DISCUSSION PAPER

1. TITLE

Occupational Disease Policy Development Priority Setting

2. ISSUE

The purpose of this discussion paper is to provide the background to and seek stakeholder comments about priority setting for occupational disease policy development.

3. BACKGROUND

The statutory scheme created by the *Workers Compensation Act* ("*Act*") compensates workers for occupational disease in addition to personal injury and death.

Occupational disease policy development is an ongoing responsibility of the Board of Directors and of the Policy & Regulation Development Bureau ("Bureau").

(a) Occupational Disease Policy and Regulation Development

(i) Previous Process

In 1998, the Occupational Disease Advisory Committee ("ODAC") was established. The ODAC had both stakeholder and Workers' Compensation Board ("WCB") representatives. The ODAC's role was to review and make recommendations on occupational disease policy development to the governing body of the WCB. The ODAC completed a number of projects, including the amendment of Schedule B items relating to tendinitis/tenosynovitis and respiratory irritation. The ODAC last met in June of 2001.

Four outstanding occupational disease issues remained on the ODAC's agenda. These were:

- Brain Cancer in Firefighters;
- HIV/Hepatitis C;
- Carpal Tunnel Syndrome; and
- Epicondylitis.

(ii) New process

The Occupational Disease Policy Development Committee ("ODPDC") was established by Terms of Reference in January 2003. The terms of reference are attached as Appendix "A". The ODPDC is internal to the WCB and differs from the ODAC in that there are no stakeholder representatives on the ODPDC. There are representatives of the Bureau, Occupational Disease Services and the Prevention Division. The ODPDC recognizes the need for external stakeholder consultation, and the process is intended to be open and transparent.

The role of the ODPDC is to review the occupational disease policies of the WCB and to make recommendations for change.

The ODPDC may determine and make recommendations on:

- Whether a probable causal relationship exists between a disease and a process, trade or occupation carried out in British Columbia.

- If so, do the circumstances warrant a recommendation that the disease be included in Schedule B?

- Whether a disease should be designated or recognized as an occupational disease that is peculiar to or characteristic of a particular process, trade or occupational disease without listing it in Schedule B of the *Act*, on the terms and limitations it considers appropriate (including designation and recognition by regulation of general application).

- Occupational disease policy in general.

(iii) Priority Setting

The ODPDC developed a priority setting process using a Priority Planning Protocol. The protocol was the subject of public consultation in early 2003, and the final version was approved by the Priorities and Board Governance Committee ("Priorities Committee") of the Board of Directors of the WCB on April 1, 2003.

The Priority Planning Protocol was developed as an objective tool to generate priorities for occupational disease policy development based on a proactive approach to policy issue identification. It is attached to this paper as Appendix "B".

In addition to consulting on the Priority Planning Protocol, stakeholders were asked to identify occupational disease issues to be considered using the priority planning tool.

The issues considered for prioritization by the ODPDC included the issues identified through the consultation process together with the outstanding issues on the ODAC agenda.

(b) Law and Policy

(i) What is an occupational disease?

"Occupational disease" is defined in section 1 of the *Act* as any disease listed in Schedule B, and any other disease which the WCB, by regulation of general application or by order dealing with a specific case, may designate or recognize as an occupational disease. Section 6 of the *Act* provides for compensation for occupational disease due to the nature of any employment in which a worker was employed, whether under one or more employments.

(ii) How is an occupational disease recognized?

The *Act* enables the Board to recognize an occupational disease in four separate ways. Each of the methods are set out below, beginning with the method that has the strongest association between a particular disease and an occupation. The methods used for less strong associations are set out in descending order.

The method of recognition used determines the level of "institutional memory" that is established for individual diseases.

a. Schedule B of the Act

If a worker develops a disease listed in the first column of Schedule B, and has, at or immediately before becoming disabled from that disease, been employed in the "process or industry" listed in the second column, the disease is deemed to be due to the nature of the worker's employment, unless the contrary is proven (section 6(3) of the *Act*).

An example of a disease listed in Schedule B is asbestosis. The presumption in section 6(3) applies where there is exposure to airborne asbestos dust.

b. Recognition under Section 6(4.2)

Section 6(4.2) enables the WCB to designate or recognize a disease as being a disease that is peculiar to or characteristic of a particular process, trade or occupation, on the terms and conditions and with the limitations set by the WCB.

The one disease currently recognized in this manner is thumb joint osteoarthritis found in physiotherapists performing deep tissue friction massage.

c. Regulation of "general application" under section 1 of the Act

The third method is recognition by a regulation of general application. The disease is recognized but without specifying any particular trade, process or industry.

Food poisoning is an example of an occupational disease recognized in this manner.

d. By order dealing with a specific case

The fourth method is by order dealing with a specific case. This method allows for acceptance of a particular claim, without creating an "institutional memory." This means that the acceptance of a claim in one circumstance does not set a precedent for other claims. The acceptance is limited to the facts of the individual claim.

(iii) Requirements for compensation

Section 6(1) of the *Act* sets out three requirements that must be met before a worker is entitled to compensation for an occupational disease other than health care benefits. They are:

- the worker has an occupational disease;
- the worker is, because of the occupational disease, disabled from earning full wages at the work at which the worker was employed, or, the worker's death was caused by the disease; and
- the disease is due to the nature of the worker's employment.

(c) Historical context

Workers' compensation coverage for occupational disease has been provided in BC since the workers' compensation scheme was first established in 1917. The number, type and complexity of occupational disease claims have increased over the years.

(d) Challenges to Determining Compensability

There are a number of particular challenges recognized in occupational disease adjudication. One such challenge is that the cause of disease, by nature, is often difficult to determine. The cause of many diseases is multifactorial, including

both occupational and non-occupational factors. It can also be difficult to distinguish between an "injury" and "disease."

Another challenge is that the "temporal" relationship between the exposure to the "cause" of the disease, and the manifestation of the disease can be difficult to establish. Some diseases, such as certain cancers, have long latency periods between exposure and the development of the disease.

There are also challenges involved in deciding whether a particular disease is an occupational disease due to the nature of a worker's employment. The most difficult challenge concerns "causation." For example, cases where there may be multiple causes of a disease, such as chronic obstructive lung disease where cigarette smoking may be a causative factor, are difficult to adjudicate.

Currently the WCB applies a standard of causation described as "causative significance." Once employment has been determined to have "causative significance," the claim is accepted in its entirety. Benefits are not apportioned based on an assessment of occupational versus non-occupational factors.

4. DISCUSSION

In April of 2003, the ODPDC utilized the Priority Planning Protocol to prioritize occupational disease policy development issues. We are seeking your input on the priority given to the issues.

Once stakeholder comments have been received and considered, direction will be sought from the Priorities Committee in July 2003 concerning occupational disease policy development priorities. Stakeholder comments will be reported to that Committee.

The ODPDC used the Priority Planning Protocol to assist in its consideration of occupational disease issues, and to develop a list of priorities. The Priority Planning Protocol provides criteria that assist the ODPDC in priority setting, and a context in which the ODPDC could exercise the judgment required in this type of process.

The issues, in order of the priority set by the ODPDC, are as follows. The issue identification process was limited to prioritizing a number of issues. The Bureau's workplan will be determined after the issue priorities are approved and the development of workplans considered.

Issue 1: Monitoring Trends and Emerging Issues

The ODPDC considers it imperative that trends and emerging occupational disease issues be monitored, and has given the monitoring and identification of

emerging issues high priority. This is particularly the case for occupational diseases because the body of scientific and medical knowledge constantly evolves. The purpose of the monitoring and identification of issues is to collect information and statistics concerning the prevalence of particular occupational diseases, and emerging trends that may require timely occupational disease policy development. A formal plan will be developed for monitoring, with emphasis on the following:

- Contagious diseases in the workplace.

  There are a number of ongoing and emerging public health issues in the infectious/contagious disease area that may affect workplaces in the province. For example, West Nile Virus and Severe Acute Respiratory Syndrome (SARS) have the potential to impact workers in British Columbia. The ODPDC considers it important to monitor and evaluate any impact on the workplace, so that the WCB is in a position to respond, as necessary, in an effective and timely manner. An action plan will be developed to monitor occupational diseases on a regular basis.

- The right to refuse unsafe work in accordance with section 3.12 of the *Occupational Health and Safety Regulation*, in the context of occupational disease prevention.

- Occupational exposure limits in the context of occupational disease claims.

Issue 2: Latency periods

Section 6(3) of the *Act*, together with Schedule B, provide for a presumption that an occupational disease is deemed to be due to the nature of a particular employment unless the contrary is proven. Section 6(3) requires that the worker be employed in the listed process or industry "at or immediately before" disablement by the occupational disease before the presumption is afforded.

The phrase "at or immediately before" has been interpreted by decision-makers to mean that the worker remained employed in the described process or industry at the time the disease became manifest, or had left that employment a very short time before the disease became apparent. However, a number of the diseases listed in Schedule B, particularly the cancers and pneumoconioses (such as asbestosis), have long latency periods measured from the time of exposure to the causative agent to the first manifestation of the disease. For example, the generally reported latency period for asbestosis is 20 to 50 years following exposure to airborne asbestos fibres.

To assist decision-makers at the WCB, the former Board of Governors, in November 1994, approved policy item #26.21 of the *Rehabilitation Services & Claims Manual* ("*Manual*") to provide flexibility in the interpretation of "immediately before," to account for long latency periods.

Policy item #26.21 in the *Manual* currently reads:

> The words "immediately before" used in section 6(3) are intended to deal with those situations where someone has been employed in the process or industry described in the Schedule, and has left that employment a very short time prior to the onset of the disease. An exception to this is where the medical and scientific evidence has established that there is a long latency period between exposure to the process, agent or condition of employment and the time the disease first becomes manifest. Individual judgment must be exercised in the circumstances of each claim to determine the meaning of "immediately before" having regard to the medical and other evidence available. For example, the manifestation of an infection caused by staphylococcus aureus or of a respiratory irritation resulting from the inhalation of an irritant gas can be expected to occur within a short period of time following the relevant exposure. In the circumstances of such a claim, the presumption would normally be considered only where the condition became manifest within a short period of time following the exposure. However, in a claim filed by a worker who suffers from a recent onset of a cancer listed in Schedule B but who has not worked in the process or industry described opposite such cancer for a number of years, it may be appropriate to conclude that such worker was employed in such process or industry "immediately before the date of disablement" by virtue of the long latency period which is known to exist with respect to such a cancer.

A number of appeal decisions from the former Appeal Division and Workers' Compensation Review Board raised the issue of whether policy item #26.21 is viable and consistent with the *Act*. The ODPDC considers that a review of this policy should be given high priority, as the issue is still unresolved and outstanding. Clarity of the policy is required to ensure fairness and consistency in the decision-making process.

Issue 3: Firefighters – Certain Cancers

Currently, a firefighter who develops a cancer alleged to be an occupational disease due to the nature of his or her employment has the claim adjudicated on the same basis as any other worker who files such a claim. There are a number of cancers listed in Schedule B for which the presumption in section 6(3) of the *Act* will apply.

In April of 1997, the BC Professional Firefighters Association requested that brain cancer in firefighters be added to Schedule B of the *Act*. Brain cancer was identified as a type of cancer that should be the subject of policy development. Brain cancer in firefighters was added to the Bureau's 1999 work schedule. Significant work was completed, including obtaining an expert report and having that report peer reviewed. However, work was not complete when the ODAC ceased functioning in July 2001.

Recently, there has been legislative activity in other provinces putting in place a presumption for a number of cancers in firefighters, including brain cancer. Manitoba currently has a presumption for several cancers.[1] Alberta introduced legislation providing similar presumptions in 2003.[2] Nova Scotia recently introduced legislation.[3] Ontario has operational policy addressing brain cancer and lymphoid leukemia. Ontario's policy states that longer employment as a full-time firefighter makes it more likely that a firefighter's brain cancer is due to the nature of employment, and that employment of twenty years or longer "provides highly persuasive evidence" that a brain cancer is due to the nature of the employment. For leukemia, 30 years or longer of full-time firefighting involving on-call fire smoke exposure provides highly persuasive evidence.[4] Saskatchewan has also very recently introduced legislation.[5]

The ODPDC considered that the recent legislative activity in other Canadian provinces compels the WCB to address the issue of the limited number of other identified cancers dealt with in other jurisdictions rather than brain cancer alone.

Issue 4: Housekeeping – Hepatitis

Current terminology related to hepatitis in Schedule B and in the list of diseases recognized by regulation of general application is outdated and should be

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1. Section 4(5.1) of the Manitoba *Act*. The minimum employment period is 10 years for primary site brain cancer. Other cancers covered include primary site bladder cancer (15 years), primary site kidney cancer (20 years), primary non-Hodgkins lymphoma (20 years) and leukemia (5 years).
2. *Workers' Compensation (Firefighters) Amendment Act, 2003*. The presumption will apply to primary site brain, bladder, kidney, colon, non-Hodgkins lymphoma and leukemia. The minimum period of service is to be prescribed by legislation.
3. Current Nova Scotia legislative session, Bill No. 1, *Firefighters' Compensation Act* received first reading on March 28, 2003. The Bill proposes to cover volunteer firefighters in addition to regular firefighters. It will provide a presumption in the case of a cancer or other disease prescribed by regulation. An opposition member's private member's bill, Bill 2, *An Act to Amend Chapter 10 of the Acts of 1994-95, the Workers' Compensation Act*, would list primary site cancers and the length of service required: brain (10 years), bladder (15 years), kidney (20 years), non-Hodgkin's lymphoma (20 years) and leukemia (5 years).
4. Operational Policy 16-02-02.
5. Bill 18, *An Act to amend the Workers' Compensation Act, 1979*. The Bill received first reading on April 10, 2003. It would provide a presumption in the case of primary site brain, bladder, kidney, non-Hodgkins lymphoma or leukemia. Minimum periods of employment would be set out in regulation.

revised. The ODPDC considers it important that occupational disease descriptions be as up-to-date as possible, and that policy reflect current scientific knowledge.

Specifically, Schedule B refers to "infectious hepatitis," which is an outdated description of the disease now known as Hepatitis A. In addition, there is a reference to "serum hepatitis" in the list of diseases recognized under section 1 that may be considered for deletion, because Hepatitis B, which was previously called "serum hepatitis," is now contained in Schedule B. This project would involve the revision and updating of this terminology.

Issue 5: Adjudication and Prevention

There are a number of occupational disease areas that were identified by the ODPDC as likely to benefit from a project aimed at improving the quality and effectiveness of adjudication and prevention activities. These include activity related soft tissue disorders (ASTDs), infectious diseases such as HIV and Hepatitis C, and other contagious diseases present in workplaces.

The ODPDC anticipates that a workplan will be developed to identify specific education needs relating to these occupational disease groups.

Issue 6: Allergies & Sensitivities – Permanent Disability

Published policy provides that a worker who develops an occupational allergy or sensitivity and is required to avoid certain workplaces is not entitled to a permanent disability award under the *Act* unless the allergy or sensitivity results in some degree of permanent functional impairment. For example, a worker who develops asthma with exposure to red cedar dust is generally not entitled to a permanent disability award unless he or she has an ongoing degree of impairment of respiratory function following removal from further exposure. The worker may be entitled to vocational rehabilitation on a preventative basis.

The 1999 Royal Commission on Workers' Compensation in British Columbia[6] addressed the issue of disability awards for workers who develop allergies and sensitivities because of exposure to certain substances in their workplaces. The Commission's recommendation was that the *Act* be amended so that a worker who has a loss of earnings caused by an underlying work-related sensitization or allergy that results solely from accumulated exposure to specific workplace contaminants should be entitled to compensation on the same basis as for other occupational disease.

Since the Bureau's last work on this issue, the *Act* has been the subject of significant amendment. In particular, the *Workers Compensation Amendment*

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[6] Royal Commission on Workers' Compensation in British Columbia, *For the Common Good: Final Report of the Royal Commission on Workers' Compensation in British Columbia*.

Act, 2002 (Bill 49) significantly amended the provisions in the *Act* concerning permanent disability entitlement. The ODPDC considers it necessary that additional developmental work concerning this issue and the potential impacts of addressing this issue on workers and employers be completed before a formal policy development project is undertaken.

Issue 7: Schedule B – Lung Cancer and Non-Malignant Asbestos Related Disease

Item 4(a) in Schedule B to the *Act* lists carcinoma of the lung when associated with two forms of non-malignant asbestos-related disease. The first is asbestosis, where there is exposure to airborne asbestos dust. The second is bilateral diffuse pleural thickening or fibrosis, over 5 mm thick and extending over more than a quarter of the chest wall, where there is exposure to airborne asbestos dust and the worker has not previously suffered collagen disease, chronic uremia, drug-induced fibrosis, tuberculosis or other infection or trauma capable of causing pleural thickening or fibrosis.

Item 3(a) in Schedule B was amended recently, and refers to diffuse pleural thickening or fibrosis, whether unilateral or bilateral. It does not specify that it be bilateral, or that a certain thickness is required.

The issue is whether item 4(a) should also be the subject of a review and possible updating. The ODPDC considers that this issue should be monitored and may be an appropriate subject for future occupational disease policy development. Noting the small number of workers and employers involved and scientific controversy, the ODPDC felt that the issue should be given low priority at this time.

Issue 8: Latency Period – Possible Statutory Amendment

This issue involves the latency periods for a number of diseases listed in Schedule B and is related to Issue 2. Incorporating a reference to latency periods in section 6(3) and/or Schedule B of the *Act* will likely require statutory amendment.

5. CONSULTATION

The Policy & Regulation Development Bureau is requesting stakeholder input on this priority list of issues.

Stakeholder comments will be accepted until **June 11, 2003**. When responding, please provide your name, organization, and address. Comments may be sent by mail, fax or e-mail to:

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The responses of stakeholders will be reported at the July 2003 Priorities Committee meeting.

Please note that all comments become part of the Bureau's database and may be published, including the identity of organizations and those participating on behalf of organizations. The identity of those who have participated on their own behalf will be kept confidential according to the provisions of the *Freedom of Information and Protection of Privacy Act*.

APPENDIX "A"

OCCUPATIONAL DISEASE POLICY DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

1. Purpose

The role of the Occupational Disease Policy Development Committee ("Committee") is to review the occupational disease policies of the Workers' Compensation Board ("Board") and to make recommendations for change to the Board of Directors. In particular, it will be the role of the Committee to determine and to make recommendations on:

- whether a probable causal relationship exists between a disease and a process, trade, or occupation carried out in British Columbia, and if so, the circumstances in which a claim for compensation for the disease should be afforded a presumption that employment played a significant causal role as per Schedule B and section 6(3) of the *Workers Compensation Act ("Act");*

- whether a disease should be designated or recognized as a disease that is peculiar to or characteristic of a particular process, trade, or occupation, without listing it in Schedule B of the *Act*, on the terms and limitations it considers appropriate (including designation and recognition by regulation of general application); and

- occupational disease policy in general and intended for publication in the *Rehabilitation Services & Claims Manual*, Volume I and II.

2. Structure

The Committee shall be chaired by the Director General of the Policy and Regulation Development Bureau ("Bureau") or his/her designate ("Chair"). The Chair shall appoint, as necessary, a Policy Director/Analyst from the Bureau to lead the development of policy on various occupational disease issues. The Chair, on mutual agreement with the Board's Administration, may also appoint other Board personnel considered necessary to carry out the mandate of the Committee, including but not limited to:

- line staff from Occupational Disease Services;
- Board medical officers;
- line staff from the Prevention Division; and
- Bureau staff.

Meetings of the Committee shall be at the call of the Chair and shall be held at least once every quarter.

Minutes shall be kept of all meetings of the Committee and, after being signed by the Chair, shall be retained by the Bureau.

3. Responsibilities

The Committee will recommend occupational disease policy and develop priorities according to criteria it may establish for that purpose, and will determine which items will be addressed during a particular calendar year. The Committee will also undertake any other tasks or responsibilities that it may be directed to undertake by the Board of Directors.

The Committee may consult with stakeholders in the community, experts in the field of occupational diseases or epidemiology, and any other persons whom the Committee considers could assist in carrying out its mandate. The Committee will identify stakeholders, by individuals or groups, who should participate in the external consultation. The Committee may invite individual or all stakeholders to submit information to the Committee, including position papers, commentary on draft language, and the like. The Committee will also make available to stakeholders such documentation as may be appropriate in order to obtain stakeholder feedback. Any stakeholder may, at any time, make written submission to the Committee on matters within the mandate of the Committee, and the Committee will consider those submissions in fulfilling its mandate.

Consultation with stakeholders will be aimed at seeking the views of stakeholders without having consensus as an objective. Rather, such consultation shall have as its objective the recording of stakeholder views in a manner that is efficient, effective, and inclusive. Such stakeholder views will be brought forward by the Committee in making its recommendations. The Committee will not rely on formal representational advisory committees for this purpose.

When assessing evidence of causal relationships between diseases and processes, trades, or occupations carried out in British Columbia, the Committee shall be guided by the Protocol for the Assessment of Medical/Scientific Information adopted by the Board on March 2, 1993 and published at 9 *WCR* 429.

Any recommendation which the Committee may make to the Board of Directors shall be based on sound scientific and medical knowledge.

The Committee will, to the best of its ability when dealing with persons or groups interested in the compensation system, operate in a fashion that is consultative, accessible and fair.

4. Accountability

The Chair of the Committee shall, when appropriate, include in the Bureau's monthly report to the Board of Directors, updates on the Committee's plans, accomplishments and work in progress.

The Chair of the Committee shall take forward to the Priorities Committee of the Board of Directors, proposed strategies for reviewing particular occupational disease policies, after receiving advice from the Committee.

APPENDIX "B"

OCCUPATIONAL DISEASE POLICY DEVELOPMENT COMMITTEE ("ODPDC")

Priority Planning Protocol

1. PURPOSE

The purpose of this document is to describe the process and criteria that the Occupational Disease Policy Development Committee (ODPDC) will use to prioritize occupational disease policy development issues.

The purpose of the Priority Planning Protocol is to:

- guide the ODPDC's priority planning by describing the general principles and values underlying the process;
- identify key factors relevant to the ODPDC's priority planning; and
- guide the ODPDC in assessing the relative importance or weight to be assigned to each factor.

2. BACKGROUND

Occupational disease policy development issues come to the attention of the ODPDC from a number of sources, including:

- Board of Directors;
- Stakeholders;
- WCB Administration;
- Appeals;
- Other jurisdictions;
- Media; and
- Others.

3. PRINCIPLES OF OCCUPATIONAL DISEASE PRIORITY SETTING

The ODPDC recognizes the following fundamental principles:

- The ODPDC has limited resources to address all identified occupational disease issues.
- Priority setting is necessary to focus available resources on the more urgent issues.
- The priority setting protocol will attempt to identify principles, values or factors that may be relevant to priority setting. These may require review from time to time.
- The priority setting process involves an exercise of judgment based on multiple factors.
- The weight given any one factor may vary from issue to issue.
- Issues raised may have broad application to occupational disease claims in general, or may be more narrow and limited in scope.

4. OCCUPATIONAL DISEASE PRIORITY SETTING

Priority setting will be completed once per year, although priorities may require revision if critical issues emerge during the year.

A summary report setting out the ODPDC's considerations in determining the priority of an occupational disease issue will be prepared in each case. The summary report will document the ODPDC's considerations under the following headings.

Defining the issue

The ODPDC will develop a clear statement of the issue under consideration.

Considering the priority of the issue

(a) Issue source

- How was the issue identified?

- Is the issue already referenced in policy or regulation?
- Is there a question of a policy being non-viable or contrary to the *Act*?

(b) History and new evidence

- How long has the issue been outstanding?
- Is there new or existing reliable medical/scientific evidence available?
- Does the issue involve a simple revision in the nature of housekeeping?
- Does the issue involve revising and updating archaic references in policy or regulation?
- Are there any practice guidelines for adjudicative or medical staff on this issue?

(c) Magnitude or scope of the issue

- Can the issue be addressed relatively quickly?
- How many workers and others in the work environment will be affected if the issue is addressed?
- How many claims are made concerning the particular disease each year?
- How many claims are denied and accepted on an annual basis?
- Is there a trend in number of claims?
- Is there a trend in the average cost or duration of claims?
- Are there a large number of appeals?
- What is the confirm/overturn rate on appeal?
- What is the experience of other jurisdictions?

(d) Medical/scientific questions

- Are there historical trends concerning incidence or prevalence? If so, in what industries/processes?
- Has the issue been identified by the medical/scientific community?
- How medically/scientifically complex is the issue?
- Is there consensus on causation/risk factors?
- What new medical/scientific evidence exists?

(e) Issue profile

- How controversial is the issue?
- What is the profile of the issue in the relevant stakeholder communities?
- What is the intensity of concern about the issue?

(f) Impact of the issue

- Are there significant worker health and safety aspects to the issue?
- Does the issue affect broad-based and generally-applied policy issues, or is it limited to narrowly-defined subject matter?
- What are the financial implications?
- Would dealing with the issue address an unfulfilled need?
- Would addressing the issue foster consistency in decision making?

(g) Propriety

- Is the issue one that the ODPDC can address?
- Would addressing the issue give rise to a policy change or would statutory amendment be required?
- What is the legislative and regulatory framework?

- What are the potential financial implications?

5. COMMENTS ON WEIGHING FACTORS

The ODPDC recognizes that the following factors will be assigned the greatest weight (i.e. level of relative importance):

- policy issues referred to the ODPDC by the Board of Directors;
- policy that is declared contrary to the *Act*;
- policy needed to provide guidance to decision-makers resulting directly from legislative changes dealing with occupational disease compensation; and
- scientific literature provides new evidence concerning causality.