bite could become enormous with passage of the bills.³⁰ In addition, some critics rejected the notion that the new system would provide fair and full compensation to claimants, and they were especially critical of provisions in the proposed legislation that would abolish the tort remedy in these cases.³¹

The debate over these two bills exemplifies the mode of debate throughout the history of workers' compensation. Proponents have infrequently addressed each other's arguments, dismissing their opponents as self-interested and ignoring the contentions of even those who share their own conclusions. If one analyzes the various arguments, it soon becomes clear that they reflect very different values, and, as a result, disputants seem almost to be speaking different languages.

Values In Compensating For Occupational Disease And Injury

In the case of H.R. 1626 and H.R. 3090, comments on the bills fell into two categories: those raising considerations based on fairness and those resting on economic efficiency. As indicated above, these have been the two major themes in this area since the emergence of the first mechanisms for compensating workplace injury more than a century ago.

A compensation model based on a criterion of economic efficiency begins with the proposition that "cost of the product should bear the blood of the working man."³² That is, the price of a product is artificial if it does not reflect the entire cost of producing that product, including the cost to workers in life or health. If a worker sustains an injury during production and it becomes known or can be predicted prior to sale, price can be adjusted upward accordingly. After agreeing on this proposition, those expressing primarily economic concerns frequently diverge over the question of how the costs might best be allocated and minimized, but the disputants generally share the same underlying assumptions.

Economic efficiency is not, however, the only value to be served by economic action. For some policymakers, fairness is the dominant value. They frequently employ two criteria in measuring the fairness of a proposed alternative: whether it places the costs of injury on the party who most benefited from the action that caused it and whether the costs rest on the party that can best afford them.

People frequently evaluate compensation mechanisms simultaneously along both value dimensions. For example, when Frederick J. Ross, president of the Raymark Corporation, appeared before the congressional committee considering the asbestos compensation bills, he sup

ported new legislation for two main reasons. First, he stressed the importance of new laws in making the costs of disease predictable for industry, an economic argument stressing predictability as necessary for internalization of the costs of injury. Second, Ross praised the proposed legislation for creating a role for the federal government in asbestos compensation, which was equitable, he felt, because the government had derived considerable benefit from the use of asbestos during World War II.³³

There is nothing inconsistent in reflecting both values in one's thinking. However, when analyzing arguments, and planning strategies, it is necessary to untangle the two and evaluate proposals along the two dimensions separately. For example, one issue that has recurred with regularity in this area is whether disease and accidental injury should be treated alike for purposes of workers' compensation.

There is no logical requirement that the two be treated in the same way by workers' compensation, by the courts, or by a federal fund. Accidental injury generally is known immediately and is also frequently predictable, at least statistically, before the fact. Employers know that in the building of a bridge or skyscraper, a given number of workers will probably die or suffer injury, and they can anticipate and incorporate the costs. If, on the other hand, a worker sustains an occupational disease with a long latency period, the claim for compensation may come long after the product that occasioned the damage has been sold and perhaps long after it has ceased to be manufactured at all. Occupational disease is often unpredictable before the fact, and the relationship between workplace toxins and illness may be subtle and confounded by synergistic effects and multiple causes. Under these circumstances, the human and financial costs of disease will not be reflected in the immediate price of the product.³⁴

Despite the very real differences between workplace injury and disease, we may wish to treat them within the same compensation framework as a matter of fairness. One such rationale for like treatment with compensation to be provided by the employer argues that the employer is the one who most directly benefited from the artificially decreased cost of production. The employer may still be enjoying the benefits of earlier deflated prices and is best able to bear the costs, since they can be passed along to consumers. This, too, meets the demands of fairness. Consumers of the earlier product enjoyed the fruits of the low price, and while they cannot be assessed with the price differential retroactively, consumers of later products from the same manufacturer can be. They undoubtedly have enjoyed some advances based on the earlier product that occasioned the harm. Previous employees may have benefited if their salaries were inflated as a result of lower production costs. On the other hand, present employees will not necessarily have derived any of these secondary

benefits. If they have not, they cannot fairly be asked to bear the costs.

Of course, the manufacturer may be disadvantaged in this later market if it alone among corporations must bear the cost of earlier actions. The consumer will be unlikely to purchase these goods at a higher price if cheaper ones are available. This prospect adds at least a deterrent and at best an incentive for prevention, of which there are others of both economic and ethical nature.

Hidden Agendas In Policy Making

This debate over whether to treat disease and injury alike provides just one example of how hidden agendas confound decisions in this area. These agendas remain buried because there may seem to be some moral stigma attached to expressing economic concerns in the area of human life and health. But, particularly after the declaration of bankruptcy by the Manville Corporation, it is obvious that economic concerns are not inherently opposed to concerns about health, as indeed an interest in fairness need not be antibusiness. Both concerns must be implicated in any sophisticated analysis of compensation for disease or injury.

However, a refusal to state the goals that motivate particular conclusions stymies progress because it forces decisionmakers to balance economics against justice instead of fostering simultaneous concern with both. Any proposed compensation system may be economically efficient or inefficient, fair or unfair, or any combination of these. Ultimately, choosing a compensation mechanism may require consideration of how much efficiency we wish to trade for how much fairness. However, to make this trade, we must know how well any alternative performs along both dimensions. This requires its evaluation with a clear indication by all parties involved of the goals they are pursuing.

This article has suggested that a compensation system is neither good nor bad in some abstract way. A federal superfund system may be an economically efficient way of handling the costs of occupational disease, but it may be grossly unfair, either to workers, to taxpayers, or even to industry. Likewise, state workers' compensation plans or reliance on litigation may make economic planning virtually impossible, at least in the case of disease if not of injury. Having employers pay may be fair or inefficient; it need not be either. It may be both.

Let this be a plea to policymakers and to those who advise and inform them: state your assumptions and value preferences before you begin to analyze the alternatives. In that way, like arguments can be considered together and the very best alternatives, those that maximize fairness and economic considerations, can be selected.

NOTES

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5. *Priestley v. Fowler*, 3 M.&W. 1, 150 Eng. Rep. 1030 (1837).
6. *Maher v. Wagner*, 62 S.D. 227, 230, 252 N.W. 647,648 (1934).
7. *Gibson v. Erie Ry. Co.*, 63 N.Y. 449 (1875).
8. 100 Neb. 584, 588-589, 160 N.W. 985 (1916).
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10. *Wager v. White Star Candy Co.*, 217 N.Y.S. 173 (1926).
11. *Adams v. Acme White Lead and Color Works*, 182 Mich. 157, 161-162 (1914); *Sylvester v. The Buda Co.*, 281 Ill. App. 139 (1935); and 1919, AC. 765,773.
12. 113 W. Va. 414, 419-420 (1933).
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17. *Industrial Commission v. Armacost*, 129 Ohio St. 176,194 N.E. 23 (1935); and *Adams v. Acme White Lead and Color Works*.
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19. Report of Illinois Commission on Occupational Diseases to Gov. Charles Deneen (1911); and R.J. Chojnacki, "Occupational Disease Under the New York Workmen's Compensation Law," *St. John's Law Review* 42 (1968): 473-507.
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22. *Ibid.*
23. I.J. Selikoff, "Occupational Respiratory Disease-Asbestos-Associated Disease," in ed. J.M. Last, *Public Health and Preventive Medicine* (New York: Appleton-Century-Crofts, 1980), 568-598.
24. *Ibid.*
25. "Asbestos Sends Manville into Reorganization," *C&E News* 60 (1982): 7.
26. "Occupational Disease Compensation Act of 1985," 99th Cong., 1st sess., 1985, H. Rept. 3090.
27. H. Rept. 3090; and "Asbestos Workers Recovery Act," 99th Cong., 1st sess., 1985, H. Rept. 1626.
28. Hearings on Compensation for Occupational Disease on H. Rept. 1626 and H. Rept. 3090 before the House Committee on Education and Labor, Subcommittee on Labor Standards, 99th Cong., 1st sess., 231-234 (1985), statements of James Storey, vice-president, Chambers Associates, Inc. and Frederick J. Ross, president and chief executive officer, Raymark Corp.

29. Ross, statement.
30. Hearings on Compensation for Occupational Disease, statement of Robert Willmore, deputy assistant attorney general, Civil Division, Department of Justice.
31. Hearings on Compensation for Occupational Disease, statement of James Fite, White Lung Association, Baltimore, Md.; and Hearings on Compensation for Occupational Disease, statement of Daniel O'Toole.
32. Somers and Somers, *Workmen's Compensation*.
33. Ross, statement.
34. R.H. Coase, *The Firm, the Market, and the Law* (Chicago: University of Chicago Press, 1988), 95-185. Coase suggests, that the right to act harmfully will be acquired by the party to whom it is most valuable. In the case of occupationally diseased workers, this implies that the corporation will continue to operate in the status quo so long as the costs of disease can be incorporated profitably in the price of the product. Likewise, workers will continue to risk disease if they are compensated sufficiently for incurring the risk. The complication in this instance, however, is that the delay between manufacture (exposure) and disease, even when foreseeable, can be so long as to discourage rational calculation of costs and benefits for both management and worker. This in turn acts as a disincentive for prevention.