New Recommendation on occupational diseases: some progress, but no harmonization in sight

On 19 September 2003, the Commission adopted a new Recommendation on occupational diseases1 which replaces that of 1990. The new Recommendation is structured broadly like its predecessor. It is based on two schedules. The first schedule (annex I) contains occupational diseases that should be recognized in all Member States. The second schedule (annex II) contains a list of diseases suspected of being occupational in origin which should be subject to notification and which may be considered at a later stage for inclusion in the first schedule.

Generally, the new Recommendation is in line with the Commission's earlier 2001 proposals. While most of the suggested improvements put forward by the European Trade Union Confederation were rejected, some were taken up:

- national statistics on occupational diseases should be broken down by sex (which does not currently happen in some countries like France, for instance);
- an active role for national health care systems and medical staff in the reporting of occupational diseases;
- new musculoskeletal disorder-related conditions expressly included in the schedule of occupational diseases: carpal tunnel syndrome and three categories of bursitis (new categories 506.10, 506.11 and 506.12).

The original proposals have been "toned down" on some points as a result of employer pressure backed by certain governments. The most appalling piece of backpedalling relates to cancer of the larynx caused by exposure to asbestos. The original plan was to include it in the occupational diseases that should be recognized by Member States, but it has been downgraded to the list of diseases suspected of being occupational in origin. There is no reason for this when cancer of the larynx caused by asbestos exposure is a recognized occupational disease in several European Union countries.

No such thing as back strain

Another serious step backwards relates to spinal column problems caused by carrying heavy loads. The Commission has seemingly forgotten about the Manual Handling of Loads Directive! This clearly established the link between load lifting and spinal column problems - a connection to which hundreds of thousands of sufferers in the building industry, hospital work, and other sectors can testify. The Commission does not even see such diseases as suspected of being occupational in origin. The economic stakes are clearly high: the huge costs will be paid by health care systems and the sufferers themselves rather than the occupational disease compensation schemes.

In terms of actual numbers, the differences between the initial proposal and the Recommendation as adopted are:

Annex I (recognized occupational diseases): of six diseases caused by chemical agents, four have been included in the final version, one was dropped and one was included in Annex II. Of the six diseases caused by the inhalation of substances and agents, five have been included. The other has been listed in Annex II (cancer of the larynx following the inhalation of asbestos dust). Neither of the two diseases caused by physical agents has been included in Annex I (both are listed in Annex II). On the other hand, four trade union proposals not included in the initial proposal have been accepted (the most significant advance being carpal tunnel syndrome).

Only three of the six diseases that were to have been transferred from Annex II into Annex I actually have been; the other three stay in Annex II.

Four new diseases and agents were proposed for Annex II, of which three have been included. Disc-related diseases of the lumbar vertebral column caused by the repeated handling and carrying of heavy loads were left out.

The Recommendation has dropped any threat of the future adoption of a Directive, previously mentioned in article 7 of the 1990 Recommendation.

The general verdict, then, is "could do better". Progress on some points, but an overall approach that leaves slim chances of any harmonization of systems for the recognition of occupational diseases. On that basis, hoping to set hard targets for reducing the rates of recognized occupational diseases seems like a pretty sick joke.

There is no real convergence to be seen between national systems either in the aggregate data summarized in the table (see p. 24), nor as regards the main diseases. The gap between the extremes has remained virtually unchanged over ten years, discounting Sweden.

[1] *OJ* L 238 of 25 September 2003.

The failure of a Community policy in figures

A Eurogip study published in 2002 illustrates the wide gaps between national systems for the reporting and recognition of occupational diseases, and the scale of the social inequalities they create.

The EU States covered by the study range from a low of 3.3 recognized occupational disease per 100,000 workers in Ireland to a high of 177 in France.

Reported and recognized occupational diseases in 12 European Union countries, 1990-2000

	New cases of reported occupational diseases per 100,000 workers			New cases of recognized occupational diseases per 100,000 workers (% of cases accepted)		
	1990	1995	2000	1990	1995	2000
Austria	151	133	103	78 (51.8 %)	52 (39.3 %)	42 (41.7 %)
Belgium	431	336	277	186 (43.2 %)	204 (60.9 %)	112 (40.5 %)
Denmark	549	669	545	90 (16.4 %)	131 (19.6 %)	124 (22.8 %)
Finland	320	331	238	160 (50 %)	110 (33.1 %)	64 (27 %)
France	63	103	237	44 (70 %)	76 (73.8 %)	177 (75 %)
Germany	192	235	211	35 (18.3 %)	66 (27.9 %)	49 (23.1 %)
Greece	–	5.3	4.5	–	4.7 (90 %)	3.5 (78.1 %)
Ireland	4.4	6.4	7.5	2.3 (52 %)	5.5 (87 %)	3.3 (44 %)
Italy	354	211	160	93 (26.2 %)	39 (18.5 %)	33 (20 %)
Luxemburg	113	49	82	8 (6.7 %)	15 (30.9 %)	14 (16.9 %)
Portugal	–	57	55	–	42 (73.1 %)	27 (48.9 %)
Sweden	1 524	642	309	1 242 (81.5 %)	258 (41.3 %)	138 (45 %)

Source : Eurogip, 2002

The gender issues in under-recognition of occupational diseases are important. They amount to systematic discrimination that waters down prevention policies as respects diseases more common among women workers and that affect women more than men. In most European Union countries, women fall within a bracket of 25% to 40% of recognized occupational diseases. In the United Kingdom, the proportion is under 10%. In Belgium, it is around 15%.

And yet, expressed in full-time equivalents, the adjusted aggregate data for the European Union collected by Eurostat for the 1999 labour force survey indicate that, in all the countries surveyed apart from Greece, work-related diseases are actually more prevalent among women[2]. ■

[2] See Dupré, Didier, "The health and safety of men and women at work", *Statistics in Focus, Population and Social Conditions,* Theme 3-4, Eurostat, 2002.