Technical Commission on Insurance against Employment Accidents and Occupational Diseases

Problems and challenges of statutory accident insurance schemes related to occupational diseases: Reporting, recording and statistics

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Summary

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Introduction

During the 2003-2005 triennium, the Technical Commission on Insurance against Employment Accidents and Occupational Diseases organized a one-day workshop with 23 experts from 13 countries, which was held in conjunction with the Conference of the International Social Security Association (ISSA) in Limassol, Cyprus in November 2003. This workshop discussed pressing issues in the field of occupational diseases (OD) on a global platform.

The idea of having such a meeting stems from the results of a worldwide questionnaire on the problems and challenges of today's statutory employment injury schemes, carried out during the past triennium. A great many replies mentioned problems related to the national list systems of occupational diseases, the lack of information available of the nature and extent of occupational diseases and in particular of new occupational diseases. Reporting, recording, notification of occupational diseases, fraud and under-reporting as well as the absence of such systems were the main concern.

The Bureau of the Technical Commission therefore decided to organize a workshop on the above topic, in particular geared to the needs of ISSA members in developing countries and countries in transition.

The workshop was structured into three topics and participants were invited to report on their national approaches to each of them:

- List systems.
- New occupational diseases.
- Reporting, recording and statistics.

This report summarizes the content and results of the discussions led throughout the day.

One finding of the workshop was that despite different schemes of coverage, heterogeneous industrial and sectoral makeups and institutional specifications, many were sharing the same or at least similar difficulties in prevention, compensation or rehabilitation of occupational diseases.

Why occupational diseases?

As the chairman of the Technical Commission stressed in his introductory remarks, nowadays occupational diseases pose a much more precarious problem, compared to occupational accidents. While the number of occupational accidents in most countries is constantly declining, data from several industrialized countries prove that the rate of occupational diseases stagnates or is even on the rise. The growing number of so called "new occupational diseases" and of ODs with long latency periods is mainly responsible for this trend. It is predicted that countries still on their way to industrialization who might currently not suffer this problem, surely will some time into the future, when latency periods of diseases like asbestosis have come to an end. The medical consequences of exposure to asbestos in the processing industry become manifest after a latency period between ten and sixty years - on average after a latency period of thirty-five years. For work related cancer the average latency period is about thirty years; for certain diagnoses it can take even up to fifty years. Hence, especially "young" countries or countries with a young history of social insurance and adequate recording of data may yet have to await the emergence of long latency occupational diseases. Participants from Saudi Arabia especially agreed to this observation, with respect to their own country's young history. A similar statement can be found in the report of the Committee on Occupational Accidents and Diseases of the International Labour Organization (ILO).[1]

Is it all on the list?

Since occupational disease is a legal term and not a medical one, the question is how to specify it. Some countries apply general clauses (or systems of proof); others opted for a system of listed – but limited – diseases. According to the "ILO Employment Injury Benefits Convention" (No. 121 from 1964), general clause systems should be adequate to cover at least the scope of the ILO's minimum list. Further cases are compensated on a case-by-case basis. Consequently, practically any disease may thus be recognized as an OD, as long as the causal link is proven.

The general pros and cons of listing occupational diseases were discussed in-depth during the meeting.

The first problem – which even proponents of list systems had to admit – was that of maintaining and updating OD-lists. The list in Cameroon, for instance, which had been established in 1962, has not been updated since 1984. Also the list from Zimbabwe is more than a decade old (1990), and the Rwandan system even stems from colonial times.

How suitable are lists that are never – or seldom – reviewed and amended? From Gambia (which does not have a list system) came the argument, that a list is never to be seen as a static matter. Consequently, since no list could ever cover all possible diseases caused by work or being work related medical expertise is needed anyway in each individual case to prove the link between exposure at work and the symptoms. This is the case in Gambia,

[1] ILO. 2002. "Report of the Committee on Occupational Accidents and Diseases", presented at the International Labour Conference, Ninetieth Session, International Labour Organization, Geneva.

where medical experts review each case and prove or discard a connection between the disease and work.

Countries that use lists generally use one of two types. Either the lists comprise a number of diseases in relation to the diagnosis (e.g. cancer, dermatitis), or lists regroup diseases in relation to the agent causing the disease (biological, chemical, physical).

The latter is the case, for instance, in Argentina, where the list comprises 89 agents, or in Cameroon. Zambia, on the other hand, lists 74 diseases, which are based on the new ILO list of occupational diseases, as does the Syrian Arab Republic (67 diseases listed) and Slovakia (47 diseases). Among the biggest lists ranks that of Saudi Arabia (updated in the late 1990s), which now comprises almost 200 ODs. One of the youngest lists of occupational diseases may be found in Lithuania, where it was set up in 1994 and in the meantime updated twice (1996 and 2001).

A complicating issue is also posed by the question: who is responsible for amending lists? In some countries this is the responsibility of the government, sometimes it is the responsibility of Parliament. It appeared notable that wherever legislature is involved in updating OD lists there is often a sense of hesitation within the social security institution to propose amendments. The reason was that often the social security system did not want to put itself on the spot before legislature, which is why they often tend to hold back suggestions for changes. This observation was shared by a majority of the participants: the higher the administration level that approves modifications/amendments to an OD-list, the lesser the inclination of the actors involved to do so.

Furthermore, whenever more than one or two actors are involved in the decision making process, the hesitation becomes only bigger. This could be reported from Hungary, where currently three agencies and three ministries are involved in the updating process (but changes are underway).

Furthermore lists can either be "open" or "closed". Open list-systems are found in most countries, some have only recently "opened" their formerly "closed" lists (e.g. Argentina five years after setting up the system). In open list systems, there is no conceptual limitation when it comes to diseases and disorders suspected of having occupational origin. Open systems generally allow more flexibility in providing coverage for "new" occupational diseases, which have been identified as a result of recent legal investigations and epidemiological studies.

Are "new occupational diseases" actually "new diseases"?

Silicosis and asbestosis are probably the best-known examples of occupational diseases. However, in different countries and regions of the world very different occupational diseases top the claims statistics. According to data from the world's biggest reinsurance company (MunichRe) from 2002, in France "diseases affecting the joints" were the number one OD. In the Russian Federation, on the other hand, it was "vibration white finger" and in Poland "inflammation of vocal cords suffered by teachers". Skin diseases are ranking highest in many other countries. The participants of the workshop reflected this variety. The main challenge in Zimbabwe with regard to occupational diseases is posed by pneumoconiosis, followed by anthrax and lead poisoning; in Rwanda it is silicosis. In addition to these well-known types of ODs new occupational diseases are challenging social security and accident insurance schemes throughout the world. But are these "new" ODs actually new types of diseases at all?

In Zambia, for instance, a major challenge emerged a few years ago with a growing number of reported cases of acid erosion of teeth, especially in mines. Being a new and before unknown phenomenon, cases were eventually accepted as claims on workers' compensation.[2]

In the Syrian Arab Republic, cancer diseases are seen as the biggest challenge for the next decade. Cancer also is expected to be the biggest challenge in Argentina, as is back pain and occupational diseases related to psychological factors. In Germany, so-called psycho-mental diseases are currently intensely researched and debated. However, so far not one single case was compensated. With regard to pensions the biggest challenge of the future is quite old and stems from a multitude of inherited burdens, mainly cases of asbestosis.

Hungarian experts expect ergonomic and environmental hazards to pose the biggest future challenges with respect to occupational diseases. An interesting development was reported from Japan, where cases of suicide as a consequence of harder working conditions (in a good economy as well as in a bad economy) have become a major concern, especially for the higher echelons of management.

It was interesting to note, that the diseases estimated to generate the biggest problems in the next few years are in most cases not "new" in the strict meaning of the word. Instead, inherited burdens of well-known – and thus "old" – diseases like cancer and asbestosis seem to pose the biggest challenge.

Interestingly enough, the case of HIV/AIDS was much less an issue for debate than the organizers of the workshop anticipated. While in the Syrian Arab Republic HIV/AIDS has already been added to the national list of occupational diseases as a new occupational disease,[3] other countries are more hesitant. It is presumed that this could mainly be attributed to the fact that in many countries AIDS was originally not considered a problem for social security, but rather a problem for the public health care system. It was, for a long period of time, not seen as a "professional risk". Yet, the societal consequences of the AIDS pandemic prove to be so destabilizing for a society, that all actors of public health and social security have to jointly shoulder the burden and share costs.

The question of who should bear the financial burden of compensating victims of HIV/AIDS is currently widely debated within social security systems of those countries, which are hit hardest by the pandemic. Among them is Cameroon. The National Social Insurance Fund would, of course, be confronted with severe financial problems if it had to compensate victims of HIV/AIDS like victims of accidents and other illnesses. This is one reason why for social security institutions in Cameroon, HIV/AIDS "remains a problem of public health". The ensuing debate on taking over of the disease in terms of occupational disease in Cameroon is turning on the manner from which the disease is contacted and the conditions on which it can have a professional character. It appears to be admitted that medical staff that are in regular contact with HIV/AIDS carriers, can merit greater attention; for other cases, people are very prudent when making their opinions. The prudence is linked to the definition itself of an occupational disease, which supposes the action of a harmful germ in the work milieu, or of substances utilized in the process of production. Moreover, such recognition should forcefully have an impact on the volume of compensations (in treatment and annuity) and by

[2] For details see the report on Zambia.

[3] For details see the report on the Syrian Arab Republic.

the same token on the rate of contributions of the branch, taking into consideration the spreading of the pandemic.[4]

Especially trade unions are pressing the government to extend more protection to victims of AIDS in Cameroon. In view of this political pressure it is quite possible that the government decides that the National Social Insurance Fund has to bear the costs. However, "the system might not be able to do that".[5]

Quite notably, while the political debate in Cameroon is going on, business is taking the initiative: "While waiting that the debate finds an answer, some enterprises are organizing themselves to assist their employees who are infected with AIDS; the assistance is resulted in the total or partial taking over of retro-viral products, moral support, and a greater understanding for the absences and the sensitization of uninfected workers on the prevention measures to respect."

In some countries potential "new" occupational diseases are not always related to the workplace at all. From Saudi Arabia it was reported, for instance, that numbers of non-occupational diseases were significantly on the rise. Potential reasons for this are still debated. Are some of these diseases wrongly diagnosed (and are they, in fact, occupational diseases, but difficult to relate to work)? In any case, this means a greater burden for the social security scheme, since people – severely ill from a disease not recognized as work related – tend to almost directly claim pensions.

Also, in Saudi Arabia, social insurance only covers the private sector. This fact, in addition with a high turnover rate in the labour market, combined with an unknown quantity of illnesses with long latency periods that are yet to come up, make it difficult to predict what types of new occupational diseases are emerging and how they best could be prevented.

The adequate diagnosis of an occupational disease is definitely a key factor. Wrong diagnoses lead to a completely distorted picture of the entire state of occupational health in a country. But what if the necessary expertise in diagnosing occupational diseases is lacking?

Reporting, recording and statistics

Who can, in the various systems, file a claim for occupational diseases? What are the channels for reporting ODs in the respective systems, and how can adequate reporting and recording best be assured?

In some systems, insured persons can file a claim (United States), in other, doctors (Estonia) or employers (Finland). In some systems (Germany) any of the three can apply for an occupational disease. But what if those responsible for reporting ODs are not aware of the reporting procedure or do not have an incentive for doing so? In these cases, deficits in reporting occupational diseases lead to major distortions. One extreme case was reported from Gambia: since the introduction of the workers' compensation scheme in this country, in 1996, exactly one case of an occupational disease has been reported. What are potential reasons? It can only be assumed that they are similar to those in most countries with young workers' compensation systems and, most important, with few or insufficiently skilled occupational physicians who have difficulties recognizing ODs.

[4] See also the report on Cameroon.

[5] Idem.

The small number of physicians experienced in occupational health is also a big challenge for the social security system in Malaysia, with only two doctors to advise the social security administration on ODs, underreporting is almost guaranteed. The role of advising physicians in Malaysia is especially important, since all reported cases of occupational diseases which are not on the national list, have to be assessed by a medical board in order to decide on its merits for compensation. A high level of expertise is thus critical for adequate assessments and compensation. But, as the expert from Malaysia put it, "the lack of expertise among occupational medicine is an issue of major concern".

Even more critical is the number of occupational physicians for countries without a list of occupational diseases. Where, like in Gambia, each individual case of a suspected OD has to be reviewed by medical experts, their sufficient quantity is of critical importance. In Zambia, new complaints of ODs are also first submitted to a team of doctors who review the cases. However, these doctors are generally working at public health hospitals and are consequently no specialists in occupational medicine. Too few doctors and too few specialized physicians in occupational medicine are the key problem, as was reported in almost the same manner from the Syrian Arab Republic.

But quantity is not everything and even a few thousand occupational physicians may sometimes not be enough, as was reported by the participating experts from Hungary, a country with roughly 3,500 occupational doctors. As critical as the sufficient number of experts in occupational medicine is their qualification. While the insufficient quantity of occupational physics may lead to underreporting, any lack of training and expertise may almost inevitably lead to mis- or under-diagnosing, which in itself is a cause for underreporting.

Take, for instance, the case of Argentina: an uninformed observer of the situation in this country might be lead to believe that hearing loss is the most frequent type of occupational disease. As was reported, of the about 2,000 occupational diseases reported in 2002, about 80 per cent were officially related to hearing difficulties. But, according to the report of Argentina, the reason is not to be found in an abundance of noisy workplaces or in the absence of other causes leading to ODs. The reason is rather a lack of toxicological and epidemiological training of medical professionals. The majority of occupational physicians in Argentina obviously does not have a long history in epidemiology, toxicology etc. Many diseases (even some that are already on the list) cannot be recognized by the majority of occupational physicians. However, hearing problems can be diagnosed fairly easily, even by insufficiently skilled medical staff. Hence, the problem is rather one of under-diagnosing than of genuine under-reporting.

What can be done in light of under-reporting and under-diagnosing?

Incentives

If underreporting is caused by gaps in the line of communication or by lacking motivation or awareness to submit cases of OD to the relevant authorities, one possible strategy might be seen in creating incentives for physicians to report occupational diseases. In Cameroon, for instance, physicians who suspect a link between illness and work, have to contact the Ministry of Labour and submit a special report. However, many physicians are not aware of that. Financial incentives for reporting ODs (e.g. through special remunerations like in Germany, Austria, Denmark, Finland and Switzerland) were discarded by the majority of experts as too costly and potentially leading to "over-reporting". However, for reasons of cost

saving and quality assurance, an alternative solution could be to pay remunerations only if the reported disease has effectively been recognized as an occupational disease.

In any case, compensated or not, international comparisons show that almost everywhere physicians are most likely to submit cases of ODs. In Germany, most declarations of ODs are initiated by doctors (20 per cent by social insurance bodies, 10 per cent by victims and only 3 per cent by employers). Physicians are the critical link in the chain of reporting.

Further international transfer of expertise

If deficits in reporting occupational diseases are themselves consequences of false or neglected diagnoses (under-diagnosing), training of occupational physicians is paramount. Experts from Saudi Arabia emphasized international exchange as one possible way to enhance the qualification of medical professionals. The Saudi Arabian General Organization for Social Insurance (GOSI) employs about 19 regionally dispersed expert physicians. In order to allow for quality assurance and to ensure that up to date information is made available, these physicians meet annually and engage in international exchange. This is also serving as a "second step in validating claims for occupational diseases".

The participants of the workshop agreed that the common problem of insufficient expertise in occupational medicine should be met by intensified training and international exchange. It was therefore suggested that the ISSA Technical Commission on Insurance against Employment Accidents and Occupational Diseases facilitate training seminars and international meetings of experts.

Prevention – generating expenses or saving costs?

The workshop confirmed one central finding of a recently finalized international survey by the Technical Commission, according to which many countries, that recently introduced or reformed an accident insurance system, were considering systems of rebates and premiums as an incentive for prevention.[6]

In Cameroon, as of now, contributions for accident insurance are divided into three different classes of rates (according to the sector in which the respective enterprise is doing business). So far no rebate/premium-system exists, but benefits for prevention are intended. Interestingly enough, it is also considered to implement incentive strategies targeting not only enterprises (i.e. contributors to the scheme) but also workers, i.e. the insured. As was reported from Cameroon, experts in social security are planning to implement a rather innovative set of incentives by allowing to cut benefits for injured workers "who did not respect work safety measures." In times of scarce financial resources of social security systems around the world it would be interesting to learn the (probably cost saving) results of this approach. However, certain legal implications might cause problems in most systems.

Linking contribution rates to prevention efforts works best, where prevention and compensation are interconnected. By providing prevention and compensation "out of one hand" the effect of prevention can best be monitored and evaluated. But often institutions responsible for compensation are not identical with prevention-institutions. In Lithuania, like in many countries around the world, prevention is the task of the labour state inspectorate, not of the State Social Insurance Fund Board. The same applies to Slovakia. Here, as well, the state is responsible for prevention, not the Social Insurance Agency. As may sometimes

[6] The results of the survey were presented at the ISSA Conference in Limassol, Cyprus, November 2003.

be the case in these arrangements, and as was reported from Slovakia, the co-operation between the relevant institutions "is problematic". In Gambia, social security institutions are not involved in prevention, which is the responsibility of the department of labour. But, as is the case all too often, prevention "is no priority" for the government. Why would it, one may ask? In the end it is the fund, which has to pay the bill.

But even where prevention and compensation are not provided "out of one hand" there may be linkages and connections between the relevant bodies. However, the problem of coordinating their activities is frequent and prone to bear inefficiencies. In Malaysia a government agency (Department of Work Safety and Health) is responsible for prevention. Its activities are supervised by the national Social Security Organisation, which has the role of a "facilitator". It contributes to governmental prevention activities by producing and distributing information material to raise public awareness on occupational safety and health (OSH).

In Cameroon the task of prevention rests on three pillars: the Ministry of Labour and Social Security, the National Social Insurance Fund and the Committee of Health and Hygiene in Enterprises. No pillar is working entirely independently. The OSH-policy of the Ministry is implemented by the National Social Insurance Fund with the help of the Labour Inspectorate. In addition, the National Social Insurance Fund has its own service of prevention (i.e. specialists who control enterprises, consult them and check whether committees of hygiene are in place and functioning). It is the focus of prevention activities of the social security institution to make employers and workers understand the benefits or experience the sanctions of good or bad preventive behaviour. As was mentioned before, the goal in Cameroon is to set up a system of rebates and premiums.

In Saudi Arabia, the social security scheme GOSI, as well as the governmental labour inspectorate, are active in prevention. Elements of a premium/rebate system are in place, insofar as enterprises which do not follow safety regulation have to pay higher contribution rates (the actual accident rate is not taken into consideration).

The present accident insurance system in Argentina is based on a compulsory insurance policy taken out by employers, both in the private and the public sector. Occupational hazards are covered by private insurance companies. The state controls and regulates the system through the Superintendency of Occupational Risks. Employers are obliged to enhance working conditions in enterprises. The private insurers, who administrate compensation funds, assist employers in their prevention activities. Consequently, prevention "pays" for the insurers which provide incentives for employers through rebates and premiums. Primary prevention is undertaken by the employer, secondary prevention by the insurance company.

Follow up activities

As the discussion of the various items (list systems, new occupational diseases, reporting/recording and prevention) showed, the need for international exchange of experiences and good practices is remarkable. Therefore, two concrete proposals were put forward at the end of the workshop:

- **to further establish the ISSA Technical Commission as platform for international exchange**

  Participants suggested to organize more small meetings like this workshop in the future, maybe on occasion of/in conjunction with other regular ISSA conferences (e.g. technical and regional conferences).

- **to organize a seminar on diagnosing and reporting occupational diseases**

  Especially with respect to diagnosing and reporting occupational diseases, more know-how and training is needed. In order to follow up on the workshop and to comply with the demand for more exchange and transfer of expertise in this field, the Technical Commission offered to organize a seminar especially focusing on the issues debated in the workshop. It is planned to hold the seminar within the next triennium, probably in Europe.