THE CHALLENGE OF OCCUPATIONAL DISEASES IN DEVELOPING COUNTRIES:
EXEMPLARY OBSERVATIONS AND GOOD PRACTICE PROPOSALS FROM A CYCLE OF SEMINARS IN FOUR CONTINENTS

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**Abstract**

Occupational diseases (OD) in their various forms and facets pose a special challenge to social security systems around the world. While a common international definition of occupational diseases does not exist, social insurance systems face certain common problems arising, for instance, from the complex multi-causality of OD as well as from a continuously changing world of work. Legal, administrative, environmental and geographical factors influence prevention and social insurance coverage of occupational diseases. This article highlights outcomes of a seminar cycle of the Technical Commission on Insurance against Employment Accidents and Occupational Diseases of the International Social Security Association (ISSA). It presents key findings from three seminars held in Latin America, Asia and Africa between 2005 and 2007. In this context, it deals in particular with the recognition, reporting and compensation of occupational diseases as well as the challenge posed by the informal sector. The paper concludes with a summary of practical solutions proposed at the seminars.

A. Introduction

Recognition, prevention and insurance of occupational diseases (OD) have been subjects of comparative research for many years. There is wide agreement in international publications that a common way to insure against and prevent occupational diseases does not exist.1 Different countries follow different strategies: some strategies comprise a list system; others use a general clause or a system of proof. Countries with a list system may even combine it with an additional open clause (resulting in so-called mixed systems). There are, however, certain recommendations for the implementation of common minimum standards of an insurance scheme against OD, stemming largely from international organisations such as the International Labour Organization (ILO). Such recommendations can be found, for example, in the ILO Employment Injury Benefits Convention and the ILO Recommendation Concerning the List of Occupational Diseases.

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and the Recording and Notification of Occupational Accidents and Diseases. For member states of the European Union (EU), the Commission Recommendation (2003/670/EC) of 19 September 2003 concerning the European Schedule of Occupational Diseases suggests ways to improve knowledge at the European level, foster prevention and provide assistance to workers by enabling them to apply for compensation. It is stipulated in this context that the EU member states introduce into their national legislation a special law on compensation for occupational diseases. Despite these efforts to introduce certain common parameters, even in the EU there are as many systems of OD coverage as there are member states. This was especially highlighted in the first of the International Social Security Association (ISSA) seminars on the challenges of occupational diseases, held in Cyprus in 2003, which focused primarily on European countries.

It would certainly be futile attempting to summarise most of the roughly 70 technical presentations on challenges and good practices in preventing, rehabilitating and insuring against occupational diseases in Latin America, Asia and Africa, which were presented in the course of the seminar cycle. However, at least some key findings of the latest three seminars shall be presented, which were held in Argentina in 2005, the People’s Republic of China in 2006 and Cameroon in 2007.

**B. ARE OCCUPATIONAL DISEASES A ‘GLOBAL’ CHALLENGE?**

It was at least the hypothesis of the Technical Commission that, despite regional particularities, certain commonly shared problems could be found, challenging social insurance in all regions of the world alike, and that, in the end, some practically relevant methods and practices should be derived in order to propose — preferably simple — strategies to answer these challenges.

In itself, occupational diseases are not a new risk insured by social security. In fact, occupational diseases have been covered by many systems throughout the world for several decades. However, today more so than in the past, this type of disease — in all its multiple forms and facets — poses a special challenge to social insurance. Problems already begin when attempting to define the subject at hand.

What is an occupational disease? Definitions of occupational diseases are diverse and vary according to jurisdiction. After all, ‘occupational disease’ is a legal and not a medical term. In the broader sense, occupational diseases can be defined as diseases caused by exposure to factors associated with work, a trade or an occupation. Other more restrictive definitions characterise occupational diseases as such chronic ailments known to occur in a given body of workers in a given industry, and at a rate significantly higher than occur in the general population. This also includes diseases that are only known to occur among workers in a given industry and nowhere else (such as black lung disease among coalminers). In these cases, where work-related factors are the only cause of a disease, its acceptance as an occupational disease generally does not cause any problem.

Another question is how to distinguish occupational diseases from occupational accidents or work-related injuries. This depends on the definition and jurisdiction in a country. Occupational diseases may also fulfil the requirements of work-related accidents or injuries according to a country’s legislation whilst in another country occupational diseases are inconsistent with occupational accidents or injuries. Moreover, an

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‘occupational disease’ in one country might be recognised as an ‘occupational accident’ in another country.

Even more complex than the definition are possible causes of occupational diseases. In many cases (and increasingly so), work-related factors increase the risk of a disease, together with other non-work-related factors. Work-related factors also often aggravate an already established disease. It is this complex multi-causality of occupational diseases which makes them not only difficult to recognise and record, but also highly difficult to prevent and insure against.

In summary, legal, administrative, environmental and geographical factors all influence the way occupational diseases are prevented and insured against in the various regions of the world. The definitions of OD and the ways to insure against and prevent OD, differ from country to country. However, the question is whether there are some globally shared characteristics which social security systems around the world have to deal with.

One clear result of all seminars in the cycle was the recognition that administrators, work safety specialists, medical practitioners, workers and employers in all parts of the world are challenged alike by the growing complexity of the issue. The multi-causality of OD, new and emerging types of diseases, the growing impact of informal work and the participation of migrant workers in a globalised economy are all problems and challenges associated with OD which demand special attention in the early 21st century.

In the three seminars between 2005 and 2007, two challenges clearly demanded most attention and shall therefore be described in the following:

1. The first challenge is marked by the difficulties relating to reporting and recording occupational diseases, especially those with long latency periods. This problem is complicated by certain new or emerging (so-called ‘contentious’) diseases which are difficult to attribute to the workplace (like work-related mental disorders).

2. The second challenge, aggravated by economic globalisation, is posed by the attempt to expand the scope of coverage of social (in particular accident) insurance to risks formerly left uncovered in the ‘informal’ sector — informal sector workers in India, for instance, have almost no access to statutory social protection. How can workers in the informal economy (in many cases the vast majority of the national workforce) be included in the system? How can these workers be granted access to occupational medical checkups, primary occupational health care, rehabilitation and compensation in case of a disease? This problem also has a flip side: in the case of successfully expanding the coverage, how can a system prepare for future claims by formerly uncovered workers without straining its financial resources? Claims, especially for diseases with long latency periods, might build up a large financial burden for accident insurers in the not so distant future, especially in currently developing countries.

C. Global Data

According to estimates by the ILO for occupational accidents and diseases, there are globally about 2.2 million work-related deaths annually. By far, the largest share of work-related fatalities is attributable to fatal diseases: between 1.7 million and 2 million deaths per year. Global statistics and estimations of this kind are methodologically questionable, but are probably the only way to at least come close to the reality of

occupational diseases today. At least they offer an idea of the magnitude of the problem. However, they do not offer any information as to what kinds of occupational diseases are most prevalent in various countries. The concept of occupational diseases and the method of recording them both depend upon legal and administrative decisions in each country. This makes comparing national statistics on occupational diseases difficult, if not impossible.

It was confirmed more than once in the cycle of seminars that a commonly recognised disease in country A might not even be recognised as an occupational disease in country B, even though it might claim a similar number of victims. From a comparison of the two respective national statistics on occupational diseases, any uninformed reader might draw the impression that country B provides healthier working environments with regard to the specific disease, simply because no cases are recognised and compensated. Consequently, figures from workers compensation insurers show that in different countries very different occupational diseases top the claims statistics. It would be a great error if one would draw any quick conclusions from this data on the reasons for their prevalence. For instance, whether or not a country recognises relatively more cases of hearing loss than another might simply be the result of different legal and administrative conditions rather than greater exposure of workers to noise at the workplace. The following table exemplifies the diversity of ‘most frequent’ occupational diseases across different countries.

<table>
<thead>
<tr>
<th>Country</th>
<th>Most frequent claims</th>
<th>Second most frequent claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Hearing loss</td>
<td>Respiratory diseases</td>
</tr>
<tr>
<td>China, People’s Republic</td>
<td>Pneumoconiosis (official share:</td>
<td>Acute and chronic poisoning</td>
</tr>
<tr>
<td></td>
<td>80% of all OD)</td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>Skin diseases</td>
<td>Back diseases/hearing loss</td>
</tr>
<tr>
<td>Korea, Republic of</td>
<td>Musculoskeletal diseases</td>
<td>Pneumoconiosis</td>
</tr>
<tr>
<td>Portugal</td>
<td>Hearing loss</td>
<td>Diseases due to other physical factors</td>
</tr>
<tr>
<td>Russia</td>
<td>Respiratory diseases</td>
<td>Musculoskeletal diseases</td>
</tr>
<tr>
<td>Sweden</td>
<td>Musculoskeletal diseases</td>
<td>Diseases due to chemical substances</td>
</tr>
<tr>
<td>USA</td>
<td>Sprains, strains (*)</td>
<td>Back injuries/diseases (*)</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Pneumoconiosis</td>
<td>n.a.</td>
</tr>
</tbody>
</table>

(*) claims include occupational injuries

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**D. RECOGNITION, REPORTING AND COMPENSATION OF OCCUPATIONAL DISEASES**

In different countries, different work-related illnesses pose the greatest challenges today. Results from a survey by the ISSA Technical Commission in 2003 show that the main challenge in Zimbabwe, with regard to occupational diseases, is pneumoconiosis, followed by anthrax and lead poisoning. In Rwanda, it is silicosis, which also affects 37 per cent of miners in Latin America. In the Syrian Arab Republic, cancer diseases are seen as the biggest challenge for the next decade. Occupational cancer is also expected to be the biggest challenge in Argentina, as are back pain and occupational diseases related to

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psychological factors. In Japan ‘karoshi’ — 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. Many of these diseases bear the risk of going unrecorded and, consequently, without proper treatment and compensation.

The seminar circle showed that especially in developing countries, underreporting is the biggest problem for insuring against OD. The seminars confirmed an observation in a publication from 1999 concerning the 11 countries of southern Africa (Botswana, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe). This paper specifically cites underreporting as a major problem in Africa. In the Southern African Development Community there are estimated to be two to seven times as many cases of OD than are reported. The most extreme distortions occur with respect to occupational diseases and, within this, to chemical- and mining-related illnesses. Both are prone to underreporting due to their relatively long latency periods and because of the large share of migrant workers in respective sectors of the economy, for which statistical data is largely unavailable. ‘Here it is possible that the underestimate may be as large as 50-fold.’

The seminars included reports from countries, like Gabon, which do not maintain any statistics on occupational diseases for the period since the time the respective national insurance system was set up. Consequently, no occupational diseases have so far been recorded. Other countries do register cases of OD, but in fact only very few. In the case of Cameroon, only three cases were reported in the last two decades. In Tanzania, since 2000, only one case of occupational disease was compensated. Similar examples could be given in abundance. However, some systems recently stepped up their processes for recording and handling OD claims. In Gambia, for instance, exactly one occupational disease case had been reported between the introduction of the workers compensation scheme, in 1996, and 2003. The system was subsequently reformed and, between 2004 and 2006, a total of 11 cases were recorded. In the seminar for the African continent, this fact was widely applauded as a great success, which says a lot about the grade of accuracy in reporting occupational diseases to which experts are usually accustomed in this region.

When assessing possible causes for rampant underreporting, experts from African and Asian countries quickly pointed towards their outdated lists of occupational diseases. In Cameroon, the list was last updated more than 20 years ago, in 1984. While this may seem a long time, in Gabon the list is exactly 40 years old and, in its current form, dates from 1967. In Mali, the list has also remained unchanged since the 1960s. While the need for reforming and updating old OD lists is obvious in these countries, it must be noted that this alone will not eliminate underreporting — perhaps not even to a significant extent. Other reasons presented for underreporting point to the fact that even victims of diseases already on the lists were not identified adequately. Additionally, insufficient diagnostics due to too few or insufficiently skilled doctors were indicated by experts from Latin America, Asia and Africa alike. Other reasons may be found in a general lack of awareness, on the part of medical practitioners, of work-related causes of diseases and their lack of diagnostic training in not only, but including, the field of occupational medicine.

10 Ibid.
Sometimes, in addition to these reasons, the insurance system itself may be the cause of severe structural and administrative hindrances. What was reported from Tanzania in this respect may be seen as an example for many countries in the developing world — not only in Africa. The medical boards, which assess cases of occupational disease, usually take between six and eight months before even meeting to deliberate a case. ‘These lengthy procedures have discouraged many to claim for workman's compensation.’

Further reasons were presented to explain why it was comparatively unattractive for workers to follow up on their claims. In the vast country of Tanzania (nearly twice the size of France), transport to the capital can be so expensive that it might simply be financially unattractive for an injured or sick worker to invest in a bus ticket in order to file a claim or follow up on it: ‘Sometimes you find that the costs that a worker incurs in the process of claiming for compensation are much higher than the compensation amounts to be paid.’

However, underreporting does not only concern developing or transition countries; it is a general challenge with regard to compensation and the prevention of OD. A survey on underreporting of occupational diseases in Europe from 2002 showed that most of the countries investigated acknowledged underreporting. The most common reasons put forward were the lack of information for employees, the lack of information and training of general practitioners about OD, the employees’ fears of job loss, and the inadequate number of industrial doctors. Other reasons mentioned in the survey report were long and complex procedures, difficulties of providing proof of exposure to risk (in open proof systems) and poor knowledge of the legislation, particularly in small- and medium-sized enterprises.

The deficient recognition of occupational diseases is further complicated by the fact that more and more diseases tend to be not exclusively caused by work, but are ‘work-related’. This makes it even more difficult to recognise any occupational causes. The term ‘work-related disease’ marks a broader concept than that of ‘occupational disease’ since it refers to all diseases where work is a contributory cause. This concept combines work-related and non-work-related factors. The annual number of non-fatal work-related diseases has been estimated by the ILO to be 160 million. The World Health Organization (WHO) estimates that 37 per cent of lower back pain, 16 per cent of hearing loss, 13 per cent of chronic obstructive pulmonary disease, 11 per cent of asthma and 8 per cent of injuries are related to work. Musculoskeletal and respiratory illnesses are among the most common types of work-related diseases. It is seldom possible to prove that these illnesses arise solely from work. Consequently, countries vary greatly in their respective methods of addressing these illnesses. Passive smoking, carpal tunnel syndrome, post-traumatic stress, depression and a few other potentially work-related ailments currently dominate debates about new occupational diseases in many countries, particularly in Europe. Despite the fact that, in the European Union, the focus of attention regarding work-related diseases currently seems to be on mental disorders, it would be wrong to believe that stress, burnout and depression were only relevant to highly industrialised or high-income countries. Neuropsychiatric conditions are in fact the most important causes of disability in all regions of the world, accounting for 37 per cent of years of healthy life lost as a result of disability (YLD) among adults aged 15 years and older. According to a study on global disease and risk factors between 1990 and 2001, depression is the leading cause of disability for males and females around the globe. The same study reveals that ‘more than 85 percent of disease burden from nonfatal health outcomes occurs in low- and middle-income countries, and South Asia and Sub-Saharan Africa account for 40

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15 Ibid.
percent of all YLD’. These countries are generally the same countries with the lowest rates of workers covered by accident insurance, which poses other challenges.

E. CHALLENGES POSED BY THE INFORMAL SECTOR

As a legal term, ‘occupational disease’ only applies to compensatable diseases caused by work. In order to be compensated for any such ailment, a worker by definition has to be covered by a workers compensation or accident insurance scheme or the general social security scheme, respectively. With respect to compensation, diseases caused by work in the informal (thus uncovered) sector usually do not appear in national statistics on occupational safety and health.

There exists no unique definition and no consensus among researchers and analysts on the term ‘informal sector’, in particular on its conceptual and operational meaning. The Central Statistical Organisation of India uses it interchangeably with the unorganized sector which means ‘all unincorporated enterprises and household industries ... that are not regulated by law and which also do not maintain annual accounts or balance sheets’. A less restrictive attempt is to look at some characteristics shared by those employed in the informal sector, which may include the lack of security in many labour dimensions (e.g., job market security, occupational safety, employment stability, income security). In a broader meaning, the lack of social insurance may therefore be one key characteristic of informal work. Workers in the informal sector normally go without coverage and compensation. However, in many countries they make up by far the largest share of the national workforce. Especially in Asia, Latin America and Africa, in many countries only a small fraction of the workforce is covered by social accident insurance.

| Percentage of workforce not covered by workers compensation system |
|-----------------------------|-----------------------------|-----------------------------|
| Pakistan | Egypt | Bangladesh | India | Venezuela | China | Thailand | Colombia |
| 97.7% | 90.89% | 90% | 90% | 88% | 87.7% | 84.3% | 69% |


While international studies estimate the informal workforce in industrialised countries to be rarely larger than 10 per cent, it may reach 70 per cent in the developing world, sometimes even contributing the largest share to the gross domestic product. In the third seminar on occupational diseases, in Buenos Aires in 2005, it was reported that 7 out of 10 new jobs in Latin America are created in the informal sector. This estimate does, of course, not apply to the entire continent. In Chile in 2001, a total of 3.4 million workers were affiliated with the industrial accidents and work-related illness insurance,

18 The Netherlands do not provide special compensation for accidents at work or occupational diseases (they have no accident insurance scheme). Nevertheless, there exist studies on occupational diseases, for example, by the Netherlands Centre for Occupational Diseases, a knowledge centre on OD.
equivalent to 57.3 per cent of the workforce. In Brazil, the social security coverage of workers aged between 16 and 59 was 63.4 per cent of the workforce in 2005 and 64 per cent in 2006.

The experience from Brazil shows that formal work and social security coverage do not necessarily correspond; workers in formal employment may not necessarily participate in the social security system. In Brazil, access to social benefits is based on the contribution principle and supplemented by several programs including welfare elements. It is estimated that in Brazil in 2005 there were about 28.8 million people without a contributive relationship to social security. According to estimates by the Ministry of Social Security of Brazil, out of these 28.8 million workers, 16.3 million could be social security contributors because they have a suitable income and a position in the labour market.

The question arises — are workers who are not covered by a social security scheme covered in other ways? In relation to countries in southern Africa, the term ‘informal social security’ is used ‘to refer to social security arrangements that fall outside social provisions’ or is defined as ‘the counterpart of formal social security, covering social protection mechanisms outside the formal social security paradigm’. The need to integrate informal social security into the formal systems derives from the weakness of informal schemes and the lack of adequate benefits. Recognition, compensation and prevention of occupational diseases are typical elements of formal social security systems and should be provided to the majority of workers and not remain exclusive.

At the seminars, the following experiences concerning informal work and lack of social insurance were reported from Africa. In Burundi, the National Social Security Institute insures only 8 per cent of the workforce, whereas 92 per cent are estimated to be informal and without any (formal) social security coverage. In Tanzania (population of 36 million people), the workforce is estimated to be 10 million. Of these, only 1 million (10 per cent) are in formal employment and only 400,000 are insured by the National Social Security Fund. In Asia, various countries encounter the same dilemma. In Vietnam, for instance, only 14.5 per cent of the workforce is covered by social security.

As was specifically addressed by experts from Latin America, the large share of informal workers somehow needs to be included in the (public) system of healthcare services. It is estimated, that only 5 per cent to 10 per cent of workers in Latin America have access to adequate occupational health care services. Accident insurance can play a crucial role in providing general practitioners — not specialised in occupational medicine.

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26 Ministry of Social Security Brazil, Brazilian Social Security Overview, Brazil, February 2008 at 25.


— with at least some guidelines on how to recognise occupational diseases. By publishing 
and distributing ‘OD bulletins’ of not more than 3–5 pages, at least the awareness of 
doctors can be raised to inquire about potential links between a disease and exposure at 
the workplace.

Some countries are also working hard on expanding their coverage in the field of 
social accident insurance. The People’s Republic of China, for instance, was already 
covering 90 million workers in 2006 (20 million more than only two years ago) and it 
aims at covering 140 million by 2010. Among the officially covered 90 million workers 
are 19 million rural migrating workers who make up a small fraction of the largest share 
of the informal sector in China.33 The rapid expansion of coverage is good news for 
workers, both formal and informal. However, the growing potential of future claims is 
also challenging the compensatory capabilities of the social security system. China has 
to reckon with a growing number of claims for compensation of occupational diseases, 
especially by workers who, until recently, have not fallen within the scope of the system. 
Given that lung diseases have already become the most frequent occupational diseases in 
China, and bearing in mind that some of them may have a long latency period (spanning 
even decades), it is very likely that in 10 or 20 years workers who are currently exposed to 
dust in coalmines or to asbestos in shipyards might file claims for occupational diseases. 
Therefore, provisions must be taken today to build adequate reserves for future claims.34

China’s situation, with many millions of migrating and informal workers, exemplifies 
what might be the greatest challenge for workers compensation systems with regard 
to occupational diseases in the next decades. In order not to be caught unprepared by 
rapidly growing claims volumes, accident insurance systems, especially in developing and 
transitional countries, should take the necessary precautions today.

### F. CONCLUSION

Industrialised as well as developing and transition countries have to deal with certain 
common challenges, most notably among them the underreporting of occupational 
diseases and the lack of coverage of people working in the informal sector. There is no ‘one 
size fits all’ answer to these challenges; instead, countries must find their own solutions, 
tailored to their individual social security systems. The following conclusions and good 
practice solutions, which were derived from the seminar cycle, met with the broadest 
consensus among experts attending the three seminars as globally applicable. They might 
be the closest to an internationally applicable toolkit and shall therefore be presented.

#### 1. Ensure Sound Reporting, Motivate to Report

The obligation to report occupational diseases should not rest exclusively with workers 
and employers. All parties involved should either be obliged (eg, employers, doctors, health 
insurance) or allowed (workers, dependants) to file their suspicion of an occupational 
disease with the relevant authority. Also, they need to be enabled to do so, eg, by filling 
out simple, one-page report sheets. Doctors might even receive a small remuneration in 
order to reward the diligence required in diagnosing work-related ailments.

This might require legal changes, depending upon the type of social security system, 
and should be accompanied by the supply of sufficient information and training for all 
parties concerned.

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33 The number of rural migrant workers in China is estimated to range between 140 million and 190 
    million people.
34 Li Dehong, ‘Pneumoconiosis in China — Advances in Prevention and Control’ (Paper presented at the 
    ISSA Seminar III, Shenzhen, China, 5-7 September 2006).
II. Strengthen Diagnostic Quality

Medical practitioners should be kept regularly informed about occupational diseases. Even short information sheets (3-5 pages) may be sufficient to keep doctors up to date on new developments. These information sheets can be made available to doctors in the public healthcare system, summarising some key features of all, or at least the most common, diseases on the national list. This enhances the doctor’s ability to detect any relationship between a disease and the workplace and reduces the number of victims going without adequate diagnosis.35

III. Follow Up on Exposed Workers

Accident insurance systems in several countries collect data on workers who have been exposed to certain hazardous substances which might lead to occupational diseases after a long latency period (e.g., asbestos-related diseases). The Korean mesothelioma surveillance system, run by the Korea Occupational Safety and Health Agency (KOSHA), is only one (non-European) example.

In order to continuously monitor the health of workers exposed to dangerous substances (even after they have left their job or retired), post-exposure medical exams are a most useful tool. The German Central Registration Agency for Employees Exposed to Asbestos Dust, for instance, collects data on exposed workers and organises regular medical exams. The agency registers formerly or currently exposed workers, organises follow-up and post-exposure examinations and stores all relevant data. For workers, participation is voluntary; expenses are borne by the German accident insurance institutions. The benefit lies in the reduction of underreporting of occupational cancers. Without such a registry, fewer cases of occupational cancers would be reported and substantiated.

IV. Review/Update Lists on Occupational Diseases

Especially in Asian and African countries, the updating of OD lists should be given high priority. If social insurance compensation is limited exclusively to diseases on an out-of-date list, workers will not be able to find adequate compensation. This applies to those countries using pure list systems (e.g., France, UK, India, Philippines, Malaysia, Cameroon and Zambia).36 A rather simple solution for these schemes might be to regularly update their lists. Another option would be a systematic and legal change of the system into a mixed system. Various countries, particularly in Europe, successfully apply such mixed systems (e.g., Germany, Italy, Belgium, Austria and Switzerland).37 These systems use lists of occupational diseases combined with an open or complementary system. This allows the recognition of diseases not listed as occupational diseases. Another alternative to regularly renewing OD lists could be to introduce a general opening clause. Some countries, among them the USA, Finland and Sweden,38 use a general clause or system of proof instead of a list. This means that every disease can be recognised as an occupational disease if the causal link to work is proven.

V. Foster Prevention of Occupational Diseases

Another ‘good’ if not ‘best-practice’ is prevention. Prevention is definitely a universally adaptable way to reduce cases of occupational diseases. Even in countries with out-of-
date disease lists, prevention can play a crucial role in reducing the number of victims of diseases, not (yet) on the list. In various countries, where certain risks are not subject to insurance coverage, the same insurers may, nevertheless, engage in preventing these very same risks. It can be deduced that prevention ‘pays’, even in these markets, since it contributes to averting greater expenses to the society. In Germany, for instance, accident insurance carriers are obliged by law to prevent all work-related health risks, which also include risks not legally qualified either as ‘occupational accidents’ or ‘occupational diseases’. This also benefits other insurance systems, such as retirement and healthcare insurance, since — due to effective accident insurance prevention — fewer workers fall ill or seek early retirement.

VI. Offer Incentives

Through a contribution system of rebates and premiums, accident insurers are able to motivate employers to take prevention seriously. An investment in safer and healthier workplaces by the employer — subsidised by lower contributions for accident insurance — can be beneficial for both workers and employers. Even young or newly reformed accident insurance systems adhere to this strategy, as the example of the People’s Republic of China shows. The bottom line is that linking prevention to accident insurance compensation enables effective mechanisms which not only reduce work-related injuries and diseases but also provide an incentive for employers to boost preventive activities in an enterprise. Incentives do not only foster prevention of occupational accidents. In Germany, for instance, occupational diseases are also included in the incentive scheme of the social accident insurance. While it is obvious that incentives are not likely to be effectively used for the prevention of long latency diseases, they can be effective in the prevention of diseases with shorter latency periods (eg, hearing loss).

Thus, prevention not only pays, but it even pays double. It is the most suitable strategy to cope with the growing challenges posed both by ‘old’ and ‘new’ occupational diseases, around the world.

G. Bibliography


