EUROGIP

Enquiry report Ref. Eurogip-34/E January 2009

Occupational diseases in Europe

1990-2006 statistical data and legal news

Study carried out with the **EUROPEAN FORUM OF THE INSURANCE AGAINST ACCIDENTS AT WORK AND OCCUPATIONAL DISEASES**

EUROPEAN FORUM of the insurance against accidents at work and occupational diseases

EUROGIP
Understanding occupational risks in Europe

eurogip
comprendre les risques professionnels en Europe
understanding occupational risks in Europe

"Occupational diseases in Europe - 1990-2006 statistical data and legal news" Report
(Ref. Eurogip-34/E)

ERRATUM CONCERNING THE DATA ON SWEDEN

Following the publication of the report entitled "Occupational diseases in Europe - Statistics 1990-2006 and legal news", the statistical data reported by Sweden proved inaccurate, because they cover accidents at work and occupational diseases as a whole.

▶ **The data concerning Sweden on pages 7, 9, 10, 15, 17, 19 and 43 of said report should therefore be ignored.**

Sweden has been able to forward corrected data concerning:

• Claims for recognition and recognised cases of occupational diseases from 2005 to 2009

SWEDEN - Claims for recognition and cases recognised (2005-2009)		
Year	**Claims for recognition**	**Recognised cases**
2005	15,515	3,974
2006	15,568	3,482
2007	13,927	3,333
2008	6,175	1,764
2009	5,820	1,873

The occupational disease insurance organisation, Försäkringskassan, specifies that the number of claims for recognition corresponds to the sum of the rejected cases and recognised cases in a given year. This number is therefore not entirely comparable with the number of claims for recognition in the sense of cases submitted for recognition to the insurance organisation.
The Försäkringskassan organisation also explains that a specific feature of the years 2005 to 2007 was the examination of a large number of cases which had suffered delays. The figures for the following years are a more accurate reflection of the real situation regarding occupational diseases in Sweden.

• The 5 occupational diseases most frequently recognised in 2009:

SWEDEN - Claims for recognition (2009)	
Type of disease	**Claims for recognition**
Musculoskeletal disorders	2,521
Psychosocial disorders	648
Hearing loss	422
Respiratory diseases	182
Circulatory system diseases	140

SWEDEN - Cases recognised (2009)	
Type of disease	**Recognised cases**
Musculoskeletal disorders	556
Hearing loss	293
Psychosocial disorders	111
Poisoning and other causes	70
Respiratory diseases	61

Contents

rapportanglais.indd 1 17/02/09 12:12:09

rapportanglais.indd 2 17/02/09 12:12:09

Introduction

In September 1998, the European Forum of Insurances against Accidents at Work and Occupational Diseases[1] set up an internal working group, coordinated by EUROGIP[2], consisting of legal experts and doctors from the insurance organisations of several European countries. Although the original assignment of this group was to collect and compare the national statistics relating to occupational diseases, it subsequently carried out work on more specific subjects. Accordingly, the following reports have been published to date:

Occupational diseases in Europe - Comparative study of 13 countries: Procedures and conditions of declaration, recognition and compensation (September 2000)

Occupational diseases in 15 European countries - Figures for 1990-2000 - Legal and practical news 1999-2002 (December 2002)

Overview of occupational cancers in Europe (December 2002)

Survey on under-reporting of occupational diseases in Europe (December 2002)

Lumbago and allergic asthma: Two case studies at the European level (December 2002)

Work-related mental disorders: What recognition in Europe? (February 2004)

Asbestos-related occupational diseases in Europe - Recognition, statistics, specific systems (March 2006)

The present report, which covers 13 countries, is an update of the 2002 report on statistics and legal and practical news relating to occupational diseases in Europe.
To process the statistical data provided by the various national occupational health insurance organisations, two approaches were adopted in succession.

A comparative approach which makes it possible to measure, at a given date, the incidence of occupational diseases in all the countries covered by the study, for a comparable insured population (I);
An evolutionary approach which summarises the statistics available in each country over a long period of time (1990-2006), thereby making it possible to assess the trends to an increase or decline in the number of occupational diseases over the last fifteen years (II);
This processing of the overall statistics is then supplemented by an analysis of the most frequent diseases in all the countries taking part in the study (III);
The report is concluded by a list of recent reforms and significant regulatory changes that have taken place in the area of occupational diseases (IV).

The following persons took part in the study
Germany/ Deutsche Gesetzliche Unfallversicherung (DGUV) - Andreas Kranig - Heinz Otten
Austria / Allgemeine Unfallversicherungsanstalt (AUVA) - Peter Pils
Belgium / Fonds des Maladies Professionnelles (FMP) - Patrick Strauss
Denmark / Arbejdsskadestyrelsen / National Board of Industrial Injuries - Lars Hog Jensen
Spain / Asociación de Mutuas de Accidentes de Trabajo (AMAT) - Carmen Escalante - Javier Trallero Vilar
Finland / Tapaturmavakuutuslaitosten Liitto (TVL) / Federation of Accident Insurance Institutions (FAII) - Mika Mänttäri
France / Caisse nationale de l'assurance maladie des travailleurs salariés (CNAMTS) - Direction des risques professionnels) - Ellen Cadi - Florence Cordenner - Virginie Fourmont
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Luxembourg / Association d'Assurance contre les Accidents (AAA) - Claude Rumé
The Netherlands / Nederlands Centrum voor Beroepsziekten (NCvB) - Gert van der Laan
Portugal / Centro Nacional de Portecçao contra os Riscos Profissionais (CNPRP) - Fatima Ventura
Sweden / Försäkringskassan - Monica Svanholm
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Study coordinated by Eurogip - Christine Kieffer

1. The European Forum of Insurances against Accidents at Work and Occupational Diseases, founded in June 1992, has set itself the objective of promoting the concept of a specific insurance against occupational injuries. In June 2008, eighteen countries - and twenty-one organisations - are represented in it. To find out more, go to: www.europeanforum.org.
2. EUROGIP is a public interest grouping of the French Social Security system, set up in 1991 to work on the subject of occupational risks in Europe. To find out more, go to: www.eurogip.fr

rapportanglais.indd 3 17/02/09 12:12:09

rapportanglais.indd 4 17/02/09 12:12:09

Preface

The reader's attention should be drawn to the difficulties involved in comparing national statistics. This is because the systems for recognition (especially the content of the national lists of occupational diseases) and compensation for occupational diseases differ greatly from one country to another. These divergences all help to explain the statistical disparities observed.

This study covers the following European countries: **Germany, Austria, Belgium, Denmark, Spain, Finland, France, Italy, Luxembourg, the Netherlands, Portugal, Sweden and Switzerland**.

However, the completeness or even sometimes the reliability of the statistical information may prove unequal from one country to another, notably due to the unavailability of certain data. Moreover, the insurance features of some countries make it hard to compare their statistics with those of the other countries.

For example, the **Spanish** statistics system does not make it possible to count the number of claims for recognition as occupational diseases.

In **Finland**, the Federation of Accident Insurance Institutions has radically reorganised its statistical recording system in recent years, so that it is not currently possible to obtain data concerning the number of recognised cases of occupational diseases comparable with the data for the years 1990-2000. Failing such data, statistical data from the Finnish Institute of Occupational Health (FIOH) have been exploited in this study.

The statistics for **Luxembourg** are hardly comparable with those of the other European Union countries, partly because the insured population is relatively small, which can give erratic statistical trends for slight differences in absolute value. Also, a very large proportion of the working population is employed in the service sector, which explains why there are proportionally fewer occupational diseases than in the other countries.

It should also be specified that since the **Netherlands** do not have a specific occupational injury insurance system, most of the comparative statistics in this report do not cover this country. The figures communicated correspond to the cases of diseases suspected as being of work-related origin reported to the *Nederlands Centrum voor Beroepsziekten* (Dutch Centre for Occupational Diseases).

rapportanglais.indd 5 17/02/09 12:12:09

rapportanglais.indd 6 17/02/09 12:12:10

SECTION I

Occupational diseases in 2006 - Statistical data

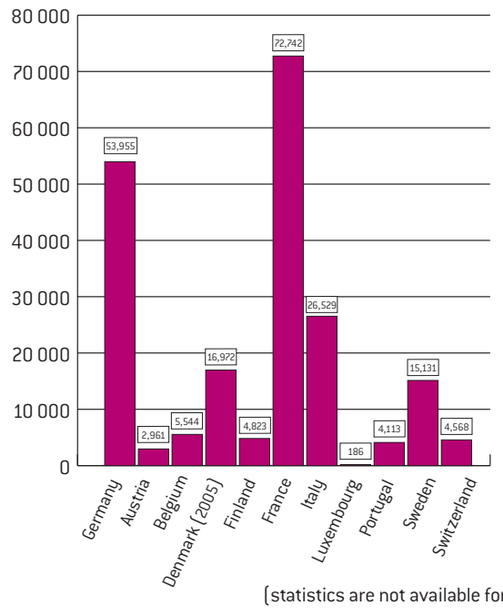
The aim of this part is to give a comparative presentation of the main data concerning claims for recognition of occupational diseases and the cases recognised in the various countries monitored.

1.1 Claims for recognition

The claim for recognition is the procedure gone through with the occupational disease insurance organisation to have the job-related nature of a disease recognised, so as to entitle the victims (or their legal beneficiaries) to rights, and in particular the payment of benefits.

In most European countries, this claim-for-recognition procedure should be distinguished from the procedure for reporting diseases suspected as being of work-related origin and affecting certain players (such as those working in healthcare). The aim of the latter procedure is chiefly to allow an empirical evaluation of the existence of work-related diseases independently of any insurance considerations.

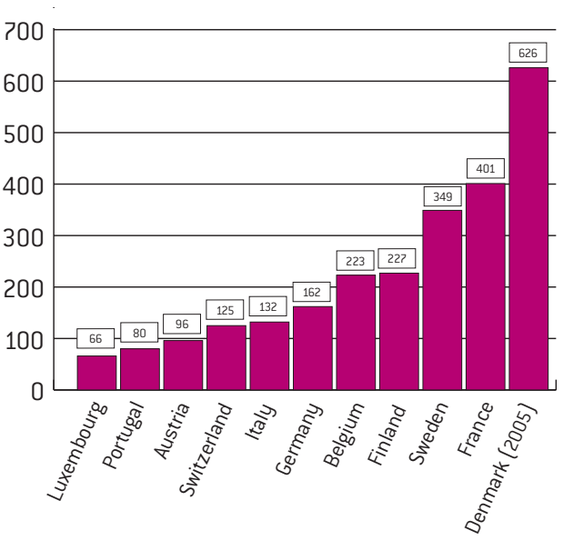
Claims for recognition (2006)



(statistics are not available for Spain)

To compare the countries with one another, irrespective of the number of people insured, the claims for recognition are expressed below in the form of a ratio per 100,000 insured[3].

Claims for recognition for 100,000 insured (2006)



A difference of 1 to 8 can be observed between the country in which the number of claims for recognition is the lowest (Luxembourg) and that in which it is the highest (Denmark).

Although such disparities are hard to interpret, several factors have been identified as capable of influencing the number of claims for recognition recorded.

More or less open nature of the claim-for-recognition procedure

The players who trigger the procedure can differ depending on the country. In Italy and Switzerland, it is incumbent on the employer to present the claim for recognition to the

3. The number of people insured used to calculate this ratio corresponds to the population insured for the year in question by the main or national occupational health insurance organisation of each country covered by the study, knowing that this does not necessarily cover the same categories of workers in all the countries (see Appendix 1).

rapportanglais.indd 7 17/02/09 12:12:10

insurance organisation, while in Belgium, France, Portugal and Sweden, only the victim is competent for this procedure. In other countries, the procedure is open to several people: the doctor and the victim in Denmark (the doctor/dentist is under obligation to present the claim for recognition, whereas the victim has a right to present the claim and the responsibility to call attention to the fact that the doctor is under obligation to present the claim); in Austria, Germany and Finland, the various players mentioned above can make the claim for recognition, even if the doctor is the starting point for most of the procedures.

It seems, however, in light of the ratios obtained, that this first factor has little impact on the quantity of claims for recognition.

Publicity for the system

There is no doubt that as the occupational disease insurance system is better known by doctors and the general public, the number of claims for recognition in a country increases. Denmark explains the very high ratio observed as follows.

Regarding the doctors, in all the countries there is an obligation to report to the appointed national body a disease for which a work-related origin is suspected (a report which is not equivalent to a claim for recognition everywhere); yet the general practitioner must be aware of the possible work-related origin of the disease and must know the procedure to be followed. Regarding the general public, the media show an increasing interest in questions of occupational diseases, and in some countries specific campaigns for certain diseases are planned regularly by the insurance organisations.

Despite all these initiatives, all the countries admit that even now there is extensive under-reporting of occupational diseases[4].

Appeal of the procedure for the victim

Although it is hard to measure the impact of this factor, it can be suggested that the victim's precise knowledge of his (her) chances of seeing his (her) disease recognised as work-related encourages them to take the initiative of a claim for recognition. Accordingly, the fact that France has a list of occupational diseases consisting of tables containing the recognition criteria is undoubtedly not unrelated to the country's high ratio.

Likewise, the specific level of compensation for occupational diseases[5] will more or less encourage the intend of the victims to make a claim for recognition.

Specific case of the Netherlands

In the Netherlands, there has no longer been any specific insurance against occupational injuries since 1967. However, statistical data on occupational diseases exist to the extent that the Ministry of Social Affairs and Employment entrusts to the *Nederlands Centrum voor Beroepsziekten* (Centre for Occupational Diseases) the task of keeping a number of registers of diseases suspected of being of work-related origin, so as to measure the incidence and dissemination of these diseases in the country.
The most important of these is the National Register of Occupational Diseases. Since 1999 there has been a legal obligation for occupational health departments and since 2005 for industrial doctors, to report diseases suspected as being work-related. The main objective is to collect the information required for the definition of appropriate policies for the prevention of occupational diseases.
In 2007, there were 5,974 reports (including 95% of electronic reports) for 7,100,000 workers.
The ratio of 84 reports per 100,000 workers is not comparable with the claim-for-recognition ratios of the other countries taking part in the study, because the diseases recorded in the Netherlands are recorded only for the purpose of prevention and not for compensation.

1.2 Recognised cases

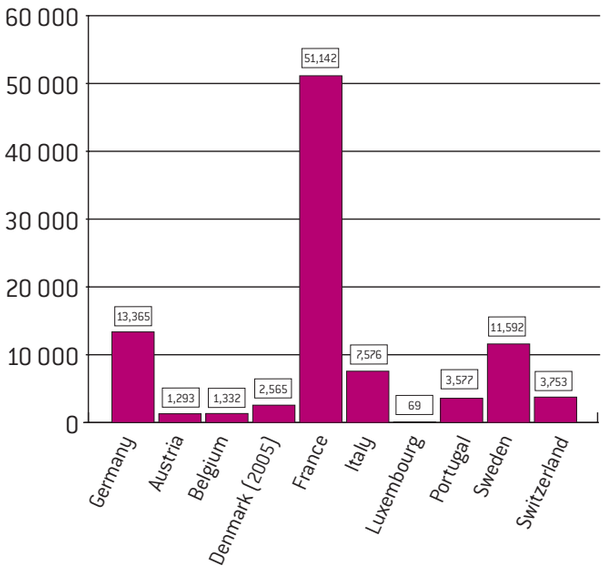
The data presented concerning the number of recognised cases of occupational diseases correspond to cases for which the recognition decision by the insurance organisation was positive in 2006, whether or not this recognition gave entitlement to benefits, and irrespective of the disability rate attributed to the victim.

This data covers cases recognised under the national lists of occupational diseases and, where applicable, those recognised under the complementary system. We may specify in this regard that Sweden has merely a proof system (no list of occupational diseases apart from infectious diseases) and that there is no complementary system in Spain, even though an off-list disease may in exceptional cases be recognised as an occupational injury.

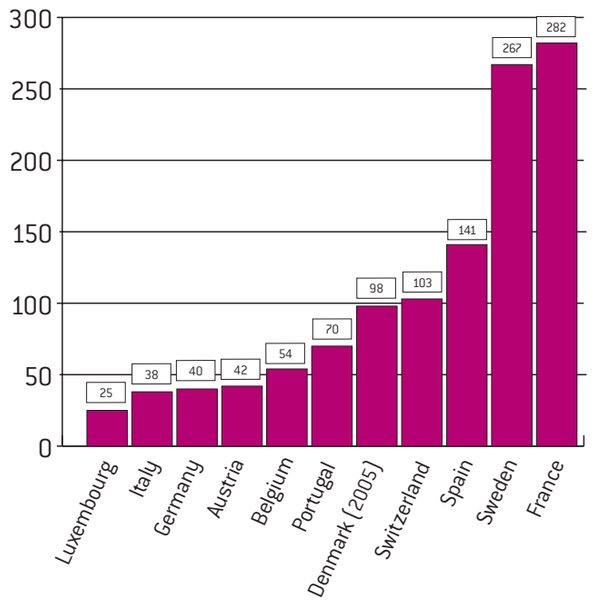
4. To find out more: *"Survey on under-reporting of occupational diseases in Europe"* (December 2002)
5. To find out more: *"Accidents at work and occupational diseases: flat rate or full reparation? European survey on the conditions of compensation for the victims"* (June 2005)

rapportanglais.indd 8 17/02/09 12:12:10

Cases recognised (2006)



Occupational diseases recognised for 100,000 insured (2006)



Here again, there is a major difference between those countries that, for a comparable insured population, recognise the most occupational diseases (France and Sweden) and those that recognise the fewest (Luxembourg, Italy, Germany, Austria and Belgium).

These disparities can without doubt be explained by legal reasons.

Content of the lists and legal criteria for recognition

Most of the cases recognised in a country are recognised under the national list of occupational diseases (except in Sweden where there is no list but a single proof system). The complementary system (under which victims must themselves prove the work-related origin of their disease) at most accounts for only between 1% and 10% of cases recognised depending on the country in question.

The content of the list on the one hand, and the legal criteria applied by the insurance organisation on the other hand, are therefore factors that will determine the number of cases recognised in a country. Now, these lists and these criteria differ greatly in Europe, because there are no binding Community regulations[6] in this area. It is true that diseases due to specific types of exposure are unanimously recognised as being of work-related origin and are therefore subject to relatively uniform conditions of recognition in Europe; this is the case in particular for asbestos-related diseases (with the exception of pleural plaques)[7].

But for other very prevalent diseases there is no consensus. For example, it can be observed that those countries that recognise the most occupational diseases are also those that recognise the most musculoskeletal disorders (MSDs): France, Spain, and to a lesser extent Sweden. And conversely, those that have a relatively low recognition ratio are often those in which few MSDs are likely to be recognised: Germany and Austria. The remainder of the study tends to confirm this predominant role of MSDs in the levels of recognition of occupational diseases. Of course, disparities are noted regarding the possibility of recognition for diseases other than MSDs, but to a lesser extent, and hence with a weaker impact on the ratios.

Other legal conditions related to recognition

Apart from the specific legal criteria for the recognition of each disease, there are in certain countries more or less restrictive conditions of recognition applicable to all occupational diseases, which can influence the total number of diseases recognised.

In nearly all the countries, recognition of the job-related nature of a disease is chiefly based on a list system. If the disease or the substance which causes it is registered on the national list, the recognition procedure will be easier for the victim, to the extent that it will be up to the insurance organisation to determine whether the disease is of work-related origin or not, and not up to the victim to provide proof of this. One may therefore speak of a certain presumption of evidence provided by this list. Now, depending on national

6. The European list of occupational diseases (Recommendation by the Commission of 19 September 2003) has merely an indicative value.
7. To find out more: *"Asbestos-related occupational diseases in Europe. Recognition - Statistics - Specific systems"* (March 2006)

rapportanglais.indd 9 17/02/09 12:12:10

regulations and the way in which the list is built, the force of this presumption of evidence varies depending on the country.

France is a country in which the list entails a very strong presumption of work-related origin, which would partly explain the country's first rank in the classification of countries recognising the most occupational diseases. Indeed, if the conditions contained in the list are complied with (namely, identification of the disease and any corresponding medical examinations, the periods of liability and jobs that could cause this disease), recognition of the job-related nature of the disease is automatic. It is true that the French insurance organisation can always provide proof to the contrary by showing that the disease is completely independent of the occupation, provided that it demonstrates the extra-occupational cause of the disease, but this procedure is very seldom undertaken.
In the other countries the lists are often less precise, and the insurance organisation will rather enquire on a case by case basis concerning the possible work-related origin of the disease. In Switzerland, for example, where the list consists of a number of harmful substances and then some generic diseases, the insurer tries to determine, for each claim, whether, of the possible causes of the disease, occupational exposure is the predominant cause (more than 50%).

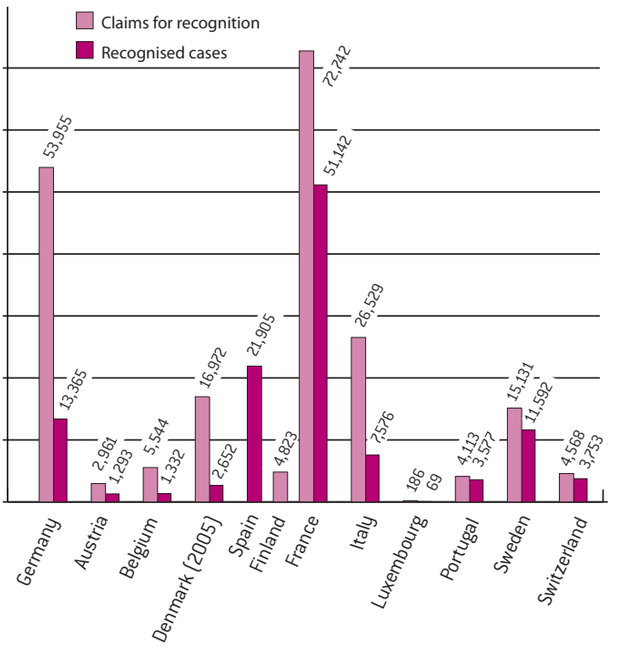
Finally, mention should be made of a feature specific to Germany and Luxembourg. For certain frequently reported diseases such as skin diseases and obstructive respiratory tract diseases, the regulations require that the severity of the disease be such that the insured is forced to give up any dangerous activity. Failing that, the benefits of the insurance organisation are confined to preventive measures (including protective medical measures required for occupational integration). Such benefits are paid frequently. These preventive measures can prevent the disease caused by work from reaching a degree of severity that would result in cessation of the occupational activity; but such situations are not formally recognised as occupational diseases and therefore do not appear in the statistics. In 2006, they accounted for 8,489 cases in Germany (compared with 13,365 cases of formally recognised occupational diseases).

1.3 Recognition rates

The recognition rate is calculated by comparing the number of cases recognised with the number of claims for recognition over a given period[8].

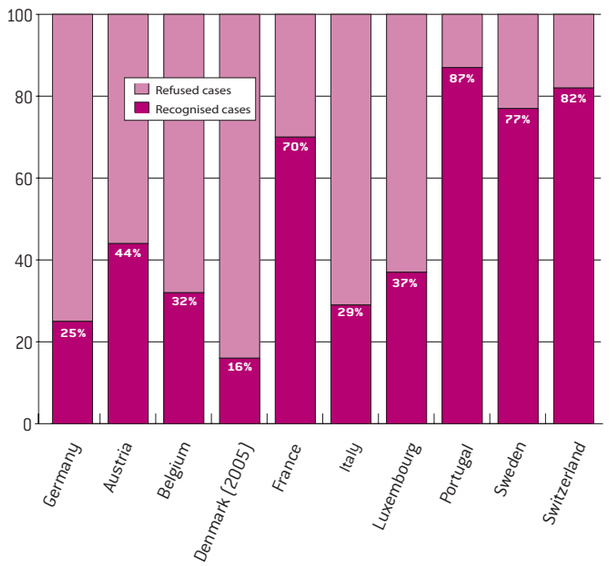
8. So as to improve the comparability of the data of this report, the same recognition rate calculation method has been used for all the countries (remember that the national methods could be different)

Claims for recognition and recognised cases (2006)



In practice, the cases recognised for a given year do not always correspond to claims for recognition submitted during the same year to the insurance organisation (due to the time needed to examine the claims). However, the calculated rate is considered as a reliable indicator to the extent that this effect of carry-over from one year to the next occurs each year.

Recognition rates (2006)



rapportanglais.indd 10 17/02/09 12:12:10

The recognition rates range from 16% in Denmark to 87% in Portugal.

It can be observed that in four countries (Portugal, Switzerland, France and Sweden), over half of the claims lead to recognition as an occupational disease.

The recognition rate is between 25% and 44% in Germany, Italy, Belgium, Luxembourg and Austria.

It is only 16% in Denmark, but it should be reminded that this country is also the one in which claims for recognition are most numerous in proportion to the insured population.

Evolution of recognition rate over a long period

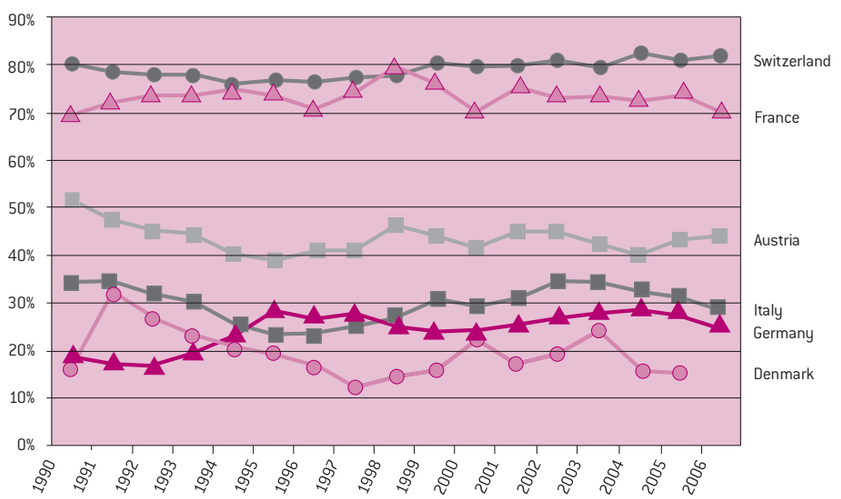
Observing this recognition rate over a long period of time (see also the tables for each country in Appendix 2), it can be seen that it is relatively stable in Germany, Austria, Denmark, France, Italy and Switzerland.

On the other hand, the recognition rate fell sharply in Sweden between 1990 and 1995, and was rather on a downward trend in Belgium throughout the period 1995-2006, while it has increased sharply in Portugal since 2004. Luxembourg is a special case insofar as the volumes are too small to draw conclusions concerning the observed variations.

The explanations for these trends may be the same as those concerning the trends in claims for recognition and numbers of cases recognised (see Section II).

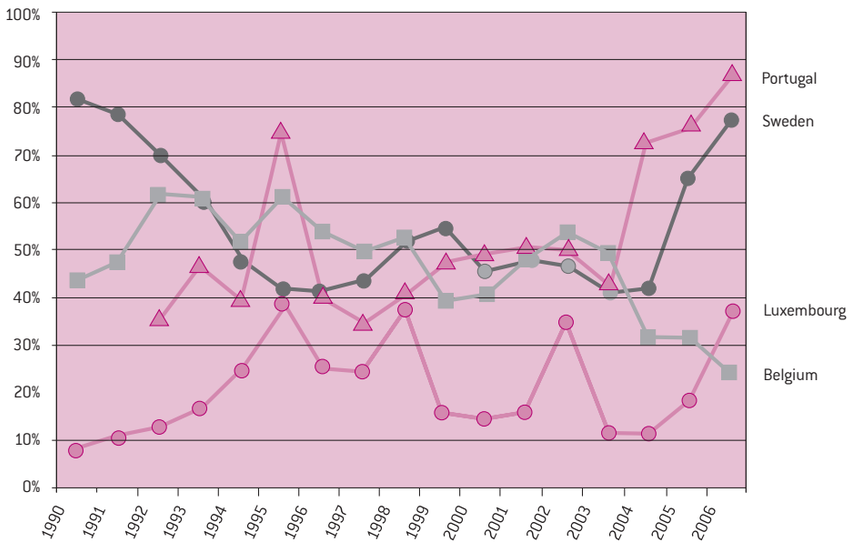
It should be specified that these overall recognition rates may cover major disparities within a given country depending on the disease in question. Thus, the tables in Appendix 3 (most frequent occupational diseases) show that some diseases have a very high recognition rate, while others for which there are a large number of claims for recognition are not found among the most frequently recognised diseases.

Countries where the evolution of recognition rate 1990-2006 is stable



rapportanglais.indd 11 17/02/09 12:12:11

Countries where the evolution of recognition rate 1990-2006 is not stable



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SECTION II

Trend for occupational diseases between 1990 and 2006

Some countries show a relative stability in the number of claims for recognition and recognised cases, while others see significant changes. The various countries have been broken down into three groups according to the trend observed over the last years.

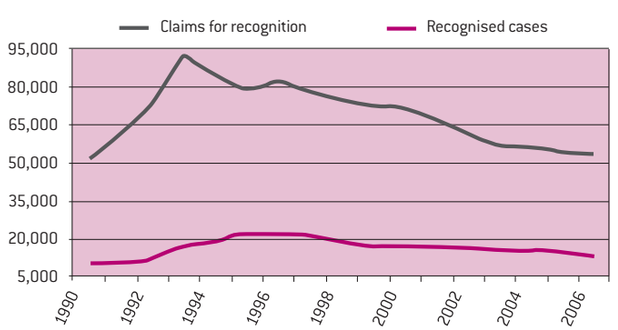
2.1 Countries in which a downward trend is observed (Belgium, Finland, Germany, Switzerland)

These countries explain that the number of occupational diseases is declining regularly because traditional work-related risks are fewer, for two reasons:

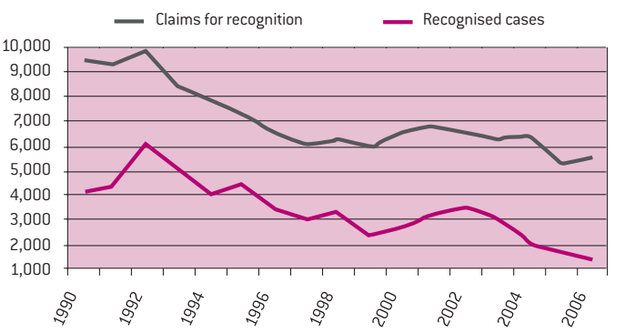
– On the one hand, efforts for prevention of traditional risks have proved successful, whether it be more demanding regulations or more efficient practices (e.g. improved medical supervision in enterprises).

– On the other hand, certain industrial activities have become scarce or have even disappeared (shutdown of coal mines, job shedding in the iron and steel industry, etc.), giving way to activities of a more intellectual nature. Now, the number of diseases caused by these old extremely dangerous jobs is not replaced by the diseases that can be caused by service sector work (lumbago, psychosocial diseases, etc.).

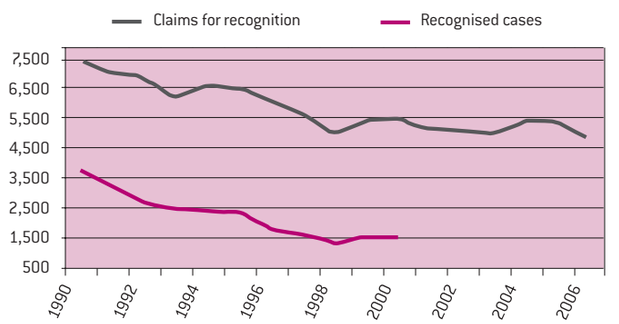
Germany



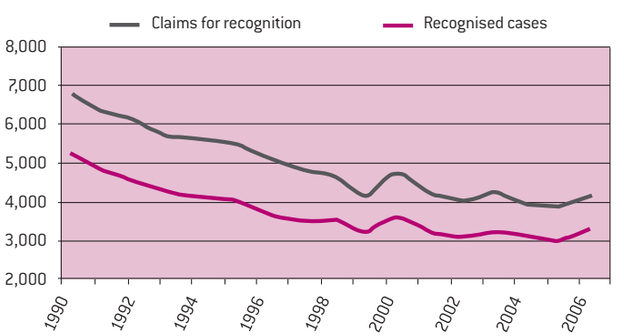
Belgium



Finland[9]



Switzerland



9. In Finland, the Federation of Accident Insurance Institutions has radically reorganised its statistical recording system in recent years, so that it is not currently possible to obtain data concerning the number of recognised cases of occupational diseases comparable with the data for the years 1990-2000.

rapportanglais.indd 13 17/02/09 12:12:11

Some details country by country

Germany

The decline in the number of occupational diseases in fact began only from the second half of the 1990s.

From 1990 to 1993, on the contrary, the number of claims for recognition increased sharply following the reunification of Germany in 1990, due to the influx of reported diseases related to ionising radiation by former employees of the uranium mines of Thuringia and Saxony. This increase can also be explained by the 1992 inclusion of spinal column complaints on the list of occupational diseases; now, since then, this has been the third most reported complaint in Germany.

In the same way, the number of diseases recognised doubled between 1990 and 1996, chiefly due to a decision by the Federal Court of Social Arbitration which resulted in a change in recognition practice: until 1992, only those complaints that required medical treatment or gave entitlement to a pension (which in Germany implies at least a 20% reduction in work capacity) were recognised as occupational diseases. Since then, this condition is no longer necessary, and diseases such as noise-induced deafness, asbestosis and silicosis - even though generally they do not require any specific medical care and result in no major disability - can be recognised as occupational diseases [10].

Switzerland

The constant and regular downward trend observed during the period 1990-2000 is confirmed, even though, in fact, it has stabilised somewhat. This decline concerns above all traumatology-related diseases (locomotor apparatus), because those due to chemical or biological factors have varied little, or even, on the contrary, are tending to increase (especially asbestos-related diseases which are expected to peak around 2015).

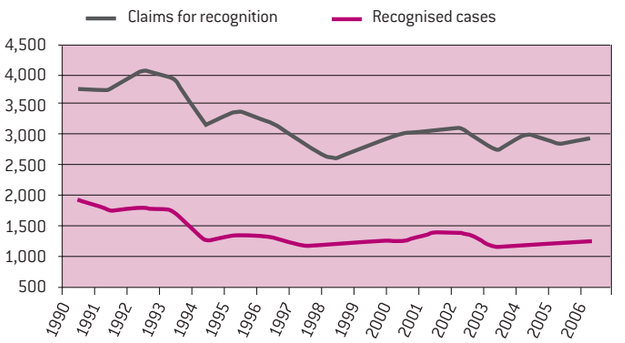
It should be added that certain specific diseases (e.g. carpal tunnel syndrome, epicondylitis, lumbago) that could weigh increasingly heavily on the statistics are recognised as occupational diseases only very restrictively in Switzerland.

10. The recognition of these diseases guarantees the insured of payment of benefits by the occupational injuries insurance organization if medical treatment subsequently proves necessary or when his (her) work capacity is greatly diminished. If the disease gets worse, the insured can file a claim with the accident insurance fund; in many cases, his (her) state of health will be subjected to regular medical monitoring.

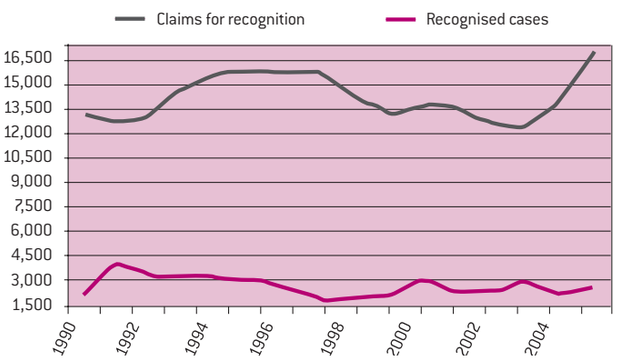
2.2 Countries that are relatively stable (Austria, Denmark, Italy, Sweden)

Although the countries mentioned below show a relative stability in claims for recognition and cases recognised in recent years, this was not always the case. And statistical effects are expected in those countries in which the list of occupational diseases has recently been profoundly altered.

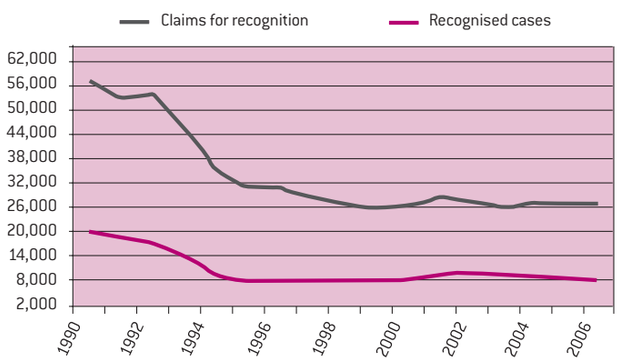
Austria



Denmark



Italy



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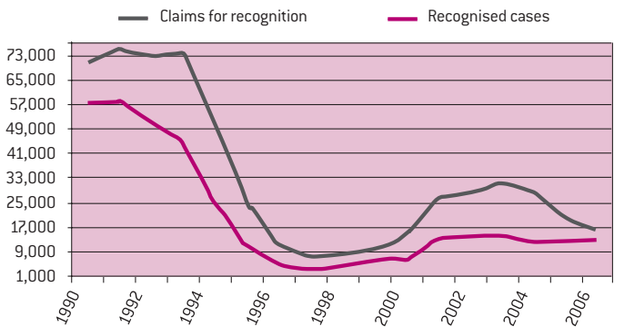
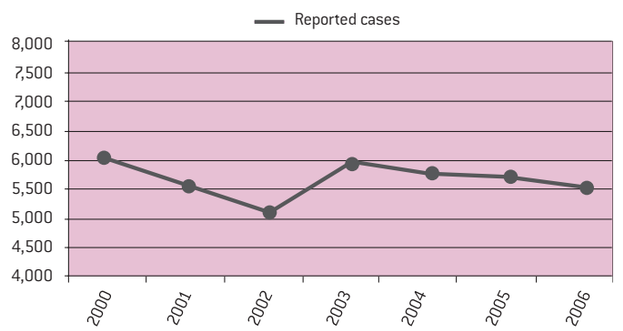
Sweden



The Netherlands



Some details country by country

Denmark

The number of occupational diseases, until now relatively stable in this country, is destined to increase insofar as one of the objectives of the workers' compensation reform adopted in 2003, which included the decision that there were to be drawn up a new list of occupational diseases, is precisely to now enable the recognition of one quarter of reported cases (as a reminder, Denmark is the European country recording by far the largest number of claims for recognition, with 626 claims per 100,000 insured). Statistical projections establish the fact that about 1000 additional cases of occupational diseases could be recognised each year. Since the reform came into effect for occupational diseases only in 2005, the first significant statistical effects are expected for 2006 or 2007 (these statistical data are not yet available). The number of claims for recognition already began to increase sharply in 2005.

Italy

Before posting stability in the number of occupational diseases, Italy experienced a period of sharp decline between 1990 and 1994 (especially in claims for recognition). This decline was due to a reduction in the number of cases of diseases classified in the list, which are mostly related to very specific types of activities for which preventive measures have been taken, or which were tending to disappear (e.g. silicosis contracted through work in the mines). On the other hand, the number of claims for recognition of off-list diseases related to new occupational risks was on the increase.

In the future, it is likely that the recent introduction of the new list of occupational diseases [11], in which the number of diseases listed increases from 58 to 85 (chiefly MSDs), will have as a consequence a gradual increase in the number of claims for recognition and cases recognised.

Sweden

The number of cases recognised has been stable since 2001. But during the decade 1990-2000 Sweden experienced a highly contrasting situation, with a sharp reversal in the trend: from 1993 to 1997, the sharp fall in the number of claims for recognition and cases recognised was the consequence of the reform of the system of recognition and compensation for work-related illnesses brought about in 1993 (but preventive measures and the economic situation undoubtedly also contributed to the observed decline). Victims now receive only health insurance compensation, except in the most serious cases (i.e. for permanent disability). The system accordingly now provides far less incentive for reporting. The 1993 reform also reversed the onus of proof; since then it has been up to the victims to prove the "highly probable" link between their disease and their occupation.
The number of reports then increased until 2003, whereas the number of cases recognised has been stable since 2001.

2.3 Countries in which an upward trend is observed (France, Luxembourg, Portugal, Spain)

Spain and France feature a regular sharp increase over the entire period 1990-2005. In Portugal, this increase in the number of occupational diseases has been observed only since 1998, and more irregularly. Given the small size of Luxembourg and the few recognised cases, the statistics of this country are hard to interpret.

11. In fact, two new lists of occupational diseases were adopted by a decree of 1st April 2008 and were published in the *Gazzetta Ufficiale* on 24 July 2008, one for the industry and service sector and the other for the agriculture sector.

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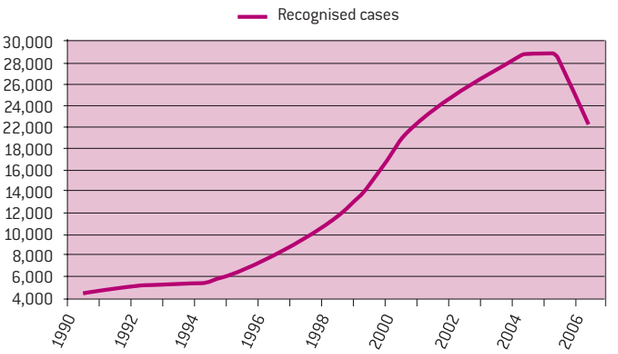
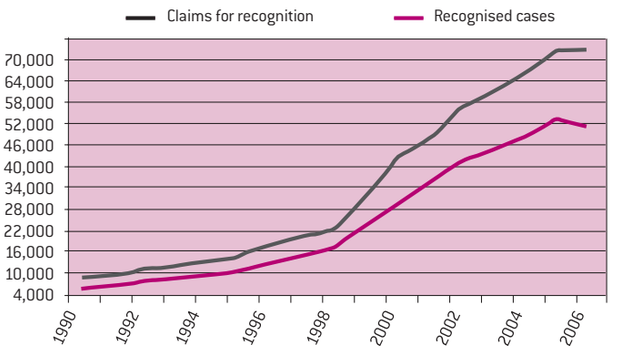
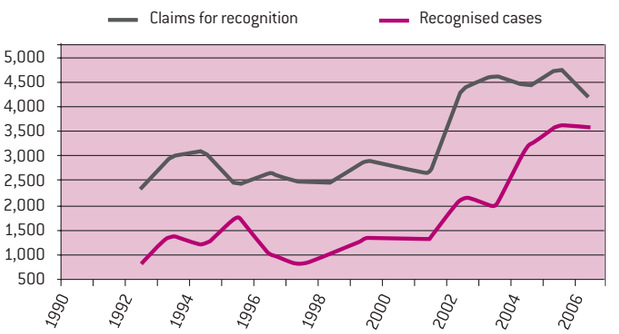
Spain



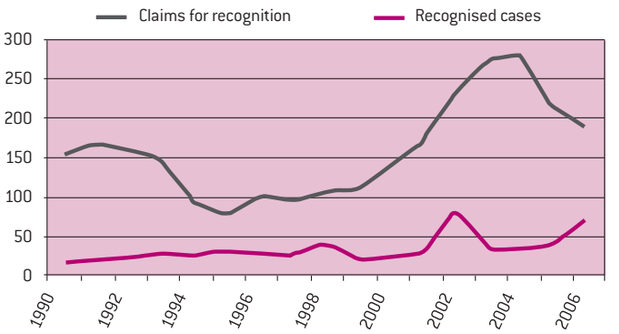
France



Portugal



Luxembourg



These countries suggest two types of explanations for this upward trend.

In general, over the last fifteen years there has been a growing awareness, among both employees and doctors, of the possible link between the occupation and the disease. And victims are increasingly aware of the system of recognition of occupational diseases and want to benefit from it.
Also, and above all, the content of the lists of occupational diseases and recognition practices in these countries obviously impact the large number of cases recognised and their exponential growth. Now, the common feature of these countries is that musculoskeletal disorders (MSDs) have for some time now formed the most commonly recognised category of occupational diseases, overwhelmingly so in the case of **Spain** (85% of total cases) and **France** (74% lower back diseases not included).

In 2005, their number had increased over 10 years by 10% to 20% each year. Several factors can explain this trend.
MSDs are the perfect example of diseases of shared aetiology, for which there are numerous risk factors, work-related or not, whose respective influence is sometimes controversial. Moreover, they receive increasing media coverage and numerous studies have been published on the subject.

On the other hand, the countries concerned must put forward the fact that in certain service activities, which are booming (such as household caretaking), the potential risks have increased as a consequence of factors such as the increase in work pace.
Finally, the working population is ageing, and there is a strong link between MSDs and the age of employees.

In addition to the growing role played by MSDs, **Portugal** considers that certain legislative changes have contributed to the marked upward trend observed since the new 1998 Act on the recognition of and compensation for occupational diseases, but especially from 2002 on. Examples of this are the agreement on working conditions, occupational health and safety and occupational risk prevention signed in 2001, with the objectives of improving the quality and reliability of statistics, the revision of the list of occupational diseases (a new list was adopted in May 2001 and reviewed in July 2007) and reinforcement of the obligation to report all cases of occupational diseases to the appropriate insurance organisation, *Centro Nacional de Portecçao contra os Riscos Profissionais* (CNPRP). The TV and radio have relayed the CNPRP message.

We might point out, moreover, that in the three countries mentioned above, the 2006 figures are for the first time lower than those for the preceding years, but this decline cannot yet be interpreted as conclusive evidence of a reversal of the trend.

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SECTION III

The most frequent occupational diseases

3.1 General overview

The following table shows the five occupational diseases most frequently recognised by each national insurance organisation in 2006.
The following charts for each country, meanwhile, make it possible to measure the various diseases most frequently recognised by each country in 2006 (see also Appendix 3) as a proportion of the total occupational diseases recognised in the country in question.
If a category of diseases does not appear in the chart for a given country, this does not mean that no case has been recognised, but merely that it is not one of the most frequent. Moreover, since the statistical classifications vary from one country to another, the same categories of occupational diseases cannot necessarily be found under the same title.

The 5 occupational diseases most frequently recognised in 2006 - General overview

	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
Germany	Hearing loss 4,971	Asbestosis and pleural plaques 1,973	Mesotheliomas 903	Silicosis 870	Lung and larynx cancers caused by asbestos 817
Austria	Hearing loss 594	Skin diseases 220	Allergic bronchial ashma 109	Respiratory diseases caused by chemical agents 81	Mesotheliomas 76
Belgium	Nerve function impairment due to pressure 292	Skin diseases 249	Hearing loss 234	Asbestos-related diseases 180	Upper limb osteoarticular disorders 179
Denmark (2005)	Skin diseases 768	MSDs 593	Hearing loss 314	Respiratory diseases 241	Cancers 135
Spain	MSDs 18,693	Skin diseases 1,405	Hearing loss 578	Respiratory diseases 345	Infectious and parasitic diseases 302
France#	MSDs 38,000	Asbestos-related diseases 6,615	Back pain 2,785	Hearing loss 1,056	Eczema due to allergy 443
Italy	MSDs 2,647	Hearing loss 2,183	Respiratory diseases 873	Cancers 767	Skin diseases 465
Luxembourg*	Infectious diseases	Asbestosis	Carpal tunnel syndrome	Periarticular diseases	Skin diseases
Portugal*	MSDs	Hearing loss	Respiratory diseases	Skin diseases	Other diseases
Sweden	MSDs 3,126	Hearing loss 440	Psychosocial disorders 307	Diseases of the digestive system 221	Respiratory diseases 156
Switzerland	Hearing loss 855	Infectious diseases 760	Skin diseases 752	Disorders of the locomotor apparatus 583	Respiratory diseases 340

Provisional figures
* Luxembourg and Portugal haven't provided statistical data for each pathology, but only a rank among the most frequently recognised diseases.

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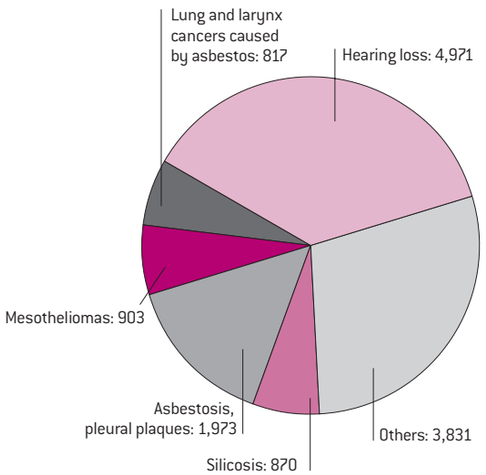
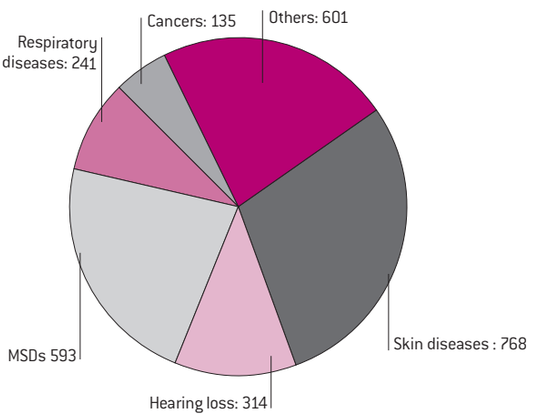
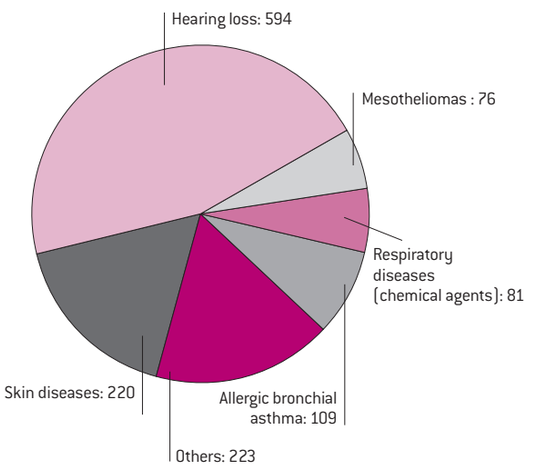
Germany



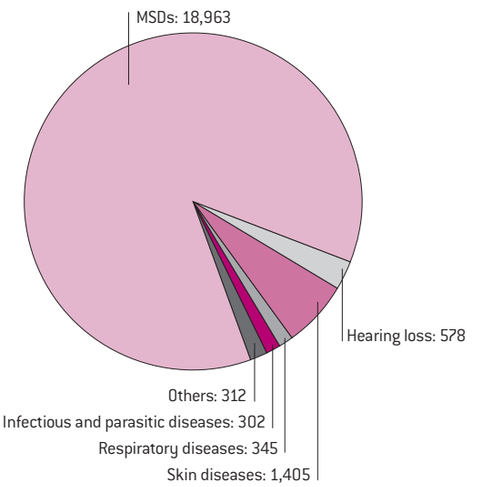
Denmark (2005)



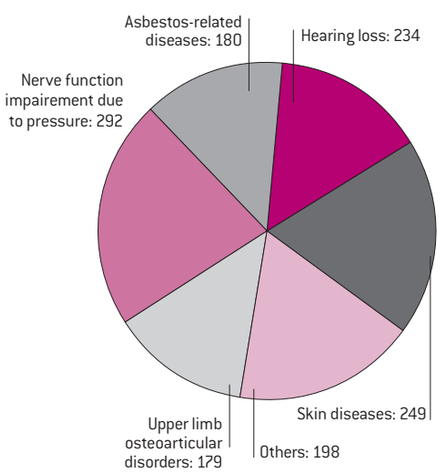
Austria



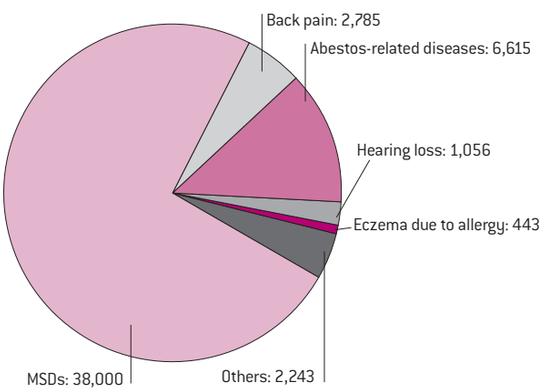
Spain



Belgium



France (provisional figures)



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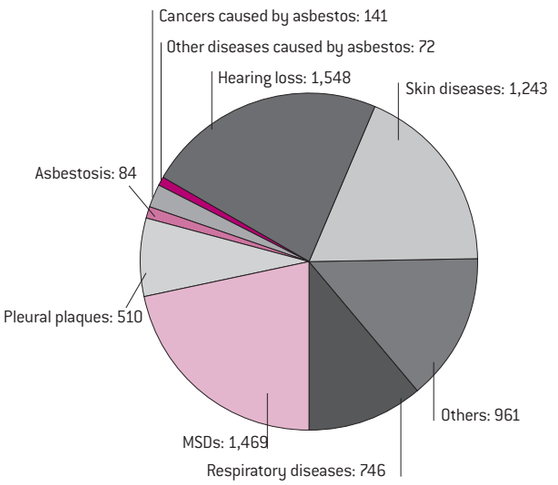
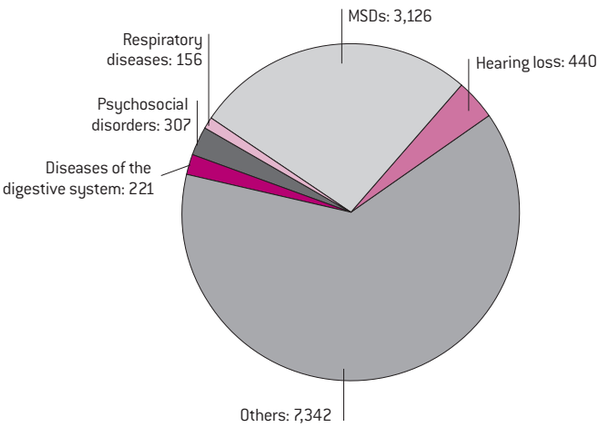
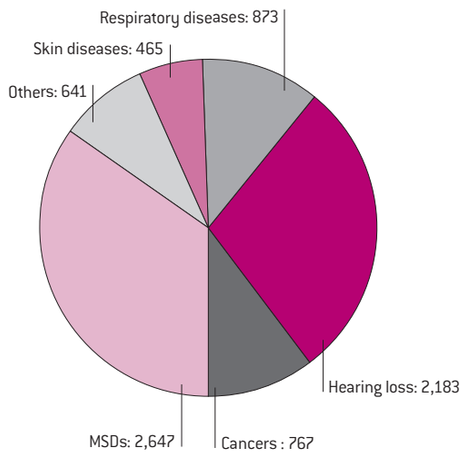
Finland (2005) [12]



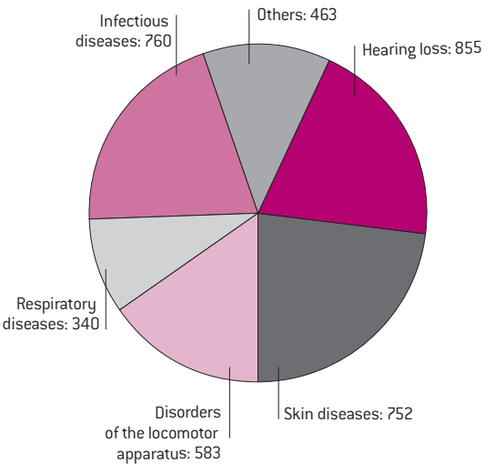
Sweden



Italy

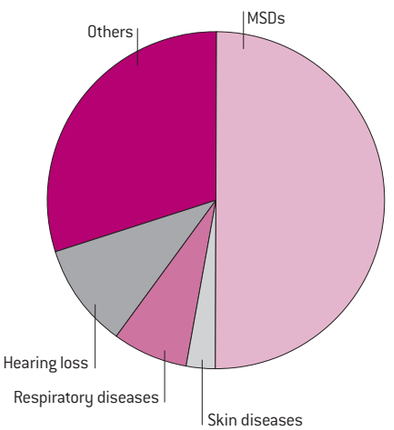


Switzerland



Portugal

(CNPRP provided this chart but not the statistical data)



12. Due to the current overhaul of the statistics system of the Federation of Accident Insurance Institutions (FAII), only the data from the Finnish Institute of Occupational Health (FIOH) is available for this study. These statistics are not completely comparable with those of the other countries, to the extent that it is the cases reported to the FIOH that are counted, and not the cases recognised by the insurance organisation. We may also specify that, in addition to the population insured by the FAII (reported cases of workers' occupational diseases), these figures cover the cases recognised by the farmers' social insurance organisation.

rapportanglais.indd 19 17/02/09 12:12:13

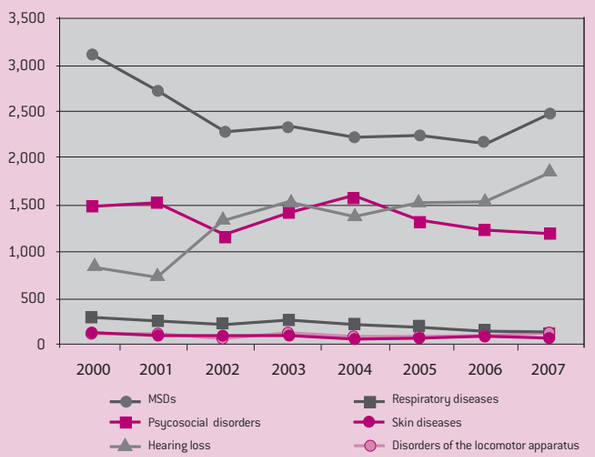
It appears, in most countries that certain types of occupational diseases by themselves account for a large proportion of recognised cases.

And it is often the same categories of frequent diseases that are found in all the countries, even though their level of importance may differ.

Currently, this concerns musculoskeletal disorders, hearing loss, asbestos-related diseases and skin diseases.

Specific case of the Netherlands

The following data concern the six categories most frequently recorded as work-related diseases over the period 2000-2006 to the Centre for Occupational Diseases.



The chart shows a downward trend in the number of MSD cases reported until 2006. This could be explained by the large-scale occupational health and safety programmes carried out in various trades at the start of the 21st century. On the other hand, the number of cases of work-related hearing loss seems to be increasing. The explanation for this can be found in industrial doctors' improved awareness of the problem on the one hand, and the existence of better programmes for monitoring the phenomenon on the other hand.

3.2 Musculoskeletal disorders

"Musculoskeletal disorders" (MSD) is a generic term referring to a set of degenerative inflammatory diseases of the locomotor apparatus. They affect the muscles, tendons and nerves of the body members and the spinal column.

The charts by country show that the incidence of MSDs in Europe is highly contrasting. They account for:
- 4/5th of recognised cases of occupational diseases in Spain (85%) and France (80% lumbago included);
- between one quarter and half of cases in Belgium (38%), Italy (35%), Portugal (50%) and Sweden (27%);
- less than one quarter in Denmark (22%) and Switzerland (15%).

In Germany and Austria, they are not mentioned among the most frequent occupational diseases.

In Europe, the term MSDs covers very different situations in terms of recognition and compensation.
Among the MSDs most frequently registered on the lists of occupational diseases can be found firstly tendinous complaints (tenosynovitis, tendinitis, epicondylitis). Then come nervous complaints (carpal tunnel syndrome), bursitis (of the knee and elbow), back pains and vascular complaints.
It therefore seemed advisable to target this study on six types of common complaints: carpal tunnel syndrome, bursitis, epicondylitis, tenosynovitis, meniscopathy and lumbago.
These complaints are all registered on the European list of occupational diseases, even though lumbago can be found only in Annex 2, i.e. in the list of diseases suspected as being of work-related origin, which must be reported and which eventually could be included in Appendix 1.

For each of these complaints, the work of comparison was not easy for several reasons:
- The expressions employed in the national lists are not always comparable;
- The criteria for recognition are very heterogeneous;
- The countries have not always been able to provide the requested information, in particular the criteria for recognition and the precise statistics on recognised cases.

Some information on compensation data have been provided by France, Denmark and Switzerland. Each of the above countries is representative according to the different levels of recognition, as far as France recognises MSDs as occupational diseases a lot, Denmark moderately and Switzerland very little.

Carpal tunnel syndrome
The carpal tunnel syndrome is an injury affecting the hand and wrist; it is due to compression of the median nerve at the wrist level. It is one of the most frequent skeletal disorders.

The job-related nature of this disease can be recognised under the list system in Austria, Belgium, Denmark (since 1993), Finland (since 2003), France (since 1982), Italy (since July 2008), Luxembourg, Portugal (since 2007), Spain and Switzerland (since 1984).

rapportanglais.indd 20 17/02/09 12:12:13

In **Belgium**, a change of terminology for the disease in the list, made at the end of 2002, permitted more extensive recognition of the carpal tunnel syndrome. Until then, the title "nerve paralysis due to pressure" allowed the Occupational Disease Fund to pay compensation only for "motor" cases of carpal tunnel syndrome, to the extent that damage to motor nerve transmission causing paralysis phenomena was necessary. Now, in practice, this disease always begins with sensory conduction disorders and at this stage it can be treated with a good chance of successful complete healing. Accordingly, since 2002, with the new title "damage to the nerve function due to pressure", all claims for recognition for sensory and/or motor carpal tunnel give entitlement to compensation under the list system, provided that they be accompanied by an electromyogram demonstrating the disease.

In **Finland**, the carpal tunnel syndrome is recognised as an occupational disease only if the work has contained prolonged movements which significantly deviate from the centre position of the wrist and strain the wrist. In practice, the recognition usually also implies that the exposure has continued for at least six months.

In **France**, exposure to the risk must have been habitual, but for this disease there is no minimum exposure period. The restrictive list of work refers to tasks customarily involving either repeated or prolonged movements of extension of the wrist or gripping with the hand, or pressing on the median nerve, or prolonged or repetitive pressure on the heel of the hand. There is an administrative condition for recognition: a period of "eligibility" of 30 days (i.e. the time between the end of exposure and the date of the first medical evidence).

In **Italy**, the new list of July 2008 requires that the tasks causing the disease be performed regularly, and involve repetitive or prolonged movements of the thumb or gripping with the hand, maintaining awkward postures, prolonged pressing or repetitive impacts on the median nerve. The maximum period of "eligibility" for compensation after the date of termination of exposure to the risk is set at two years.

In **Portugal**, the national list contains an indicative list of work; there is also a condition known as the "characterisation period" which sets a maximum period of 30 days between the end of the exposure and the claim for recognition.

In **Switzerland**, established precedents include the carpal tunnel syndrome in the "peripheral nerve paralysis by pressure" category mentioned in the list of occupational diseases. As regards risky occupational exposure, the chief activities in question are highly repetitive work and work performed with the wrist in an extreme position and which require strength.

The specific causes of a carpal tunnel syndrome (e.g. diabetes) should be excluded as differential diagnosis. And major predisposing factors such as bilaterality should be taken into account at the time of the procedure of recognition.

Denmark

The new 2005 list of occupational diseases refers, for qualification of the carpal tunnel syndrome as an occupational disease, to the following situations of exposure to risk:

- Work with heavily vibrating, hand-held tools for a considerable period of time.
- A combination of quickly repeated, strenuous and/or awkward, wrist-loading work movements for a considerable period of time. The condition of strenuousness can be attenuated if the work has been repeated rapidly and performed in stressful work postures. Likewise, the condition relating to repetition can be attenuated if the work has been tiring and/or uncomfortable.
- Work with objects leading to a direct and persistent pressure on the median nerve of the carpal tunnel for a considerable period of time.
- The disease can be recognised as a complication to tenosynovitis at the flexion side of the wrist when this disease is recognised on the basis of the list.

In theory, the exposure must have lasted over a consecutive period of at least two years, but this condition can be adapted if the exposure has been intense.

All the conditions of recognition were relaxed in 2005, when the requirement of the monotonous nature of the work was eliminated. Now, the work must simply have caused significant stress during at least half of the day, but there may have been different activities during that workday. And the conditions relating to the strenuousness and repetitiousness of the work were attenuated.

If the conditions relating to exposure are not met, the case may in specific situations be submitted to the Occupational Disease Committee and in special cases be qualified for recognition.

rapportanglais.indd 21 17/02/09 12:12:13

Carpal tunnel syndrome: number of cases recognised between 1992 and 2006

	Austria[13]	Denmark	France	Italy[15]	Switzerland
1992	–	17	–	–	–
1993	–	27	–	–	–
1994	–	35	–	–	–
1995	–	55	–	–	–
1996	–	53	–	–	–
1997	–	35	3,907	–	16
1998	–	25	4,517	–	18
1999	–	39	5,664	130	10
2000	10	55	7,374	170	8
2001	8	52	8,446	212	14
2002	9	52	10,147	409	9
2003	9	63	11,293	446	13
2004	8	65	12,460	558	14
2005	14	87	14,460	471[16]	8
2006	9	77	13,770[14]	454[17]	8[18]

In **Denmark**, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for a carpal tunnel syndrome is generally between 5% and 20%. The typical rate is 5%, and it seldom exceeds 12%. When it exceeds 20%, this is often a bilateral syndrome. As regards the compensation for loss of earning capacity (occupational prejudice), the rates attributed were between 15% and 80% in 2007, on average around 25%, but usually 15%.

In **Switzerland**, the carpal tunnel syndrome gives entitlement to payment of medical expenses and daily benefits (for temporary work disability). A single case justified the payment of a disability pension (for permanent/long-term work disability) after 1118 days' compensation (in 2002).

13. In Austria, recognised carpal tunnel and tenosynovitis cases are entered under the same statistical code.
14. Provisional figure.
15. Sector of industry and sector of agriculture combined.
16. Provisional figure.
17. Provisional figure.
18. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

Cost of benefits paid for the carpal tunnel syndrome in 2006

Country	Total cost of occupational diseases	Cost of carpal tunnel syndrome	Cost of carpal tunnel syndrome as a % of total cost of ODs
Denmark • of which physiological damage • of which loss of earning capacity	€98,084,712	€3,158,232 €2,573,159 €585,073	3.2%
France (healthcare and daily benefits only)	€374,763,550	€75,423,337	20.1%
Switzerland (2005) Average cost per case	€69,054,472	€419,635 €52,455	0.61%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

Bursitis

Bursitis is an inflammation of the bursae that are located between the tendons and the bones to enable the tendons to move easily and without any friction over the surface of the bones. These bursae can be found in the knees, elbows, shoulders and wrists. If the tendons thicken or become gnarled due to an excessive effort, the bursae are subjected to friction which may cause them to become inflamed.

The job-related nature of this disease can be recognised under the list system in **Austria**, **Belgium** (since 1989), **Denmark** (since 1995), **France** (since 1972 for the knee and since 1982 for the elbow), **Germany**, **Italy** (since July 2008), **Luxembourg**, **Spain** and **Switzerland** (since 1984), and under the complementary system in **Portugal**.
In **Finland**, bursitis is not recognised as an occupational disease. However, bursitis of the knee or the elbow can be compensated as a special kind of accident at work. The criteria for recognition of bursitis of the knee or the elbow as an accident at work are that it is caused by constant or repetitive or exceptional pressure on the knee or elbow, and that it has developed under a short period of time, maximum 24 hours.

In **Belgium**, the victim's work station is examined physically and exposure to repeated pressures is looked for at the location of the bursitis. Although there is no restrictive list of work, exposure is, for example, typically taken into account for tile layers for pre-patellar bursitis.

In **Denmark**, recognition of the job-related nature of a bursitis implies a persistent external pressure (for example against the kneecap) for days or longer. The stressful work must have been performed for at least half of the working day.

rapportanglais.indd 22 17/02/09 12:12:13

In **France**, the syndromes covered by the list are acute hygroma of the bursae or inflammatory attack of the subcutaneous tissues of the elbow or knee support zones, and chronic hygroma of the bursae of the elbow and knee. The exposure situations that could lead to qualification as an occupational disease are tasks habitually involving prolonged leaning on the lower surface of the elbow, and tasks habitually involving prolonged leaning on the knee, respectively. The exposure must be habitual, but there is no minimum duration. There is an administrative condition for recognition: a period of "eligibility" of 7 days for acute hygroma and 90 days for chronic hygroma (i.e. the time between the end of exposure and the date of the first medical evidence).

In **Italy**, the new list of July 2008 requires that the tasks causing the disease be performed regularly, and involve, for bursitis of the knee, prolonged pressing on the knee, and for bursitis of the upper extremity repetitive movements involving loading of the shoulder or the maintenance of awkward postures for a long time. The maximum period of "eligibility" for compensation after the date of termination of exposure to the risk is set at two years.

Bursitis: number of cases recognised between 1992 and 2006

	Austria [19]	Denmark (knee)	France	Italy [21]	Switzerland	of which knee	of which elbow
1992	-	1	-	-	-	-	-
1993	-	1	-	-	-	-	-
1994	-	1	-	-	-	-	-
1995	-	1	-	-	-	-	-
1996	-	21	-	-	-	-	-
1997	-	17	848	-	277	268	9
1998	-	16	763	-	299	282	17
1999	-	12	909	79	271	259	12
2000	0	12	870	188	237	227	10
2001	7	12	892	308	235	225	10
2002	5	7	925	728	240	232	8
2003	16	17	845	712	233	224	9
2004	10	16	872	791	220	207	13
2005	10	17	830	969 [22]	204	197	7
2006	12	11	756 [20]	966 [23]	208 [24]	205	3

19. In Austria, recognised cases of bursitis and epicondylitis are entered under the same statistical code.
20. Provisional figure.
21. In Italy, recognised cases of bursitis of the elbow and tenosynovitis of the elbow are entered under the same statistical code.
22. Provisional figure.
23. Provisional figure.
24. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

In **Switzerland**, the essential criterion for recognition of a bursitis of the knee as an occupational disease is long or repetitive work in kneeling position in a high-risk occupation, such as tile laying for example. Likewise, for bursitis of the elbow, the condition of constant pressure on the elbow during work must be complied with. No minimum period of exposure is defined, but in most cases (chronic) bursitis develops after a long period of constant pressure.

In **Denmark**, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for a bursitis is generally between 5% and 12%. As regards the compensation for loss of earning capacity (occupational prejudice), the rare cases that have received compensation have always been at a rate of less than 50%, usually around 15%.

In **Switzerland**, bursitis gives entitlement to payment of medical expenses and daily benefits (for temporary work disability). Four cases justified the payment of a disability pension (for permanent/long-term work disability) after on average 400 days' compensation (in 1996, 2004, 2005 and 2006).

Cost of benefits paid for bursitis in 2006

Country	Total cost of occupational diseases	Cost of bursitis	Cost of bursitis as a % of total cost of ODs
Denmark (physiological damage only)	€98,084,712	€19,879	0.02%
France (healthcare and daily benefits only)	€374,763,550	€2,707,746	0.7%
Switzerland (2005)	€69,054,472	€771,513 Of which elbow: 11,483 Average cost/elbow case: 1,640 Of which knee: 760,030 Average cost/knee case: 3,858	1.1%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

Tenosynovitis

Tenosynovitis is defined as an inflammation of the synovial sheath, which is the membrane surrounding certain tendons, making it easier for them to slide.

The job-related nature of this disease can be recognised under the list system in **Germany**, **Austria**, **Denmark** (since 1989), **Spain**, **Finland**, **France** (since 1991), **Luxembourg** and **Switzerland** (since 1984), **Portugal** (since 1980), and under

rapportanglais.indd 23 17/02/09 12:12:14

the complementary system in **Belgium** (since 1991) and **Italy**.

In **Belgium**, tenosynovitis is recognised only if it follows a tendinitis, and it is up to the person concerned to provide proof that they are affected by the disease (only show artists benefit from the list system for this disease). The disease must be directly and decisively a consequence of the harmful factor mentioned, and the harmful factor taken into account for De Quervain's tendinitis, for example, is repeated use of the thumb with active extreme abduction/extension of the thumb, the wrist being in position of dorsal flexion.

In **Denmark**, the type of exposure taken into consideration for the recognition of tenosynovitis is work involving strenuous and repetitive movements. Whether the working posture was awkward for the hand/forearm will also be taken into consideration.

In **Finland**, tenosynovitis is recognised only if the work has contained repetitive, unilateral (i.e. monotonous) or exceptional (i.e. new kind of) and strenuous movements prior to the appearance of symptoms.

In **France**, recognition of tendinitis and tenosynovitis of the hand (and finger) and the wrist implies that the exposure has been habitual, but there is no minimum duration. This exposure consists of tasks involving repeated or prolonged movements of the flexor or extensor tendons of the hand and fingers. There is an administrative condition for recognition: a period of "eligibility" of 7 days (i.e. the time between the end of exposure and the date of the first medical evidence).

In **Germany** and **Luxembourg**, recognition of diseases of the synovial sheaths or peritendinous tissues and tendinous or muscle attachments is possible only on condition that the worker's state of health requires that he (she) abandon any activity which has had or which may have a causal relationship with the origin, aggravation or recurrence of the disease.

In **Portugal**, the national list contains an indicative list of work; there is also a condition known as the "characterisation period" which sets a maximum period of 3 months between the end of the exposure and the claim for recognition.

In **Switzerland**, synovitis and tenosynovitis of the forearm are recognised under the list system if they are accompanied by crepitations. In the absence of crepitations, it is the complementary system that applies; in practice, the recognition rate is high for the former and relatively low for the latter. Note that De Quervain's stenosing tenosynovitis can be recognised under the complementary system.

Tenosynovitis: number of cases recognised between 1992 and 2006

	Austria[25]	Denmark	France	Italy[27]	Portugal	Switzerland (forearm)	with crepitations	without crepitations
1992	-	43	-	-	-		-	-
1993	-	38	-	-	-		-	-
1994	-	62	-	-	-		-	-
1995	-	34	-	-	-		-	-
1996	-	26	-	-	-		-	-
1997	-	21	3,356	-	-	557	*351*	*206*
1998	-	28	4,181	-	-	554	*358*	*196*
1999	-	25	5,241	79	-	491	*332*	*159*
2000	10	24	7,161	188	-	454	*302*	*152*
2001	8	21	8,782	308	-	448	*293*	*155*
2002	9	22	10,887	728	-	337	*213*	*124*
2003	9	21	11,597	712	-	30	*219*	*111*
2004	8	26	12,145	791	-	317	*211*	*106*
2005	14	31	13,512	969[28]	235	265	*170*	*95*
2006	9	31	13,843[26]	966[29]	153	196[30]	*147*	*49*

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

25. In Austria, recognised tenosynovitis and carpal tunnel cases are entered under the same statistical code.
26. Provisional figure.
27. In Italy, recognised cases of tenosynovitis of the elbow and bursitis of the elbow are entered under the same statistical code. Sector of industry and sector of agriculture combined.
28. Provisional figure.
29. Provisional figure.
30. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

rapportanglais.indd 24 17/02/09 12:12:14

In **Denmark**, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for a tenosynovitis is generally between 5% and 12%. Few cases exceed 12%. When this is the case, a bilateral tenosynovitis is often involved. As regards the compensation for loss of earning capacity (occupational prejudice), the rates attributed were between 15% and 65% in 2007, usually around 25%.

In **Switzerland**, tenosynovitis gives entitlement to payment of medical expenses and daily benefits (for temporary work disability). A single case (recognised under the complementary system in 2003) justified the payment of a disability pension (for permanent/long-term work disability) after 947 days' compensation.

Cost of benefits paid for tenosynovitis in 2006

Country	Total cost of occupational diseases	Cost of tenosynovitis	Cost of tenosynovitis as a % of total cost of ODs
Denmark	€98,084,712	€966,265	1%
• of which physiological damage		€132,834	
• of which loss of earning capacity		€17,813	
France (healthcare and daily benefits only)	€374,763,550	€ 146,815,259	39.2%
Switzerland	€69,054,472	€1,028,920	1.5%
• of which cases with crepitations		€580,129 average cost per case: €3,412	
• of which cases without crepitations		€448,791 average cost per case: €4,724	

Exchange rate at 6 june 2008 : 1 DKK = €0,134 1 SF = €0,617

Epicondylitis

Epicondylitis is a painful inflammation of the elbow tendons. It can be considered as a complaint of particularly multifactorial origins, in which age and individual physical constitution play an essential role.

The job-related nature of this disease can be recognised under the list system in **Austria**, **Denmark** (since 1989), **Finland**, **France** (since 1982), **Germany**, **Italy** (since July 2008), **Luxembourg**, **Portugal** and **Spain**, and under the complementary system in **Belgium** (since 1991) and **Switzerland** (since 1984).
In **Belgium**, epicondylitis must be directly and decisively the consequence of repeated movements of strong gripping and dorsal flexion of the wrist.

The exposure to this harmful factor must be inherent in exercise of the occupation of the applicant and greater than that of the population in general (a typical occupation concerned by this disease is that of checkout clerk); the work station will undergo a physical examination.

In **Denmark**, the type of exposure taken into consideration for the recognition of epicondylitis is work in the form of exertion in combination with either repeated or awkward work movements, or static work which is stressful for the elbow in a relevant way. The requirement regarding the duration of exposure (some weeks or months) depends on the nature and severity of the exposure, but the stressful work must in principle have been performed for at least half of the working day. Generalised or diffuse pain cannot be recognised on the basis of the list (regarding this subject, cases of epicondylitis due to intensive work with a computer mouse have already been recognised under the complementary system).

In **Finland**, the recognition of epicondylitis implies the same criteria as tendinitis: the work must contain repetitive, unilateral or exceptional and strenuous movements.

In **France**, the recognition of epicondylitis implies that the exposure has been habitual, but there is no minimum duration. This exposure consists of tasks involving repeated grasping or extension movements of the hand on the forearm or movements of supination and pronosupination. There is an administrative condition for recognition: a period of "eligibility" of 7 days (i.e. the time between the end of exposure and the date of the first medical evidence).

In **Italy**, the new list of July 2008 requires that the tasks causing the disease be performed regularly, and involve repetitive movements of the forearm and/or strong gripping actions by the hand. The maximum period of "eligibility" for compensation after the date of termination of exposure to the risk is set at two years.

In **Switzerland**, as for any disease/exposure which does not appear on the list, the causal role played by the occupational activity in the origin of the disease must be at least 75%. Very restrictive criteria [31] are applied, because in theory epicondylitis is not considered as an occupational disease. Each case must be assessed individually by a doctor, and an in-depth knowledge of the work station of the affected person is necessary to assess in detail the actual occupational risk.

31. The medical criteria for recognition were published in 2000 by the Suva in its "Medical Information" *(E. Bär and B. Kiener, "Epicondylitis is not an occupational disease; a paradigm change on the medical level)*.

rapportanglais.indd 25 17/02/09 12:12:14

Epicondylitis: number of cases recognised between 1992 and 2006

	Austria[32]	Denmark	France	Switzerland
1992	–	67	–	–
1993	–	111	–	–
1994	–	119	–	–
1995	–	147	–	–
1996	–	112	–	–
1997	–	86	1,781	32
1998	–	97	2,154	37
1999	–	93	2,757	31
2000	0	80	3,607	35
2001	7	92	4,157	32
2002	5	55	4,854	22
2003	16	79	5,330	30
2004	10	81	5,438	19
2005	10	109	6,016	25
2006	12	123	6,014[33]	19[34]

In **Denmark**, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for an epicondylitis is generally between 5% and 12%. It seldom exceeds 15% (except in the case of bilateral epicondylitis). As regards the compensation for loss of earning capacity (occupational prejudice), the rates attributed were between 15% and 80% in 2007, usually around 25%.

In **Switzerland**, epicondylitis gives entitlement to payment of medical expenses and daily benefits (for temporary work disability). No case has led to the allocation of a disability pension (permanent/long-term loss of earning capacity).

32. In Austria, recognised cases of epicondylitis and bursitis are entered under the same statistical code.
33. Provisional figure.
34. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

Cost of benefits paid for epicondylitis in 2006

Country	Total cost of occupational diseases	Cost of epicondylitis	Cost of epicondylitis as a % of total cost of ODs
Denmark	€98,084,712	€6,089,084	6.2%
• of which physiological damage		€501,825	
• of which loss of earning capacity		€5,587,259	
France (healthcare and daily benefits only)	€374,763,550	€38,952,597	10.4%
Switzerland (2005) Average cost per case	€69,054,472	€361,213 €14,449	0.5%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

Meniscopathy

The meniscus is the cartilage of certain knee joints. The job-related nature of meniscus diseases can be recognised under the list system in **Germany**, **Austria**, **Denmark** (since 1989), **France** (since 1985), **Italy** (since July 2008), **Luxembourg** and **Spain**, and under the complementary system in **Belgium** (since 1991), **Portugal** and **Switzerland** (since 1984). Meniscus diseases are usually not recognised as occupational diseases in **Finland**, despite the fact that a complementary system exists.

In **Belgium**, meniscopathy complaints are not recognised as such, but can be taken into consideration as part of a claim for recognition of a gonarthrosis. The disease must be directly and decisively the consequence of the harmful factor mentioned, and the harmful factor taken into account for gonarthrosis is repeated kneeling or squatting and straightening-up movements. These movements are weighted by their frequency, duration, percentage of time, and the number of years' exposure. The exposure to this harmful factor must be inherent in exercise of the occupation of the applicant and greater than that of the population in general, and the work station will undergo a physical examination (tile layers' work is considered a typical exposure in this instance).

In **Denmark,** the onset of the meniscus disease can be relatively acute, but it can develop into a chronic condition. The victim must have worked in a squatting position under cramped conditions for days or longer.

In **France**, the diseases that can be recognised are chronic meniscus lesions of a degenerative nature, and their complications: cracking or rupture of the meniscus. The initial criteria relating to exposure required that the work

rapportanglais.indd 26 17/02/09 12:12:15

that caused the disease have been performed habitually in a kneeling or squatting position in underground mines. In 1991, the requirement of work in underground mines was eliminated. However, the work performed must now involve exertion or the carrying of loads. There is an administrative condition for recognition: a period of "eligibility" of 2 years (i.e. the time between the end of exposure and the date of the first medical evidence).

In Germany, lesions of the meniscus can be recognised as an occupational disease in the case of physical labour, either repeated or sustained over several years, imposing strain upon the knee joints.

In Italy, the new list of July 2008 requires that the tasks causing the disease be performed regularly, and involve repetitive extension or flexion movements of the knee and/or maintaining awkward postures. The maximum period of eligibility for compensation after the date of termination of exposure to the risk is set at two years.

In Luxembourg, the list mentions meniscus lesions due to overstraining of the knee joints after prolonged exposure over several years or frequently repeated exposure.

In Switzerland, meniscopathy complaints are considered as very predominantly of a degenerative nature, independent of work-related mechanical influences. They can therefore be recognised only under the complementary system, and in fact very few cases are recognised (only 7 cases recognised in ten years).

Meniscopathy complaints: number of cases recognised between 1997 and 2006
(Unavailable data between 1992 and 1996)

	Austria	Denmark	France	Switzerland
1997	–	1	123	0
1998	–	4	115	0
1999	–	1	150	0
2000	4	3	210	1
2001	6	3	254	1
2002	8	2	320	1
2003	9	1	332	3
2004	6	4	373	0
2005	13	8	406	0
2006	8	7	408[35]	1[36]

35. Provisional figure.
36. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

In Denmark, most of the cases are attributed a permanent disability rate (measuring the physiological damage and loss of amenities of life) of 5%. As regards the compensation for loss of earning capacity, the rare cases that have received compensation on these grounds have always been at a rate of between 15% and 40%, and generally around 20-25%.

In Switzerland, too few cases are recognised to be able to establish the slightest profile.

Cost of benefits paid for meniscopathy complaints in 2006

Country	Total cost of occupational diseases	Cost of meniscopathy complaints	Cost of meniscopathy complaints as a % of total cost of ODs
Denmark	€98,084,712	€337,026	0.3%
• of which physiological damage		€31,754	
• of which loss of earning capacity		€305,273	
France (healthcare and daily benefits only)	€374,763,550	€3,314,972	0.9%
Switzerland (2004)	€58,510,846	€19,409	0.03%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

Lumbar complaints

Most countries liable to recognise the job-related nature of certain lumbar complaints take into consideration two types of occupational exposure: vibrations transmitted to the whole body and the carrying of heavy loads.
The job-related nature of certain lumbar complaints can be recognised under the list system in Belgium (since 1974), Denmark (since 1999), France (since 1999), Germany (since 1992) and Italy (since July 2008), and under the complementary system in Portugal and Switzerland (since 1984). Such recognition is in practice not possible in Austria, Finland, Luxembourg and Spain.

In Denmark, degenerative arthritis of the spine, back pain or other diseases of the spine or of discs of other vertebrae than of the neck can be recognised as occupational diseases. The diagnoses concerned include the following: lumbago/sciatica, lumbar prolapsed disc (lumbar rachis) and degeneration of the low back (osteochondrosis, spondylosis, spondyloarthrosis, spinal stenosis). Furthermore, there must be daily or frequent pain.

rapportanglais.indd 27 17/02/09 12:12:15

The new 2005 list defines types of exposure which have in particular been made slightly more flexible for workers in the personal healthcare sector:

- Heavy back-loading lifting work with lifting/upward pulling of heavy objects. The work must usually have involved a total daily lifting load of at least 8-10 tons for 8-10 years.
- Very heavy back-loading lifting work with extremely heavy and awkward single lifts. The work usually needs to have involved a total daily lifting load of at least 3 tons a day for at least 8 years.
- Back-loading care work with usually at least 20 daily handlings of adults or older handicapped children aged 8-10 years.
- Back-loading whole-body vibrations from heavily vibrating vehicles for usually at least 8-10 years.

In **France**, the types of lumbar complaints whose occupational nature can be recognised are L4-L5 or L5-S1 herniated disc sciatica with radicular injury and L2-L3 or L3-L4 or L4-L5 herniated disc crural radiculalgia with radicular injury. A five year regular exposure to low- and medium-frequency whole-body vibrations or to heavy loads manual handling is required, and a restrictive list of tasks accompanies each of these types of exposure. There is an administrative condition for recognition: a period of "eligibility" of 6 months (i.e. the time between the end of exposure and the date of the first medical evidence). Lumbar complaints occurring suddenly (with or without hernia) are usually reported and recognised as occupational injuries.

In **Germany**, discogenic conditions of the lumbar spine can be recognised as occupational diseases if they are caused by the lifting or carrying of heavy loads over many years or by performance of work for many years in an extreme bent posture, or caused by predominately vertical vibration of the entire body in a seated position over many years.
The occupational nature of the disease is recognised only if the condition is so severe as to have forced the affected individual to refrain from any activity which led or could lead to the development, aggravation or recurrence of the condition.

In **Italy**, the new list of July 2008 requires that the lumbar disc hernia be caused either during tasks performed regularly on machinery exposing the operator to vibrations transmitted to the whole body (material handling machinery, tractors, port cranes, lift trucks, coastal and deep-sea industrial fishing vessels), or during tasks involving manual handling of loads performed regularly without effective auxiliary facilities. The maximum period of eligibility for compensation after the date of termination of exposure to the risk is set at one year.

In **Switzerland**, lumbar complaints is not considered as an occupational disease by law, because it is a complaint of particularly multifactorial origins, and accordingly the causal role of a particular occupation cannot be described as exclusive or clearly predominant. The complementary system permits its recognition only exceptionally (only 9 cases recognised in 10 years).

Belgium

In Belgium, the criteria for recognition of lumbar complaints have become more restrictive.
From 1974 to 2002, Belgium recognised lumbar osteoarthritis proved by radiographic examinations of the lumbo-sacral column. Exposure to mechanical vibrations transmitted to the body by the seat are taken into consideration, at an exposure rate of 0.62 m/sec^2 weighted over 8 hours' work per day during a period of five years.
In November 2002, the conditions of recognition became tougher: complaints of the lumbar column related to mechanical vibrations must necessarily appear at an early stage (around 40 years). This change reflects a policy of paying compensation only for those diseases actually caused by work and not those occurring due to ageing. The number of cases recognised began to fall from 2003 onward.
In February 2005, the possibility of recognition of lumbar osteoarthritis was extended to take into account the risk involved, since it now covers the carrying of heavy loads and no longer just vibrations. Exposure to mechanical vibrations transmitted to the body by the seat is assessed at an exposure rate of 0.80 m/sec^2 weighted over 8 hours' work per day during a period of 1,250 days (ISO Standard 2631-1 / 1997). And exposure to the carrying of heavy loads is calculated according to the Mainz-Dortmund dose model. But the possibility of recognition was above all restricted by a more specific definition of the diseases that can be recognised: documented monoradicular or polyradicular syndrome of the sciatica type, cauda equina syndrome and syndrome from narrowing of the lumbar vertebral canal, following a degenerative disc hernia, provided that the radicular syndrome occur during the exposure to the occupational risk or at the latest one year after the end of said exposure, or following a precocious degenerative spondylosis-spondyloarthrosis at the L4-L5 or L5-S1 level. As a result, recognition has become far more difficult, and the number of cases recognised has declined sharply.

rapportanglais.indd 28 17/02/09 12:12:15

Lumbar complaints: number of cases recognised between 1992 and 2006

	Denmark	France	Italy[38]	Switzerland
1992	87	–	–	–
1993	112	–	–	–
1994	91	–	–	–
1995	102	–	–	–
1996	130	–	–	–
1997	93	3	–	1
1998	64	130	–	0
1999	140	2,235	–	1
2000	241	2,608	–	3
2001	256	2,812	–	0
2002	229	2,897	204	2
2003	294	2,928	253	1
2004	296	2,872	377	0
2005	253	2,986	497[39]	1
2006	206	2,785[37]	423[40]	0[41]

In Denmark, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for lumbar complaints is generally between 5% and 25%, usually around 10%. As regards the compensation for loss of earning capacity (occupational prejudice), the rates attributed are between 15% and 100% (although seldom above 75%).
In Switzerland, too few cases are recognised to be able to establish the slightest profile.

Cost of benefits paid for lumbar complaints in 2006

Country	Total cost of occupational diseases	Cost of lumbar complaints	Cost of lumbar complaints as a % of total cost of ODs
Denmark	€98,084,712	€23,132,103	23.6%
• of which physiological damage		€1,868,591	
• of which loss of earning capacity		€21,263,511	
France (healthcare and daily benefits only)	€374,763,550	€51,270,183	13.7%
Switzerland (2005)	€69,054,472	€1,112	0.0016%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

37. Provisional figure.
38. Sector of industry and sector of agriculture combined.
39. Provisional figure.
40. Provisional figure.
41. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

3.3 Noise-induced hearing loss

Deafness or hearing loss (i.e. a decline in auditory acuity) is one of the most frequent complaints in all the countries. It ranks first in Germany (37% of total cases of occupational diseases recognised in 2006), Austria (46%) and Switzerland (23%), and second in Italy (29%). It accounts for a smaller proportion in Belgium (15%), Denmark (12%), Spain (3%), France (2%), Sweden (5%) and Portugal (13%).

The job-related nature of noise-induced hearing loss can be recognised under the list system in all the European countries taking part in the study. Tinnitus[42] can also be taken into account if it is concomitant with hearing loss in Finland, in France (since 2003), in Italy, in Portugal (since 2007), in Switzerland and in its own right in Denmark (since 2005) if it is severe.

In Denmark, an audiogram must reveal a bilateral hearing deficit. Exposure to the risk must have lasted at least five years and have been at least 85 dB on average over a workday.

In Finland, an audiogram must reveal a bilateral and rather symmetrical hearing deficit of at least 20 dB at the frequencies of 4-6 kHz. Exposure to noise must also be sufficient to induce this deficit. The minimum period of exposure required is one year with some exceptions. There is no indicative or restrictive list of work.

In France, a tonal and vocal audiogram performed at least three days after termination of exposure to the risk must reveal a bilateral hearing deficit of cochlear origin of at least 35 dB on the better ear. Moreover, there is a restrictive list of work and the minimum period of exposure is one year (reduced to 30 days for certain activities). Lastly, there is an administrative condition for recognition: a period of "eligibility" of one year (i.e. the time between the end of exposure and the date of the first medical evidence).

In Italy, the new list of occupational diseases in force since July 2008 contains a restrictive list of work but provides that in the case of work not registered in this list, the daily or weekly exposure must have been greater than 80 dB. There is also an administrative condition: a maximum period of four years between the end of the exposure and the claim for recognition.

In Portugal, an audiogram must be performed at least one year after termination of exposure to the risk, and must reveal a bilateral hearing deficit of at least 35 dB on the better ear. The national list contains an indicative list of work; there

42. Auditory impression corresponding to the perception of a sound; audible impressions that are not related to an external acoustic wave, i.e. that are perceived merely by the subject.

rapportanglais.indd 29 17/02/09 12:12:15

is also a condition known as the "characterisation period" which sets a maximum period of one year between the end of the exposure and the claim for recognition.

In Switzerland, a tonal audiogram must show that the reduction in hearing capacity is at least 50% in the case of a unilateral complaint and 70% in the case of a bilateral complaint (knowing that intact hearing in both ears equals 200%). To verify the exclusive or predominant causal link with work, doctors use the results of the audiometric examinations undergone by workers exposed to excessive occupational noise[43].

Hearing loss: number of cases recognised between 1992 and 2006

	Germany	Austria	Belgium	Denmark	Spain	France	Italy[45]	Portugal	Sweden	Switzerland
1992	–	–	–	672	–	–	–	248	–	–
1993	–	–	–	883	–	–	–	590	–	–
1994	–	–	–	872	–	–	–	396	–	–
1995	–	–	–	696	–	–	–	769	–	–
1996	–	–	–	531	–	–	–	386	–	–
1997	–	–	–	287	–	709	–	441	–	664
1998	–	–	–	269	–	642	–	435	–	694
1999	–	–	–	332	–	615	1996	672	–	549
2000	6,228	399	–	726	–	607	1,375	593	–	676
2001	6,701	444	221	443	–	634	869	233	250	504
2002	6,685	507	206	418	–	642	3,616	510	337	642
2003	6,424	409	297	458	–	907	3,228	651	346	647
2004	6,281	440	234	294	490	1,107	2,976	557	408	696
2005	5,481	532	258	451	577	1,177	2,512[46]	628	500	698
2006	4,971	594	–	530	578	1,056[44]	1,880[47]	619	440	847,[48]

In France, the benefits offered consist, in practice, of compensation for the permanent disability. There is nothing to prevent benefits in kind and daily benefits (for temporary disability) being paid; however, deafness in theory entails no sick leave and requires no or little medical care. Hearing aids are reimbursed within the limits of a fixed price well below their actual cost.

For a bilateral loss of 35 dB, a permanent disability rate of 12% is attributed, giving entitlement to a pension equivalent to 6% of the salary. If the bilateral loss is 70 dB, the permanent disability rate attributed will be 70%, for a pension equivalent to 55% of the salary.

In Denmark, the permanent disability rate (measuring the physiological damage and loss of amenities of life) attributed for a case of deafness is generally between 5% and 8%. It seldom exceeds 20%. Very few cases of deafness give entitlement to compensation for loss of earning capacity (occupational damage).

43. In Switzerland, 200,000 workers are exposed to a dangerous noise level in the context of their work. They all - even those working in the smallest enterprises - undergo hearing check-ups by means of *"audiomobiles"* (hearing test buses). These check-ups take place every five years, or even more frequently for recently hired workers and the most exposed and youngest workers.
44. Provisional figure.
45. Sector of industry and sector of agriculture combined, list system and complementary system combined.
46. Provisional figure.
47. Provisional figure.
48. For the year 2006, only the cases recognised by the SUVA (the leading insurer for occupational injuries) are counted.

rapportanglais.indd 30 17/02/09 12:12:16

In Portugal, the permanent disability rate attributable is stipulated in a schedule and ranges between 15% for a bilateral loss of 35 dB to 44 dB and 60% for a bilateral loss of at least 80 dB.

In Switzerland, the benefits awarded for deafness are basically compensation for bodily harm (a lump sum payment) and reimbursement of a hearing aid. The rates of bodily harm applicable to hearing are stipulated in a schedule and can range between 5% for a 70% decline in keenness of hearing to 85% for a total bilateral loss. A rate of 5% to 10% can be applied for tinnitus, depending on its severity. Reimbursement of a hearing aid can be awarded even if the threshold of 70% loss of hearing for a bilateral disorder is not reached, and the amount will depend on the results of the vocal audiogram. It is only in very rare cases that benefits corresponding to medical treatment or to temporary or permanent loss of earning capacity are allocated. Compensation for change of occupation is also rare (cash benefits over a limited period of time following an unfitness decision).

Cost of benefits paid for hearing loss cases in 2006

Country	Total cost of occupational diseases	Cost of hearing loss	Cost of hearing loss as a % of total cost of ODs
Denmark	€98,084,712	€1,524,613	1.6%
• of which physiological damage		€1,404,954	
• of which loss of earning capacity		€119,660	
France (healthcare and daily benefits only)	€374,763,550	€278,805	0.1%
Switzerland (2005) Average cost per case	€69,054,472	€6,670,335 €9,556	9.7%

Exchange rate at 6 June 2008: 1 DKK = €0.134 1 SF = €0.617

3.4 Skin diseases

These diseases are mentioned by all the countries as among the five most frequent diseases, with the exception of Germany (where this can be explained by the requirement that the disease be severe enough to oblige the victim to give up his or her hazardous work) and Sweden.

3.5 Asbestos-related diseases

Exposure to asbestos dusts causes various diseases such as mesothelioma (cancer of the pleura), lung cancer, and more seldom cancer of the larynx, but also less serious diseases such as asbestosis and pleural plaques, the latter being rather a symptom of exposure than a disease.

Asbestos-related diseases are mentioned among the five most frequent diseases by only four countries: Austria, Germany, Belgium and France. But these diseases can be found in some countries under more generic statistical codes such as "diseases of the respiratory tracts".

The recognition and compensation for asbestos-related occupational diseases have already been dealt with in-depth in a previous study[49] by the working group which has produced the present document.

49. *"Asbestos-related occupational diseases in Europe, Recognition, Statistics, Specific Systems"* (March 2006).

rapportanglais.indd 31 17/02/09 12:12:16

SECTION IV

Legal news on occupational diseases 2002-2008

4.1 General insurance system reforms

Denmark

In 2003, the Danish parliament enacted a reform of the compensation for accidents at work and occupational diseases victims. Although it came into force on 1st January 2004, the new definition of occupational diseases was applicable only on 1st January 2005. First of all, the reform extended occupational injuries insurance coverage to the extent that it enabled self-employed workers and spouses working with them to be now covered by the Workers' Compensation Act. However, their membership of this insurance regime remains voluntary: they must take out an insurance contract with the Labour Market Occupational Diseases Fund to be covered for occupational diseases, and with a private insurance company for accidents at work. The new law also extended the coverage for medical expenses. Long-term healthcare treatment can now be reimbursed, provided that the treatment be curative and that it be not confined to relieving symptoms (e.g. permanent treatment of asthma and eczema).

But above all, this reform brought about major changes for occupational diseases by introducing a new list of occupational diseases. The objective is to ensure that in the future 25% of reported cases may be recognised, which represents a 40% increase in the rate of recognition of occupational diseases. It is estimated that, with the coming into effect of the new list, about 1000 additional cases could be recognised each year.

Finland

In January 2007, the Finnish Ministry of Social Affairs and Health set up a working group in order to reform the current legislation on occupational injuries insurance.

The Finnish Employment Accident Insurance Act, enacted in 1948, has often been amended, especially since the '70s. Moreover, the initial legislation was completed by an Act on Occupational Diseases and other separate laws. Other laws related to social insurances (Health Insurance Act, Pensions Act) were also amended since 2004 and the reform of legislations in connection with the occupational injuries insurance (Insurance Companies Act, Motor Insurance Act) is underway.

The working group's objective is to submit proposals to reform the structure of the legislation on occupational injuries insurance as of its content.

It will deposit its report in autumn 2008 and the preparation of the legislation will begin after that.

Netherlands

The changes made to the social security legislation in the Netherlands have led to a substantial reduction in the financial compensation paid to Dutch workers in a situation of partial disability. Now, workers suffering from an occupational disease often come within this category. Regulations on this subject, called "supplementary regulations on the coverage of occupational injuries", were prepared in 2004. The introduction of these regulations will depend on the trend concerning the number of claims for compensation and the assessment that may be made of the situation in the Netherlands by the International Labour Organization (ILO) with regard to social security benefits requirements as set out in ILO convention 121.

4.2 Changes in the national lists of occupational diseases

Denmark

Process for registration of new diseases on the list

As part of the reform, the list of occupational diseases was revised on 1st January 2005, with the introduction of a new documentation requirement.

Prior to the reform, the documentation requirements for the registration of new diseases on the list were very extensive. Previously, what was required for diseases to be registered on the list was "medical and technical experience". With the reform, this requirement has become a "medical documentation" requirement. The aim was thus to make the requirements for the registration of new diseases on the list more flexible.

rapportanglais.indd 33 17/02/09 12:12:16

The concept of medical documentation implies that the following conditions be met:
– A natural and logical biological explanation for the disease
– Exposure of a nature and duration which makes the disease possible
– A correlation between exposure and the disease, e.g. an increase in exposure resulting in an aggravation of the disease
– Studies of prevalence in the population which confirm a correlation
– Convincing case reports established in relation to examinations performed by doctors
– A very high frequency of occurrence of the disease in people subjected to the exposure in question, by comparison with unexposed people.

In theory, all the conditions must be met. During the pragmatic assessment carried out to find out whether a disease can be registered on the list of occupational diseases, it is possible to give greater weight to specific conditions, but there must always be a documented correlation between exposure and the disease.

New list of occupational diseases

The new list of occupational diseases came into force on 1st January 2005. This list now defines less strict recognition criteria for diseases reported after the 1st of January 2005. In practice, the introduction of the new list of occupational diseases means that there will in future be two lists of occupational diseases in force. One list is used to assess diseases reported from 1st January 2005 onward in accordance with the new Workers' Compensation Act. The old list is used to assess diseases reported before 2005.

When working on the preparation of the new list, the Occupational Disease Commission placed special emphasis on musculoskeletal diseases, for example in the sectors of social work, healthcare and cleaning.
It accordingly considered the potential for recognition of the following diseases:

– Mental illness and stress
– Complaints of the hand and forearm
– Elbow complaints
– Complaints of the shoulder and neck-shoulder region
– Lumbar complaints
– Neurological diseases of the musculoskeletal system
– Rheumatic complaints
– Diseases due to work performed with the computer mouse
– Hearing complaints
– Knee complaints
– Diseases due to exposure to manganese
– Sick building syndrome
– Diseases caused by cleaning work, social work and healthcare work.

The work of the Commission resulted in a series of less strict exposure conditions for several types of diseases, in particular diseases of the hand, forearm, elbow and shoulder, and to the introduction of new complaints such as post-traumatic stress, arthrosis of the knee joint, degeneration of the biceps tendon of the arm, and pleural plaques.

The new list of occupational diseases was supplemented by a new detailed guide to occupational diseases which, chiefly by means of examples, describes a number of cases of diseases which may or may not be recognised. The guide also includes exposures.

Cancer

In August 2005, a general review was performed in the area of cancer in order to update the two lists of occupational diseases on the basis of new knowledge acquired in cancerology. Updating was performed based on the research results obtained in this specialty, in particular based on the most recent results of the International Agency for Research on Cancer (IARC), which is part of the World Health Organisation.

The recent results compiled in 88 IARC monographs on the correlations between various types of cancer and various work-related exposures were examined, assigning special importance to the fields in which the causal relations between a disease and specific exposures are classified by the IARC as certain or probable (categories 1 and 2a).

Based on the IARC results, a number of new cancers and exposures that could cause cancer were included in the two lists of occupational diseases on the basis of the most recent IARC list. Accordingly, the Danish lists now reflect the results of the most recent international research.

The old list applicable to diseases reported prior to 2005 contains ten new entries in all, including seven new types of exposure that could cause certain types of cancer. An example is inorganic lead compounds which can cause a stomach cancer.

The new list applicable to diseases reported from 2005 on contains - due to less strict medical documentation conditions - sixteen new entries in addition to the ten new entries that it shares with the old list. This concerns, among other things, bladder cancer which can now be recognised on the basis of the list as being related to painting work, and cancer of the nose and sinuses caused by exposure to chromium.

In addition, the National Board of Industrial Injuries has simplified the structure of cancers on the new list of occupational diseases. It has grouped all cancers together in

rapportanglais.indd 34 17/02/09 12:12:16

a single category, thereby giving a better view of the types of cancer likely to be recognised as occupational diseases.

Lung cancer due to passive nicotinism
Lung cancer due to passive nicotinism is now registered on both lists. Lung cancer can be recognised on the basis of the lists if there has been heavy exposure to passive nicotinism every day at work for a large number of years. The victim must never have smoked and, moreover, must have been only very moderately exposed to tobacco in his (her) private life.

Post-traumatic stress
This complaint has been registered on both lists. It must have been caused by exposure to traumatising situations or events of an exceptionally threatening or catastrophic nature for a short or long period of time.
The conditions relating to exposure largely correspond to the former recognition practice of the Occupational Disease Commission, but registration on the list will in future ensure faster and more flexible management of claims for recognition. Moreover, it will be possible to adapt the conditions of recognition defined in the new accompanying guide to allow for the new knowledge acquired in this area.

Pleural plaques without pulmonary asbestosis
This complaint has been registered on both lists. There must have been exposure to asbestos. In theory, the exposure must have lasted several months, but this condition can be reduced to several days or weeks in the event of massive exposure.

Spain
Since January 2007, a new list of occupational diseases (Royal Decree 1299/2006 of 10 November 2006) has come into force. The last list dated from 1978 and was no longer adapted to present-day occupational health problems.

This new list is organised on the same model as the European list of occupational diseases (European Commission Recommendation of 19 September 2003), with a first appendix containing the diseases that can be recognised, broken down into six groups, and a second appendix containing an additional list of diseases for which a work-related origin is suspected and which could in future be included in Appendix 1. The diseases not contained in the list (Appendix 1) can still be recognised as an accident at work provided that the occupational activity is the exclusive cause of the disease.

The restrictive list of work corresponding to each harmful agent is more exhaustive than in the 1978 list of occupational diseases (this is the case for MSDs in particular), and new substances have been added.

The system for reporting and recording occupational diseases has also been changed. An electronic reporting procedure has been established, and follow-up of the report is now incumbent on the *Mutuas* (insurance organisations against occupational injuries) and no longer on the company.

Portugal
A new list of occupational diseases was published by decree on July 17th, 2007. The modifications concern mainly skin diseases and diseases caused by physical agents.
The name of certain pathologies has been updated and some diseases have been added to the list. Causal agents and a "characterisation period" (maximum period between the end of the exposure and the claim for recognition) have also been integrated.

Italy
A new list of occupational diseases was enacted by a decree signed on 1st April 2008; it came into force on the 24 July of the same year.

The number of diseases registered on the list goes from 58 to 85 for the industrial sector and from 27 to 24 for the agriculture sector; the main new diseases are musculoskeletal disorders caused by biomechanical strains, previously recognised under the complementary system. Pleural plaques have also entered the list. In addition, the precise description of the disease now appears (and no longer merely exposure to the harmful agent), as well as the corresponding ICD-10 code of the World Health Organization. Finally, a maximum period of eligibility for compensation, to be calculated from the date of retirement, has been introduced for each disease.

Germany
Discussions are underway on "co-carcinogenic" effects, especially in the case of lung cancer occurring after exposure to asbestos and polycyclic aromatic hydrocarbons. In November 2005, the HVBG (now DGUV) organised a workshop on this subject. The speeches and the corresponding discussions were published in the summer of 2006. In light of the results of the workshop, in the spring of 2006 the HVBG recommended the recognition of lung cancer in the event that exposure to asbestos for at least 12.5 fibres-year and at least 50 benzopyrene-years can be proved.

rapportanglais.indd 35 17/02/09 12:12:17

4.3 Compensation for occupational diseases

Germany

In the spring of 2002, the HVBG (now DGUV) published the results of a workshop concerning the assessment of the working capacity reduction for victims of accident at work or occupational diseases. These results are supposed to provide help for occupational injuries experts and insurance and prevention organisations.

Belgium

An asbestos victim compensation fund (AFA) was created by the framework Act of 27 December 2006 ("Moniteur belge" of 28 December). Effective since 1st April 2007, it enables the victims of mesothelioma or asbestosis (or diffuse bilateral pleural thickening) to obtain compensation. In the event of the victim's death, the AFA pays compensation to any legal beneficiaries, provided that the victim's death occurred after the system came into force.

In theory, anyone can bring a claim for compensation, whether they be a civil servant, a self-employed worker, an employee or unemployed. For this claim to be accepted, the disease must have been caused by exposure to asbestos in Belgium. Mesothelioma victims receive a fixed monthly pension of 1,500 €.

In the event of death, the legal beneficiaries receive a lump sum, the amount of which varies depending on the status of the legal beneficiary: for example, the surviving spouse receives € 30,000 in compensation and each dependent child is entitled to € 25,000.

Victims affected by asbestosis (or diffuse bilateral pleural thickening) receive a pension of € 15 per month for each percentage point of disability resulting from the asbestosis (for example, a pension of € 750 for a 50% disability rate). In this case the legal beneficiaries will receive a lump sum ranging between € 7,500 and € 15,000.

The pensions granted can be cumulated in full with any other social allocation and with social assistance. Neither the pension nor the lump sum paid to the legal beneficiaries are taxable.

Management of the AFA has been entrusted to the Occupational Disease Fund. It is financed by the government and by contributions payable by employers and certain categories of self-employed workers.

France

Since 2002, various regulatory changes have improved the compensation for victims of occupational injuries and their legal beneficiaries.

We may mention, in particular, the improvement in compensation for legal beneficiaries due to:

- the extension of the concept of legal beneficiaries to common law spouses and the partners in a civil partnership *(PACS)*,
- the 10-percentage-point increase in the legal beneficiary pension rate for injuries occurring since 1st September 2001 (spouse: 40%; child: 25% if two orphans or 20% beyond that),
- and the raising of the age limit for orphans to receive pensions, accordingly set at 20 years irrespective of the child's personal situation.

We may also note in 2002 the 10% increase in the value of compensation paid in the form of a lump sum to victims suffering from a permanent disability of less than 10%, and the lowering from 100% to 80% of the permanent disability threshold to benefit from the increase in the pension allocated to a person whose state of health means that third-party assistance is required.

Luxembourg

The Government Council enacted on 2 May 2008 a draft occupational injury insurance reform, which is due to come into force on 1st January 2010. The main innovation is the fact that the treatment of ad hoc compensation is now more similar to that for common-law compensation. Since it has been observed that the victims' loss of occupational income is no longer proportional to their permanent disability rate, the loss of income will now be compensated for separately from the other damage. The current flat-rate compensation will be replaced by a pension for effective loss of income, and if the accident or disease leaves permanent sequels, by flat-rate compensation for non-material damage, i.e. compensation for physiological harm and loss of amenities of life, the pain endured and disfiguration damage.

Netherlands

In 2005 the Health Council of the Netherlands published a "protocol" on asbestos, tobacco and lung cancer[50]. Unlike the existing regulations in other countries[51], within the framework of statutory law or civil liability, the approach proposed here is a calculation of probabilities concerning the relationship of cause and effect. This approach, which is based on proportional probability, has been applied to a number of cases of claims for compensation within a civil law framework. A calculation model has been designed on the basis of epidemiological data; the number of cigarettes consumed (expressed in pack-years)

50. Health Council of the Netherlands. Asbestos diseases: lung cancer. The Hague. Health Council of The Netherlands. 2005 ; publication no 2005/09 ISBN-10 : 90-5549-571-9

51. Asbestos, asbestosis and cancer: Helsinki criteria for diagnosis and attribution. Scand J Work Environ Health. 1997 ; 23:311-6.

rapportanglais.indd 36 17/02/09 12:12:17

and the number of years' exposure to asbestos fibre have been incorporated in this formula, thereby making it possible to obtain a level of causal probability for each of these two factors. However, the feasibility of this approach for claims for compensation is disputed.

Portugal

A new disability scale for victims of occupational injuries was approved in 2007 and came into force in 2008.

France

A judgment[52] by the social chamber of the *Cour de Cassation* (supreme court of appeal) of 28 February 2002 redefined the concept of "inexcusable fault of the employer".
By virtue of the work contract binding them to their employees, employers have towards them an absolute obligation of safety, especially regarding occupational diseases contracted by the employee due to the products manufactured or used by the enterprise.
A failing in this obligation has the nature of an "inexcusable fault" when the employer was or ought to have been aware of the danger to which the employee was exposed, and did not take the necessary measures to protect him (her) from it.

Beyond the fact of this new definition of the "inexcusable fault" for the employer, the judgment accepts that the legal beneficiaries of the victim of an occupational disease due to the inexcusable fault of the employer who dies from the sequels of this disease are able not only to take legal action for compensation of the moral prejudice sustained by them personally as a result of this death, but also action for compensation of the victim's personal moral prejudice resulting from his (her) disease.

4.4 Studies, research and initiatives concerning specific diseases

Denmark

At the end of 2004, the National Board of Industrial Injuries commissioned four studies (examination of the scientific literature) from the scientific committee of the Danish society for protection of the working environment *(DASAM/ Dansk Selskab for Arbejds- og Miljømedicin)* in the following fields:

1. Carpal tunnel syndrome following work on a PC with a keyboard and mouse (completed)
2. Other musculoskeletal complaints following work on a PC with a keyboard and mouse (hand, elbow, shoulder and neck) (completed)
3. Chronic neck pains and tendinitis of the shoulder after various types of exposure (not completed)
4. Arthrosis of the hip and knee (work involving the carrying of heavy loads and movement in stairways or on ladders) (not completed).

The two studies concerning bodily injury caused by computer work have been delivered and concluded that there is currently no adequate medical documentation to prove a correlation between work on a computer with a keyboard and mouse and the carpal tunnel syndrome on the one hand, and the other musculoskeletal complaints investigated on the other hand.

Campaign concerning under-reporting of occupational cancers

A new report dating from March 2005, concerning reported cases of cancer, concluded that a very small proportion of cases of pleural mesothelioma and adenocarcinoma of the nose and sinuses are reported to the National Board of Industrial Injuries. Now, these two diseases are found almost exclusively in people who have been exposed, during their working life, to asbestos and wood dust respectively.

Only 55 percent of presumed cases of pleural mesothelioma of a job-related nature and only 41 percent of presumed cases of adenocarcinoma of the nose and sinuses are reported to the National Board of Industrial Injuries. Now, for these two diseases, almost 90 percent of the cases reported are recognised as occupational diseases.

In theory, doctors are obliged to report cancers that have been proved or are presumed to be of a job-related nature to the National Board of Industrial Injuries and the Working Environment Authority *(Arbejdstilsynet)*, but this report suggests that in many cases they do not do so.

As a consequence, the National Board of Industrial Injuries has decided to launch a campaign having the following objectives:

- Targeted information, intended for doctors who work in the hospital sector and who deal with such patients, regarding their obligation to report these diseases and drawing their attention to the problem of under-reporting;
- Focus, in scientific medical magazines, on the doctor's obligation to report such diseases and on the problem of under-reporting of cases.

Wishes concerning future research on occupational diseases

Knowing that it has become possible, since 2006, to obtain financing for this type of study from the Fund for research on the conditions of the working environment (Arbejdsmiljøforskningsfonden), the National Board of

52. Cass.soc. 28 février 2002 SA Eternit industries c/veuve Hammou et a.

rapportanglais.indd 37 17/02/09 12:12:17

Industrial Injuries has made a commitment to commission in the future various studies on occupational diseases, with a view to constant updating of the list of such diseases.

In the meantime, the National Board of Industrial Injuries and the Occupational Disease Committee recognise that the following subjects will be especially relevant for the additional studies to be launched in 2006/2007:

- Ischaemic cardiomyopathy and cancer (including breast cancer) related to night work;
- Cardiomyopathy and mental illnesses (stress-related syndromes and depression) resulting from occupational stress;
- Influence of gender on the occurrence of musculoskeletal disorders;
- Shoulder complaints.

Mercury

An epidemiological study has been launched to be able to determine whether nurses specialised in dental care, who have worked in clinics and who could have been in contact with mercury up to the mid-1980s suffer from certain complaints more than others. This study will make it possible to determine more precisely, via disease diagnosis registers, whether dental surgery assistants, dentists and other high-risk groups that have been exposed to metallic mercury in their working life up to the mid-1980s have more serious diseases than other groups. The study will also concern congenital diseases found in the children of this population.

Germany

Since October 2002, the HVBG (now DGUV) has financed a study for monitoring of epidemiological cases in order to establish a "dose-response" relationship concerning discopathy complaints of the lumbar vertebrae due to the carrying of heavy loads.

In the spring of 2005, the *Berufsgenossenschaften* organised a "longitudinal" study with a view to establishing standards for the prevention, diagnosis, therapy and rehabilitation of work-related skin diseases and analysing the combined effects of ambulatory and hospital rehabilitation programmes for this type of complaint.

In the autumn of 2005, the study concerning coal miners in the Sarre region was finalised. The adverse effects of exposure to dust on cancer mortality and morbidity have not been able to be confirmed.

France

In 2006 the Ministry of Labour, within the framework of the Occupational Diseases Committee of the Higher Council for Occupational Risk Prevention, established a think tank in charge of examining the possibility of registering mental diseases in the list of occupational diseases. This was an exploratory phase designed to define the range of mental diseases that could be included in the list of occupational diseases and to determine the work method appropriate to the specific nature of the subject. A report has already been given to the Committee about the above. Consequently the Committee asked the CNAMTS to do a prospective survey which is underway.

rapportanglais.indd 38 16/02/09 18:24:34

Appendices

rapportanglais.indd 39 17/02/09 12:12:17

Appendix 1: Population insured by the organisations taking part in the study

Country	Workers in industry, business and services	Self-employed workers	Farmers	Civil service	Employees of state-owned enterprises	Civil servants strictly speaking	The military	Others
Germany	X	A minority	Separate statistics	-	-	-	-	-
Austria	X	A majority	-	-	Partially	-	-	Apprentices, school pupils, students
Belgium	X	No except for asbestos fund	Agricultural employees	Provincial and local govt. departments (APL) only	-	No except for APL	-	Students (if minimum basic wage)
Denmark	X	Optional	X	X	X	X	X	Pupils and students on courses
Spain	X	Optional	-	-	-	-	-	-
Finland	X	Optional separate statistics	Separate statistics	X	X	X	X	Certain students and apprentices
France	X	-	-	-	-	-	-	Pupils and students in technical training
Italy	X	Tradesmen	X	X	Management on behalf of the government	Civil servants as per legislative decree 38/00	-	Students, housewives, professional sports people
Luxembourg	X	Self-employed intellectual workers	Separate statistics	X	X	X	X	School pupils and students in Luxembourg; apprentices students on courses
Portugal	The whole employed working population (voluntary occupational disease insurance for self-employed workers)							
Sweden	X	X	Employees	X	X	X	-	Trainee if risk similar to normal risks of working life
Switzerland	X	Optional	Employees Self-employed workers: optional	X	X	X	-	Unemployed persons, domestic help workers, apprentices, students on courses, voluntary workers and people working in technical schools or protected workshop

rapportanglais.indd 40 17/02/09 12:12:17

Appendix 2: Statistical data by country

Germany

Source: DGUV (previously HVBG)

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	26,650,192	51,105	9,363	18 %
1991	33,823,405	61,156	10,479	17 %
1992	33,660,511	73,568	12,227	17 %
1993	32,796,465	92,058	17,833	19 %
1994	32,729,257	83,847	19,419	23 %
1995	33,323,536	78,429	21,886	28 %
1996	33,134,669	82,349	21,985	27 %
1997	33,560,008	77,310	21,187	27 %
1998	33,266,663	74,470	18,614	25 %
1999	33,650,713	72,722	17,046	23 %
2000	33,721,319	71,172	16,414	23 %
2001	33,551,426	66,784	16,888	25 %
2002	32,794,110	62,472	16,669	27 %
2003	32,263,599	56,900	15,758	27 %
2004	32,308,950	55,869	15,832	28 %
2005	32,595,246	53,576	14,920	28 %
2006	33,382,080	53,955	13,365	25 %

Belgium

Source: FMP

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	2,198,518	9,476	4,100	43 %
1991	2,200,813	9,314	4,357	47 %
1992	2,196,049	9,896	6,076	61 %
1993	2,143,016	8,404	5,092	61 %
1994	2,133,306	7,863	4,047	51 %
1995	2,172,174	7,305	4,449	61 %
1996	2,187,391	6,542	3,498	53 %
1997	2,216,040	6,075	3,011	49 %
1998	2,266,928	6,231	3,250	52 %
1999	2,310,126	5,935	2,323	39 %
2000	2,395,364	6,575	2,661	40 %
2001	2,434,335	6,798	3,242	48 %
2002	2,421,744	6,508	3,462	53 %
2003	2,416,198	6,199	3,043	49 %
2004	2,483,368	6,453	2,027	31 %
2005	2,446,358	5,255	1,660	40 %
2006	2,483,948	5,544	1,332	32 %

Austria

Source: AUVA

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	2,490,360	3,768	1,950	52 %
1991	2,548,260	3,776	1,796	48 %
1992	2,569,430	4,098	1,834	45 %
1993	2,559,990	3,955	1,753	44 %
1994	2,573,250	3,216	1,279	40 %
1995	2,580,540	3,440	1,353	39 %
1996	2,564,530	3,246	1,321	41 %
1997	2,578,970	2,893	1,175	41 %
1998	2,609,980	2,631	1,211	46 %
1999	2,646,070	2,870	1,259	44 %
2000	2,951,160	3,040	1,268	42 %
2001	3,018,988	3,090	1,395	45 %
2002	3,017,806	3,116	1,402	45 %
2003	2,974,708	2,771	1,178	43 %
2004	3,003,420	3,023	1,218	40 %
2005	3,035,536	2,866	1,249	44 %
2006	3,089,167	2,961	1,293	44 %

Denmark

Source: Arbejdsskadestyrelsen

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	2,395,154	13,157	2,156	16 %
1991	2,385,023	12,686	4,151	33 %
1992	2,351,612	13,134	3,503	27 %
1993	2,340,334	14,789	3,445	23 %
1994	2,323,712	15,550	3,268	21 %
1995	2,369,544	15,857	3,115	20 %
1996	2,405,476	15,655	2,640	17 %
1997	2,430,709	15,608	1,987	13 %
1998	2,470,113	14,201	2,094	15 %
1999	2,519,407	13,242	2,181	16 %
2000	2,523,878	13,679	3,131	23 %
2001	2,772,868	13,502	2,391	18 %
2002	2,782,306	12,545	2,430	19 %
2003	2,741,386	12,376	3,045	25 %
2004	2,706,434	13,994	2,302	16 %
2005	2,710,462	16,972	2,652	16 %

rapportanglais.indd 41 17/02/09 12:12:17

Spain

Source: AMAT

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	10,135,000	*	4,285	-
1991	10,275,000	*	4,890	-
1992	10,186,000	*	5,110	-
1993	9,773,000	*	5,489	-
1994	9,665,000	*	5,373	-
1995	9,886,000	*	6,459	-
1996	10,047,000	*	7,958	-
1997	10,149,000	*	9,640	-
1998	10,751,000	*	12,125	-
1999	10,431,100	*	14,755	-
2000	12,404,800	*	19,622	-
2001	12,890,900	*	22,844	-
2002	13,315,500	*	25,040	-
2003	13,696,000	*	26,857	-
2004	14,205,824	*	28,728	-
2005	14,818,682	*	28,904	-
2006	15,502,738	*	21,905	-

* As non existing or non communicated data.

France

Source: CNAMTS-DRP

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	14,920,798	9,423	6,592	70 %
1991	15,091,754	10,392	7,512	72 %
1992	15,001,936	12,022	8,847	74 %
1993	14,709,877	12,433	9,198	74 %
1994	14,794,701	13,714	10,345	75 %
1995	15,037,929	15,421	11,387	74 %
1996	15,345,626	18,546	13,278	72 %
1997	15,413,389	20,865	15,554	75 %
1998	15,503,568	22,436	17,722	79 %
1999	15,803,680	31,646	24,208	76 %
2000	18,125,267	42,957 (reconstructed figure)	30,224	70 %
2001	18,216,098	47,279	35,715	75 %
2002	18,251,639	56,675	41,673	73 %
2003	17,963,365	60,546	44,653	74 %
2004	17,865,295	66,032	48,130	73 %
2005	18,222,254	71,926	52,979	74 %
2006	18,146,434	72,742	51,142*	70 %

* Provisional figure.

Finland

Source: Federation of Accident Insurance Institutions (FAII)

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	2,324,500	7,434	3,716	50 %
1991	2,203,400	7,011	3,154	45 %
1992	2,044,600	6,842	2,628	38 %
1993	1,921,400	6,181	2,404	39 %
1994	1,906,600	6,543	2,368	36 %
1995	1,962,400	6,492	2,246	33 %
1996	1,988,000	6,054	1,776	29 %
1997	2,055,700	5,621	1,546	27 %
1998	2,129,194	4,940	1,300	26 %
1999	2,205,734	5,408	1,460	27 %
2000	2,016,000	5,428	1,495	27 %
2001	2,060,000	5079	*	-
2002	2,068,000	5,038	*	-
2003	2,061,000	4,954	*	-
2004	2,064,000	5,337	*	-
2005	2,098,000	5,346	*	-
2006	2,129,000	4,823	*	-

* As non existing or non communicated data.

Italy

Source: INAIL

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	17,300,000	57,449	19,561	34 %
1991	18,100,000	53,088	18,212	34 %
1992	18,000,000	54,032	17,063	32 %
1993	17,400,000	45,980	13,810	30 %
1994	17,300,000	35,098	8,860	25 %
1995	17,400,000	30,809	7,026	23 %
1996	17,400,000	30,453	7,050	23 %
1997	17,400,000	28,104	7,118	25 %
1998	17,700,000	26,535	7,125	27 %
1999	17,700,000	25,253	7,727	31 %
2000	17,900,000	25,912	7,601	29 %
2001	18,653,000	28,359	8,724	31 %
2002	18,850,000	26,824	9,284	35 %
2003	19,466,000	25,208	8,674	34 %
2004	19,683,000	26,460	8,469	32 %
2005	19,842,000	26,579	8,236	31 %
2006	20,163,000	26,529	7,576	29 %

rapportanglais.indd 42 17/02/09 12:12:18

Luxembourg

Source: Association d'Assurance contre les Accidents

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	158,642	153	12	8 %
1991	165,797	167	17	10 %
1992	171,932	160	20	13 %
1993	176,168	146	24	16 %
1994	180,751	91	22	24 %
1995	190,668	75	29	39 %
1996	187,823	99	25	25 %
1997	195,751	95	23	24 %
1998	206,030	102	38	37 %
1999	216,331	109	17	16 %
2000	229,661	135	19	14 %
2001	244,483	169	26	15 %
2002	251,945	233	80	34 %
2003	254,622	274	30	11 %
2004	262,955	281	31	11 %
2005	269,652	212	38	18 %
2006	279,810	186	69	37 %
2007	294,194	330	201	61 %

Portugal

Source: CNPRP

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1992	3,970,482	2,300	820	36 %
1993	3,872,043	3,030	1,413	47 %
1994	4,025,383	3,093	1,231	40 %
1995	4,197,313	2,413	1,785	73 %
1996	4,153,959	2,657	1,063	40 %
1997	4,204,837	2,458	856	35 %
1998	4,986,800	2,504	1,024	41 %
1999	5,046,800	2,942	1,378	47 %
2000	5,113,100	2,796	1,370	49 %
2001	5,122,800	2,660	1,317	50 %
2002	5,137,300	4,343	2,193	50 %
2003	5,118,000	4,622	1,965	43 %
2004	5,122,800	4,385	3,188	73 %
2005	5,133,800	4,752	3,624	76 %
2006	5,142,800	4,113	3,577	87 %

Sweden

Source: Försäkringskassan (previously Riksförsäkringsverket)

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	4,473,350	68,186	55,544	81 %
1991	4,304,567	72,682	56,243	77 %
1992	4,052,827	70,453	48,779	69 %
1993	3,748,125	71,312	43,214	51 %
1994	3,800,427	50,479	23,846	47 %
1995	3,850,862	24,048	9,943	41 %
1996	3,827,502	10,078	4,066	40 %
1997	3,813,221	6,460	2,781	43 %
1998	3,929,974	6,901	3,514	51 %
1999	3,959,795	9,169	4,991	54 %
2000	4,220,000	13,030	5,840	45 %
2001	4,091,079	25,110	11,945	48 %
2002	4,135,698	26,890	12,545	47 %
2003	4,157,828	29,800	12,370	42 %
2004	4,162,497	27,194	11,275	41 %
2005	4,262,600	18,353	11,825	64 %
2006	4,341,000	15,131	11,592	77 %

Switzerland

Source: Suva

Year	Insured population	Claims for recognition	Recognised cases	Recognition rate
1990	3,420,000	6,922	5,555	80 %
1991	3,383,000	6,510	5,124	79 %
1992	3,308,000	6,294	4,904	78 %
1993	3,246,000	5,908	4,599	78 %
1994	3,247,000	5,912	4,509	76 %
1995	3,228,000	5,810	4,457	77 %
1996	3,200,000	5,405	4,152	77 %
1997	3,206,000	5,162	3,987	77 %
1998	3,233,000	5,077	3,966	78 %
1999	3,337,000	4,537	3,644	80 %
2000	3,442,722	5,119	4,084	80 %
2001	3,524,157	4,623	3,706	80 %
2002	3,500,272	4,417	3,589	81 %
2003	3,475,711	4,607	3,668	80 %
2004	3,571,393	4,341	3,597	83 %
2005	3,542,693	4,304	3,494	81 %
2006	3,651,709	4,568	3,753	82 %

rapportanglais.indd 43 17/02/09 12:12:18

Appendix 3: The most frequent occupational diseases 2000-2006 Claims for recognition and recognised cases

Germany

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Allergic respiratory diseases
2001	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Allergic respiratory diseases
2002	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Allergic respiratory diseases
2003	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Lung or larynx cancer caused by asbestos
2004	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Lung or larynx cancer caused by asbestos
2005	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Lung or larynx cancer caused by asbestos
2006	Skin diseases (except cancer)	Hearing loss	Back diseases	Asbestosis and pleural plaques	Lung or larynx cancer caused by asbestos

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Hearing loss 6,228	Asbestosis and pleural plaques 1,765	Silicosis 1,641	Skin diseases 1,455	Allergic respiratory diseases 851
2001	Hearing loss 6,701	Asbestosis and pleural plaques 1,946	Silicosis 1,564	Skin diseases 1,390	Lung or larynx cancer caused by asbestos 768
2002	Hearing loss 6,685	Asbestosis and pleural plaques 1,929	Skin diseases 1,463	Silicosis 1,346	Lung or larynx cancer caused by asbestos 755
2003	Hearing loss 6,424	Asbestosis and pleural plaques 1,978	Skin diseases 1,241	Silicosis 1,168	Mesothelioma 788
2004	Hearing loss 6,281	Asbestosis and pleural plaques 2,056	Skin diseases 1,198	Silicosis 1,189	Mesothelioma 880
2005	Hearing loss 5,481	Asbestosis and pleural plaques 2,119	Silicosis 1,015	Mesothelioma 853	Skin diseases 836
2006	Hearing loss 4,971	Asbestosis and pleural plaques 1,973	Mesothelioma 903	Silicosis 870	Lung or larynx cancer caused by asbestos 817

rapportanglais.indd 44 17/02/09 12:12:19

Austria

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2002	Skin diseases (except cancer) 1,044	Hearing loss 685	Allergic bronchial asthma 373	Infectious diseases 314	Respiratory diseases caused by chemical agents 182
2003	Skin diseases (except cancer) 849	Hearing loss 608	Allergic bronchial asthma 360	Infectious diseases 203	Respiratory diseases caused by chemical agents 182
2004	Skin diseases (except cancer) 863	Hearing loss 697	Allergic bronchial asthma 387	Infectious diseases 197	Respiratory diseases caused by chemical agents 193
2005	Hearing loss 784	Skin diseases (except cancer) 743	Allergic bronchial asthma 327	Asbestosis 194	Respiratory diseases caused by chemical agents 187
2006	Hearing loss 909	Skin diseases (except cancer) 747	Allergic bronchial asthma 312	Respiratory diseases caused by chemical agents 210	Asbestosis 185

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2002	Hearing loss 507	Skin diseases (except cancer) 374	Infectious diseases 175	Allergic bronchial asthma 116	Respiratory diseases caused by chemical agents 81
2003	Hearing loss 409	Skin diseases (except cancer) 264	Infectious diseases 123	Allergic bronchial asthma 117	Respiratory diseases caused by chemical agents 68
2004	Hearing loss 440	Skin diseases (except cancer) 268	Allergic bronchial asthma 122	Infectious diseases 100	Respiratory diseases caused by chemical agents 71
2005	Hearing loss 532	Skin diseases (except cancer) 224	Allergic bronchial asthma 119	Respiratory diseases caused by chemical agents 73	Infectious diseases 66
2006	Hearing loss 594	Skin diseases (except cancer) 220	Allergic bronchial asthma 109	Respiratory diseases caused by chemical agents 81	Mesotheliomas 76

rapportanglais.indd 45 17/02/09 12:12:19

Belgium (private sector only)

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2001	Osteoarticular diseases 2,119	Hearing loss 615	Asbestos-related diseases 445	Skin diseases 420	Silicosis 364
2002	Osteoarticular diseases 2,197	Hearing loss 634	Asbestos-related diseases 420	Skin diseases 402	Silicosis 311
2003	Osteoarticular diseases 2,280	Hearing loss 597	Skin diseases 427	Asbestos-related diseases 374	Silicosis 299
2004	Osteoarticular diseases 2,348	Hearing loss 605	Skin diseases 398	Asbestos-related diseases 368	Silicosis 314
2005	Osteoarticular diseases 1,595	Hearing loss 553	Asbestos-related diseases 381	Skin diseases 381	Silicosis 242
2006*	Back diseases 1,455	Hearing loss 634	Nerve function impairment due to pressure 628	Asbestos-related diseases 366	Upper limb osteoaticular disorders 362

* Some statistical codes and designation of pathologies changed in 2002 and 2005 concerning MSDs.

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2001	Osteoarticular diseases 1,132	Skin diseases 462	Hearing loss 221	Asbestos-related diseases 207	Nerve paralysis due to pressure 145
2002	Osteoarticular diseases 1,263	Skin diseases 477	Nerve function impairment due to pressure 278	Hearing loss 206	Asbestos-related diseases 180
2003	Osteoarticular diseases 961	Skin diseases 364	Nerve function impairment due to pressure 327	Hearing loss 297	Asbestos-related diseases 207
2004	Osteoarticular diseases 478	Skin diseases 267	Hearing loss 234	Nerve function impairment due to pressure 197	Asbestos-related diseases 166
2005	Osteoarticular diseases 338	Nerve function impairment due to pressure 293	Hearing loss 258	Skin diseases 256	Asbestos-related diseases 170
2006*	Nerve function impairment due to pressure 292	Skin diseases 249	Hearing loss 234	Asbestos-related diseases 180	Upper limb osteoaticular disorders 179

* Some statistical codes and designation of pathologies changed in 2002 and 2005 concerning MSDs.

rapportanglais.indd 46 17/02/09 12:12:19

Denmark

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	MSDs	Hearing loss	Back diseases	Skin diseases	Psychosocial disorders
2001	MSDs 5,579	Hearing loss 1,925	Back diseases 1,510	Skin diseases 1,389	Psychosocial disorders 1,048
2002	MSDs 5,021	Hearing loss 1,798	Back diseases 1,481	Skin diseases 1,304	Psychosocial disorders 1,165
2003	MSDs 4,994	Hearing loss 1,571	Psychosocial disorders 1,394	Back diseases 1,310	Skin diseases 1,233
2004	MSDs 5,368	Psychosocial disorders 2,004	Hearing loss 1,717	Back diseases 1,435	Skin diseases 1,224
2005	MSDs 7,003	Psychosocial disorders 2,508	Back diseases 1,759	Hearing loss 1,695	Skin diseases 1,313

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Skin diseases	Hearing loss	MSDs	Respiratory diseases	Cancers
2001	Skin diseases 713	MSDs 511	Hearing loss 468	Respiratory diseases 178	Cancers 100
2002	Skin diseases 892	Hearing loss 437	MSDs 407	Respiratory diseases 157	Cancers 105
2003	Skin diseases 1,247	MSDs 513	Hearing loss 463	Respiratory diseases 238	Cancers 109
2004	Skin diseases 806	MSDs 526	Hearing loss 297	Respiratory diseases 164	Cancers 112
2005	Skin diseases 768	MSDs 593	Hearing loss 314	Respiratory diseases 241	Cancers 135

rapportanglais.indd 47 17/02/09 12:12:19

Spain

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	MSDs 16,019	Skin diseases 2,043	Respiratory diseases 450	Infectious and parasitic diseases 429	Diseases caused by chemical agents 361
2001	MSDs 18,601	Skin diseases 2,084	Respiratory diseases 521	Diseases caused by chemical agents 480	Infectious and parasitic diseases 435
2002	MSDs 20,653	Skin diseases 1,969	Respiratory diseases 570	Infectious and parasitic diseases 502	Diseases caused by chemical agents 433
2003	MSDs 22,906	Skin diseases 2,079	Diseases caused by chemical agents 433	Respiratory diseases 410	Infectious and parasitic diseases 410
2004	MSDs 24,814	Skin diseases 2,004	Hearing loss 490	Infectious and parasitic diseases 463	Respiratory diseases 461
2005	MSDs 26,224	Skin diseases 1,989	Hearing loss 577	Respiratory diseases 513	Infectious and parasitic diseases 347
2006	MSDs 18,963	Skin diseases 1,405	Hearing loss 578	Respiratory diseases 345	Infectious and parasitic diseases 302

rapportanglais.indd 48 17/02/09 12:12:20

France

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2004	MSDs	Abestos-related diseases	Back diseases	Hearing loss	Skin diseases
2005	MSDs	Abestos-related diseases	Back diseases	Hearing loss	Skin diseases
2006	MSDs	Abestos-related diseases	Back diseases	Hearing loss	Skin diseases

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	MSDs (back diseases excluded) 19,862	Asbestos-related diseases 3,621	Back diseases 2,608	Hearing loss 607	Eczema due to allergy 540
2001	MSDs (back diseases excluded) 23,621	Asbestos-related diseases 5,134	Back diseases 2,812	Hearing loss 634	Eczema due to allergy 565
2002	MSDs (back diseases excluded) 28,531	Asbestos-related diseases 5,885	Back diseases 2,897	Hearing loss 642	Eczema due to allergy 530
2003	MSDs (back diseases excluded) 30,847	Asbestos-related diseases 6,134	Back diseases 2,928	Hearing loss 907	Eczema due to allergy 562
2004	MSDs (back diseases excluded) 33,648	Asbestos-related diseases 7,197	Back diseases 2,872	Hearing loss 1,354	Eczema due to allergy 522
2005	MSDs (back diseases excluded) 38,271	Asbestos-related diseases 7,698	Back diseases 2,986	Hearing loss 1,177	Eczema due to allergy 522
2006 provisional figures	MSDs (back diseases excluded) 38,000	Asbestos-related diseases 6,615	Back diseases 2,785	Hearing loss 1,056	Eczema due to allergy 443

rapportanglais.indd 49 17/02/09 12:12:20

Italy

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Hearing loss 11,492	Respiratory diseases 3,505	MSDs 3,380	Skin diseases 1,773	Cancers 1,001
2001	Hearing loss 10,131	MSDs 4,202	Respiratory diseases 3,293	Skin diseases 1,626	Cancers 1,272
2002	Hearing loss 6,670	MSDs 4,248	Respiratory diseases 2,996	Cancers 1,323	Skin diseases 1,210
2003	Hearing loss 6,185	MSDs 4,738	Respiratory diseases 2,933	Cancers 1,415	Skin diseases 1,092
2004	Hearing loss 6,891	MSDs 6,774	Respiratory diseases 2,952	Cancers 1,554	Skin diseases 1,161
2005	MSDs 8,659	Hearing loss 6,765	Respiratory diseases 3,304	Cancers 1,864	Skin diseases 1,156
2006	MSDs 9,803	Hearing loss 6,063	Respiratory diseases 2,877	Cancers 1,796	Skin diseases 953

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Hearing loss 3,521	Respiratory diseases 1,055	MSDs 1,016	Skin diseases 952	Cancers 503
2001	Hearing loss 3,716	MSDs 1,371	Respiratory diseases 1,300	Skin diseases 942	Cancers 633
2002	Hearing loss 3,661	Respiratory diseases 1,698	MSDs 1,692	Skin diseases 852	Cancers 763
2003	Hearing loss 3,281	MSDs 1,750	Respiratory diseases 1,546	Skin diseases 777	Cancers 739
2004	Hearing loss 3,051	MSDs 2,105	Respiratory diseases 1,258	Cancers 739	Skin diseases 723
2005	Hearing loss 2,613	MSDs 2,456	Respiratory diseases 1,164	Cancers 810	Skin diseases 576
2006	MSDs 2,647	Hearing loss 2,183	Respiratory diseases 873	Cancers 767	Skin diseases 465

rapportanglais.indd 50 17/02/09 12:12:20

Luxembourg

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Infectious diseases	Periarticular diseases	Hearing loss	Skin diseases	Carpal tunnel syndrome
2001	Infectious diseases	Hearing loss	Periarticular diseases	Carpal tunnel syndrome	Skin diseases
2002	Infectious diseases	Hearing loss	Periarticular diseases	Skin diseases	Respiratory diseases
2003	Infectious diseases	Periarticular diseases	Carpal tunnel syndrome	Hearing loss	Asbestosis
2004	Infectious diseases	Periarticular diseases	Hearing loss	Carpal tunnel syndrome	Asbestosis
2005	Periarticular diseases	Hearing loss	Carpal tunnel syndrome	Diseases caused by vibrations	Asbestosis
2006	Periarticular diseases	Infectious diseases	Asbestosis	Carpal tunnel syndrome	Hearing loss
2 007	Infectious diseases	Periarticular diseases	Hearing loss	Asbestosis	Carpal tunnel syndrome

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Skin diseases	Respiratory diseases	Carpal tunnel syndrome	Hearing loss	Periarticular diseases
2001	Hearing loss	Periarticular diseases	Asbestosis	Carpal tunnel syndrome	Respiratory diseases
2002	Infectious diseases	Respiratory diseases	Hearing loss	Bursitis	Periarticular diseases
2003	Infectious diseases	Asbestosis	Periarticular diseases	Silicosis	Carpal tunnel syndrome
2004	Asbestosis	Carpal tunnel syndrome	Periarticular diseases	Skin diseases	Silicosis
2005	Periarticular diseases	Asbestosis	Carpal tunnel syndrome	Hearing loss	Infectious diseases
2006	Infectious diseases	Asbestosis	Carpal tunnel syndrome	Periarticular diseases	Skin diseases
2 007	Infectious diseases	Carpal tunnel syndrome	Asbestosis	Periarticular diseases	Hearing loss

The insurance organisation hasn't provided statistical data for each pathology.

rapportanglais.indd 51 17/02/09 12:12:20

The 5 diseases giving rise to the greatest number of declarations as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	MSDs 3,116	Psychosocial disorders 1,484	Hearing loss 861	Respiratory diseases 288	Dermatologic disorders 100
2001	MSDs 2,698	Psychosocial disorders 1,517	Hearing loss 735	Respiratory diseases 257	Neurological disorders 115
2002	MSDs 2,278	Hearing loss 1,344	Psychosocial disorders 1,159	Respiratory diseases 221	Dermatologic disorders 98
2003	MSDs 2,333	Hearing loss 1,520	Psychosocial disorders 1,406	Respiratory diseases 259	Dermatologic disorders 122
2004	MSDs 2,214	Psychosocial disorders 1,582	Hearing loss 1,389	Respiratory diseases 226	Dermatologic disorders 87
2005	MSDs 2,236	Hearing loss 1,545	Psychosocial disorders 1,336	Respiratory diseases 180	Dermatologic disorders 93
2006	MSDs 2,164	Hearing loss 1,555	Psychosocial disorders 1,228	Respiratory diseases 154	Neurological disorders 96
2007	MSDs 2,443	Hearing loss 1,868	Psychosocial disorders 1,192	Dermatologic disorders 188	Respiratory diseases 111

rapportanglais.indd 52 17/02/09 12:12:21

Portugal

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Pulmonary diseases	Hearing loss	MSDs	Skin diseases	Ocular diseases
2001	MSDs	Hearing loss	Pulmonary diseases	Skin diseases	Other diseases
2002	MSDs	Pulmonary diseases	Hearing loss	Skin diseases	Ocular diseases
2003	MSDs	Pulmonary diseases	Skin diseases	Hearing loss	Ocular diseases
2004	MSDs	Hearing loss	Pulmonary diseases	Skin diseases	Ocular diseases
2005	MSDs	Hearing loss	Pulmonary diseases	Skin diseases	Allergies
2006	MSDs	Hearing loss	Pulmonary diseases	Skin diseases	Other diseases

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Silicosis	Hearing loss	Diseases caused by physical factors	Skin diseases	Other lung diseases
2001	Diseases caused by physical factors	Respiratory diseases	Skin diseases	Diseases due to chemical agents	Other diseases
2002	Diseases caused by physical factors	Respiratory diseases	Skin diseases	Diseases due to chemical agents	Other diseases
2003	MSDs	Hearing loss	Respiratory diseases	Skin diseases	Other diseases
2004	MSDs	Hearing loss	Respiratory diseases	Skin diseases	Other diseases
2005	MSDs	Hearing loss	Respiratory diseases	Skin diseases	Other diseases
2006	MSDs	Hearing loss	Respiratory diseases	Skin diseases	Other diseases

The insurance organisation hasn't provided statistical data for each pathology, except for recognised cases of hearing loss.

rapportanglais.indd 53 17/02/09 12:12:21

Sweden

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Diseases due to ergonomic factors	Hearing loss	Diseases due to other physical factors	Psychosocial disorders	Diseases due to chemical agents
2001	Diseases due to ergonomic factors 11,092	Psychosocial disorders 1,011	Hearing loss 633	Respiratory diseases 495	Skin diseases 368
2002	Diseases due to ergonomic factors 11,886	Psychosocial disorders 1,508	Hearing loss 676	Diseases due to other physical factors 541	Respiratory diseases 455
2003	Diseases due to ergonomic factors 12,722	Psychosocial disorders 1,883	Hearing loss 776	Diseases due to other physical factors 658	Skin diseases 334
2004	Diseases due to ergonomic factors 11,429	Psychosocial disorders 2,161	Diseases due to other physical factors 691	Hearing loss 677	Respiratory diseases 383

The statistical system changed in 2005; since then, it is no longer possible to classify the claims for recognition according to the type of pathology.

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	MSDs	Hearing loss	Skin diseases	Respiratory diseases	Diseases due to other physical factors
2001	MSDs 4,409	Hearing loss 250	Respiratory diseases 222	Skin diseases 207	Psychosocial disorders 146
2002	MSDs 4,174	Hearing loss 337	Respiratory diseases 220	Skin diseases 187	Psychosocial disorders 177
2003	MSDs 3,650	Hearing loss 346	Psychosocial disorders 238	Skin diseases 168	Diseases due to other physical factors 152
2004	MSDs 3,575	Hearing loss 408	Psychosocial disorders 213	Skin diseases 155	Respiratory diseases 140
2005	MSDs 3,965	Hearing loss 500	Psychosocial disorders 347	Respiratory diseases 173	Digestive system diseases 156
2006	MSDs 3,126	Hearing loss 440	Psychosocial disorders 307	Digestive system diseases 221	Respiratory diseases 156

rapportanglais.indd 54 17/02/09 12:12:21

Switzerland

The 5 diseases giving rise to the greatest number of claims for recognition

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Disorders of locomotor apparatus 1,347	Skin diseases 1,308	Important hearing loss 903	Infectious diseases 690	Respiratory diseases 418
2001	Disorders of locomotor apparatus 1,272	Skin diseases 1,188	Infectious diseases 747	Important hearing loss 691	Respiratory diseases 389
2002	Disorders of locomotor apparatus 1,147	Skin diseases 1,018	Important hearing loss 818	Infectious diseases 727	Respiratory diseases 366
2003	Disorders of locomotor apparatus 1,089	Skin diseases 913	Infectious diseases 902	Important hearing loss 816	Respiratory diseases 355
2004	Disorders of locomotor apparatusr 980	Important hearing loss 890	Infectious diseases 879	Skin diseases 816	Respiratory diseases 356
2005	Skin diseases 931	Disorders of locomotor apparatus 916	Important hearing loss 899	Infectious diseases 750	Respiratory diseases 343
2006	Important hearing loss 1,080	Disorders of locomotor apparatus 890	Skin diseases 843	Infectious diseases 788	Respiratory diseases 429

The 5 diseases most frequently recognised as occupational diseases

Year	Nr 1	Nr 2	Nr 3	Nr 4	Nr 5
2000	Skin diseases 1,169	Disorders of locomotor apparatus 935	Important hearing loss 676	Infectious diseases 639	Respiratory diseases 293
2001	Skin diseases 1,081	Disorders of locomotor apparatus 874	Infectious diseases 695	Important hearing loss 504	Respiratory diseases 264
2002	Skin diseases 919	Disorders of locomotor apparatus 779	Infectious diseases 691	Important hearing loss 642	Respiratory diseases 262
2003	Skin diseases 808	Infectious diseases 765	Disorders of locomotor apparatus 739	Important hearing loss 647	Respiratory diseases 253
2004	Infectious diseases 857	Skin diseases 723	Important hearing loss 696	Disorders of locomotor apparatus 691	Respiratory diseases 256
2005	Skin diseases 820	Infectious diseases 699	Important hearing loss 698	Disorders of locomotor apparatus 613	Respiratory diseases 259
2006	Important hearing loss 855	Infectious diseases 760	Skin diseases 752	Disorders of locomotor apparatus 583	Respiratory diseases 340

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The goal of the **EUROPEAN FORUM**, founded in 1992, is to promote and safeguard the principle of a specific insurance against accidents at work and occupational diseases; moreover, it monitors actively the process of convergence between the systems in place. The European Forum commits itself actively to improving the situation of workers in Europe who have suffered from an accident at work or an occupational disease and therefore is playing a significant part in creating a Europe of the future that is socially just.
Today, members come from sixteen countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Luxembourg, Norway, Poland, Portugal, Russia, Spain, Sweden and Switzerland. The presidency of the European Forum rotates each year.

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EUROGIP is the link between the French Social Security system and Europe in the area of occupational risks: it analyses developments at the community level and in the other EU countries and puts forward the viewpoint of the Social Security system.
Since 1991, this public interest grouping have informed the social partners and Social Security personnel, performed comparative surveys, taken part in projects of community interest and acted energetically to make the occupational risk prevention voice heard both in the standardisation bodies and by the notified bodies.

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